Course work notes: Module 3 The context of mental health and human rights

Overall Learning Objective:
To develop an understanding of human rights framework as applied to persons with mental disabilities

Rationale: People with mental disabilities have been subject to human rights violations throughout history. Mental health legislation can play an important role in preventing human rights violations and promoting rights based approach to the treatment and care of persons with mental disabilities. There is an international (United Nations) human rights framework and in some parts of the world also a regional human rights framework that impose obligations on governments to respect and protect human rights, including the rights of people with mental disabilities. These human rights frameworks are a critical means of promoting the rights of people with mental disabilities and guiding the development of national mental health laws, policies, services and strategies.

Module Content:

a. Introduction
b. Link between human rights and mental health
c. Human rights violations of persons with mental disabilities in institutions and community
d. UN human rights conventions, standards and instruments
e. Regional human rights conventions, standards and instruments
f. Key rights of people with mental disorder and international human rights provisions to protect them
g. The rights of families and caregivers

A. INTRODUCTION

People with mental disabilities around the world are exposed to a wide range of human rights violations. The stigma surrounding mental disabilities means that mental health issues remain low on the political agenda of governments and consequently people do not have access to adequate and appropriate mental health care services. In addition, many people living in psychiatric institutions are exposed to inadequate, degrading and harmful care and treatment as well as unhygienic and inhuman living conditions.

Beyond the health care context, violations and discrimination also occur in the community context, with people all over the world facing discrimination in the fields of education, employment and housing. Some countries even prohibit people from voting, marrying or having children (*Module 3 below, along with other Modules of the Diploma, examine these violations in greater detail*).

The international (United Nations) and regional human rights frameworks described below represent an important means of promoting and protecting the rights of people with mental disabilities. Human rights are afforded to *all* people on the basis of their humanity and consequently people with mental disabilities too, are entitled to the enjoyment of the same human rights, in equal measure, as all other people.

International human rights law place duties on governments to a) respect human rights, that is, refrain from infringing on rights; b) Protect human rights, that is, states have a duty to take action to prevent violations by third parties; and c) fulfil human rights, which requires states to adopt appropriate legislative, administrative budgetary, judicial and other measures to promote human rights.
This module will explore some of the human rights violations experienced by people with mental disabilities, describe the international and regional framework for promoting and protecting human rights and examine key human rights standards that are relevant to the area of mental health. Finally, this module will touch on issues related to families and caregivers of people with mental disabilities.

First, this Module will explore in greater detail the relationship and interaction between human rights and mental health.

B) INTERACTION BETWEEN HUMAN RIGHTS AND MENTAL HEALTH:

Human rights and mental health are both important approaches to advancing human well-being[1]. Yet the widespread stigma surrounding people with mental disabilities (that they are dangerous, violent and in need of confinement and seclusion) means that government policies, laws and strategies regarding mental health often erroneously emphasize the need for protection of the general public from these individuals rather than highlighting the need to provide treatment, rehabilitation and protection for this vulnerable population. Because many current approaches to mental health rest upon the use of this outdated model, where objectives can only be achieved through deprivation of liberty and coercion, human rights and mental health are often perceived to be at odds with one another. In reality, mental health programs and human rights are two important tools that can advance and improve human health.

There are three main relationships between mental health and human rights: mental health policy affects human rights, human rights violations affect mental health, and positive promotion of mental health and human rights are mutually reinforcing.[2]

The first relationship is that mental health policies, legislation and programs can promote, or conversely violate, human rights by the way in which they are designed or implemented. Mental health policies and legislation allow the exercise of government power to restrain, treat and deprive individuals of basic rights. Although the mental health powers associated with these policies and laws can be exercised for the welfare of the individual, family and society, as mentioned above, these powers can also give rise to human rights violations when they are exercised arbitrarily, discriminatorily or without procedural protections.[3]

The second relationship stems from the fact that violations of human rights can adversely affect the mental health of persons with mental disabilities in direct and indirect ways. Extreme forms of human rights violations, including rape, torture, genocide and inhuman and degrading treatment, cause direct, obvious and serious mental health problems for victims. However, there is not enough attention given to the extent to which mental health problems persist following a severe human rights violation. Such abuses often result in lifelong suffering, including anxiety, stress and depression, in the individual, his or her family and the community at large.

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[1] Gostin L. Human Rights of Persons with Mental Disabilities: The European Convention of Human Rights. *International Journal of Law and Psychiatry.* Volume 23(2), 2000, 125-159 at 127.

[2] Ibid.

[3] Ibid.

However, it is not just extreme forms of human rights violations that have a negative impact on the mental health of the population. Over the last decade, for example, the link between poverty and increased risk of mental disabilities has become more apparent.[4] Unemployment, limited educational opportunities, lack of food, shelter and access to healthcare, including health insurance, restrict one's ability to be active and productive members of society, to realize one's potential and ultimately to be mentally and physically healthy. The negative social and economic factors associated with poverty also act as barriers to access of mental health care services. Additionally, stigmatization and discrimination against people with mental disabilities can adversely affect mental health. The negative repercussions, along with the sense of alienation and loneliness that comes from discrimination, can deeply affect a person's dignity and self-worth which is detrimental to mental health and well-being.[5]

Restrictions in civil liberties such as the right to vote, to take part in public affairs, to express one's opinion, to seek, receive and impart information, freedom of association, assembly and movement can also adversely affect the mental health of a population. Without these freedoms an individual cannot participate in the community, be part of the decision-making process on issues that impact their lives, or improve their social and economic standing. This too negatively impacts mental health.[6]

The third relationship is that mental health and human rights are inextricably linked.[7] A minimum level of both human rights and mental health are necessary for people to lead lives that allow them to completely integrate and participate in society. Some level of mental health is important for the exercise of human rights as those who maintain a reasonable level of well-being may more fully engage in political and social life. Similarly, human rights are essential to the promotion of sound mental health since they provide protection from harm and the freedom to participate in society. Mental health is dependent upon the realization of fundamental human rights, including the right to health, non-discrimination, privacy, work, education, integration and participation. Without these rights secured, maintaining a high level of mental health almost impossible.[8]

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[4] *World Health Report,* Geneva, World Health Organization, 2001

[5] See, e.g., Hendrick A. Disabled Persons and their Right to Treatment: Allowing Differentiation while ending Discrimination. *Health and Human Rights,* 1995, 1: 152, Neufeldt A. H. & Mathieson R. Empirical Dimensions of Discrimination Against Disabled People. *Health and Human Rights,* 1995, 1: 174.

[6] Gostin, L. Human Rights of Persons with Mental Disabilities: The European Convention of Human Rights. *International Journal of Law and Psychiatry,* 2000, 23(2): 125-159 at 127.

[7] Ibid.

[8] Ibid.

C) HUMAN RIGHTS VIOLATIONS OF PEOPLE WITH MENTAL DISABILITIES

As briefly outlined above, people with mental disabilities are susceptible to having their rights violated on several fronts. The low priority of mental health on national agendas means mental health services in many parts of the world are poorly funded, inadequate and not easily accessible to the people who need them. Some countries have hardly any services, while in others services are available only to certain segments of the population[9]. This violates the right to the highest attainable standard of physical and mental health, a right which should be afforded to everyone without discrimination.[10] In some countries mental health services are paid for out-of-pocket and people simply can't afford to seek treatment and care. Health insurance schemes in many countries specifically exclude payment for mental health care or offer lower levels of coverage for shorter periods of time. This also violates the right to mental health as it is discriminatory and creates economic barriers to accessing mental health services.

The stigma associated with mental disabilities means that many people become completely ostracised from society. Isolation and rejection leaves people feeling hopeless and alone. They descend into poverty as they fail to receive the treatment and care they require. Many become homeless. In some countries mental illness is considered to be a magical, supernatural event, caused by spirits that take over the body. People with mental disabilities are considered dangerous or contagious and are abandoned by their families. As a consequence they are physically exiled from society all together – they are banished to the edge of town where they are chained to tree trunks, left alone, semi-naked or in rags, hidden from the rest of the society. Some are beaten and left with little food to 'purge the evil spirits' through physical suffering[11].

Many people living in psychiatric institutions fare little better. Indeed many such institutions are more like human warehouses than places of care and treatment. Conditions in many of these facilities are miserable. The buildings are decrepit and filthy, lacking even basic sanitation and hygiene standards. People do lack proper clothes, clean water, food, heating, decent bedding or privacy. The extract from a letter sent to WHO below captures some of the appalling conditions to be found in psychiatric institutions around the world.

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[9] WHO Resource Book on Mental Health, Human Rights and Legislation, Geneva 2005

[10] This right is guaranteed by Article 25 of the UN Convention on the Rights of Persons with Disabilities, discussed in detail later in this module and in the module on Access to Care.

[11] Humble beginnings: Grégoire Ahongbonon and the St Camille Association, See WHO Photo Essay - Denied Citizens: mental health and human rights.
http://www.who.int/features/2005/mental_health/en/index.html

“The conditions there are miserable. As soon as I entered there I was overwhelmed by a nightmarish atmosphere: dirty patients; dishevelled and very skinny [patients] surrounded me asking me for some bread. As for the building, it is pitiful to look at: many broken glasses, walls without painting for many years and, worse, not even one bed per patient, hence the need to sleep on mattresses placed directly on the floor.…The toilets, totally out of order, without running water. Most of the time cooking is done with water caught from the rain. The worst was, and remains, the problem of food. For one year now, I go every week.…only to see on the plates of the inmates pig’s feet or heads….”
“Through several conversations and letters I tried to improve the lives of those poor inmates, whose lives have already been stricken enough by their destiny and do not need to made worse by other men… (S)omeone has even answered me: “Why are you fighting that much? This place is but the waste of society.”

Source: Letter to WHO from a concerned mother about the conditions in the ‘sanatorium’ to which her son was admitted, extracted from *Voices from the Shadows: A selection of letters addressed to the World Health Organization 1994 – 2002,* WHO, Geneva, 2004.

Many people living in psychiatric institutions are exposed to inhumane or degrading treatment, including physical, sexual and mental abuse and neglect. Abusive use of seclusion and restraints are common practice in certain facilities; Residents are locked away in small, prison-like rooms for long periods of time with no human contact. Sometimes, adults as well as young children are locked up in caged beds, confined, and with no hope of movement day after day.[12]

In some institutions, adults and children are subjected to violence and rape — sometimes at the hands of the very people who should be caring for them[13]. These practices often go unreported and unpunished, leaving the perpetrators free to continue the abuse.

Three girls of 12-13 years of age were found to be locked in a very small cold barren room on this cold winter day and they were naked. The reason for locking them was that they had tried to escape from the institution. The institution director told the parliamentarians that girls were there for a few hours but it was found out that they had been there for the last 12 hours. One of the girls had diabetes.
Source: Behind Closed Doors: Human Rights Abuses in the Psychiatric Facilities, Orphanages and Rehabilitation Centers of Turkey, Mental Disability Rights International, 2005

[12] Students should review different international NGO reports for example:
a) Mental Disability Advocacy Center (MDAC) (2003). *Caged Beds: Inhuman and Degrading Treatment in Four EU Accession Countries,* Budapest, Mental Disability Advocacy Center.
b) Mental Disability Rights International (2005) *Behind Closed Doors: Human Rights Abuses in the Psychiatric Facilities, Orphanages and Rehabilitation Centers of Turkey*
c) Mental Disability Rights International (2004) *Human Rights and Mental Health in Peru*
d) : Behind Closed Doors: Human Rights Abuses in the Psychiatric Facilities, Orphanages and Rehabilitation Centers of Turkey, Mental Disability Rights International, 2005
[13] Ibid

A patient detained in one of the seclusion rooms appeared over-drugged, his eyelids heavy and drool dripping from his mouth. He was banging a plastic cup against the seclusion room door and pleading, almost incoherently, for water. Investigators informed staff at the nursing station a few feet away, and within sight, that the individual in detention wanted water. Staff responded that they would get to it, and continued talking among themselves.
Source: Mental Disability Rights International (2004) Human Rights and Mental Health in Peru

Many people living in institutions receive no form of stimulation, and spend days, months and even years living in excruciating boredom. Some people are over-medicated so that they remain docile and 'easy to manage'. This aimlessness, inactivity, and social isolation is not conducive to recovery, and is inhuman and degrading[14].
People find themselves languishing in these institutions, deprived of their liberty, for weeks, months or even years. They are inappropriately admitted and treated against their will, as issues concerning consent for admission and treatment are ignored, and independent assessments of incapacity are not always undertaken. They lack access to legal processes and mechanisms which means their involuntary internment is not reviewed by an independent body and that they do not have the possibility to appeal against decisions to involuntarily admit or treat them. Nor do they have access to complaints mechanisms should they wish to report human rights violations being committed against them.

People with mental disabilities face human rights violations and discrimination not only within the health care context but in all areas of their lives. Many, for example, are discriminated against in seeking employment and others are dismissed from their jobs because of their mental illness. Others are restricted in their access to educational opportunities. Most basic rights, such as the right to vote, to a fair trial and due process of law, to marry, or to have children are routinely denied to people with mental disabilities. Many are also prevented from engaging in financial transactions such as signing cheques. As such, they are prevented from fully integrating into society and engaging in social, economic and political life.[15]

People with mental disabilities are often inappropriately detained in prisons. Indeed in many countries the rate of mental disabilities in prisons is

[14] Ibid
[15] *WHO Resource Book on Mental Health, Human Rights and Legislation.* Geneva, World Health Organization, 2005

disproportionately high. This is in large part due to the widespread misconception that all people with mental disabilities are a danger to the public and to the general intolerance of many societies to difficult or disturbing behaviour. Consequently many people with mental disabilities are incarcerated for minor misdemeanours or for causing a public disturbance, instead of being diverted away from the criminal justice system and towards mental health services. In some countries, people are locked up in prisons simply because there is a lack of mental health services to provide them with treatment. With so many people inappropriately imprisoned, mental disabilities continue to go unnoticed, undiagnosed and untreated[16].

D) INTERNATIONAL (UN) AND REGIONAL HUMAN RIGHTS SYSTEMS

The international human rights system, comprising of the UN system as well as several regional systems, are a critical tool in addressing the broad spectrum of human rights violations experienced by people with mental disabilities around the world.

The sections below describe both the key UN and regional human rights instruments relevant to the rights of people with mental disabilities as well as the different UN and regional treaty monitoring bodies, which are responsible for overseeing the implementation the different legally binding human rights instruments.

The UN human rights system [17]

1. Legally binding UN instruments
    a. *International Bill of Rights*

The major international human rights instruments within the UN system, known collectively as the International Bill of Rights, are: the Universal

[16] WHO and ICRC Information Sheet on Mental Health and Prisons. http://www.who.int/mental_health/policy/mh_in_prison.pdf

[17] The below paragraphs are extracts from the WHO Mental Health and Human Right; Health and Human Rights Publication Series Issue No. 6 (to be published in 2007) and the WHO Resource Book on Mental Health, Human Rights and Legislation (WHO 2005)

Declaration of Human Rights (**UDHR**)[18] adopted in 1948; the International Covenant on Economic, Social and Cultural Rights (**ICESCR**)[19] and the International Covenant on Civil and Political Rights (**ICCPR**)[20] both adopted in 1966. Since then, numerous treaties, declarations and other legal instruments have been adopted. Although most of these do not make specific reference to disabilities or mental health, they apply to all people. Many of these provisions are especially relevant to people with mental disabilities.

The **UDHR** states that all humans are "born free and equal in dignity and rights." Among the rights enshrined under the UDHR are several that are of particular relevance to people with mental disabilities. These include the rights to equality before the law; to freedom from torture and cruel, inhuman or degrading treatment; the right to employment and to remuneration ensuring "an existence worthy of human dignity"; the right to education, and the right to share in the cultural life of the community and to benefit from scientific advancements. Many of these most basic rights are routinely denied to people with mental disabilities.

The two International Covenants (the **ICESCR and the ICCPR**) address many of the same rights found in the UDHR but in some instances expand them significantly.[21] The ICESCR elaborates on a number of economic, social and cultural rights. For instance, Article 12 requires governments to recognize and take steps to respect, protect and fulfil the right of everyone to the highest attainable level of physical and mental health and General Comment 14 of the ICESCR provides guidance on what measures need to be taken by governments for this to be achieved.[22] General Comment 5 of the ICESCR also provides advice on rights of persons with disabilities, including those with mental disabilities.[23]

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[18] *Universal Declaration of Human Rights* (1948). Adopted and proclaimed by UN General Assembly Resolution 217 A (III) of 10 December 1948 (UDHR). http://www.unesco.org/shs/human_rights/hrbc.htm

[19] *International Covenant on Economic, Social and Cultural Rights* (1966). Adopted by UN General Assembly Resolution 2200A(XXI) of 16 December 1966; entered into force 23 March 1976 (ICESCR). Geneva, Office of the United Nations High Commissioner for Human Rights (ICESCR). http://www.unhchr.ch/html/menu3/b/a_cescr.htm

[20] *International Covenant on Civil and Political Rights* (1966). Adopted by UN General Assembly Resolution 2200A (XXI) of 16 December 1966; entry into force 23 March 1976, in accordance with Article 49. Geneva, Office of the United Nations High Commissioner for Human Rights (ICCPR). http://www.unhchr.ch/html/menu3/b/a_ccpr.htm

[21] Gostin L, Gable L (2004). The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health. *Maryland Law Review.* Volume 63(1), 20-121 at 33.

[22] United Nations Economic and Social Council, Committee on Economic, Social and Cultural Rights. *Substantive issues arising in the implementation of the International Covenant on Economic, Social and Cultural Rights, General Comment No. 14 (2000) The Right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights).* Geneva, United Nations, 2000 (E/C.12/2000/4).

[23] United Nations Economic and Social Council, Committee on Economic, Social and Cultural Rights. *Persons with Disabilities, General Comment 5 (1994).* Geneva, Office of the High Commissioner for Human Rights, paragraph 34.

In recognition that economic and social rights, including the right to health, are more likely to require the investment of resources and to require government planning and reform (eg. To reform laws, policies and practices) the ICESCR creates a requirement of progressive realization – this creates *immediate* obligations on governments to begin planning ("to undertake to take steps") to bring about the full enforcement of the rights recognized under the ICESCR. However, there are aspects of the ICESCR which also create immediate obligations on States Parties to the convention (for example, the principle of non-discrimination has immediate effect).

The ICCPR also contains important rights relevant to people with mental disabilities. These include the right to freedom from torture and cruel, inhuman or degrading treatment or punishment, the right to liberty and security of person, the right to recognition as a person before the law, right to privacy, the right to marry and found a family, as well as freedom of thought, conscience and religion among others.

Governments have a legal obligation to take actions that protect the fundamental human rights of people with mental disabilities and the International Bill of Rights contain important norms and principles which need to be considered in the design of mental health laws, policies, services and strategies. The vast majority of countries around the world have signed up to one or both of the Covenants.

In addition to the ICCPR and the ICESCR, the UN human rights system includes five other important legally binding human rights treaties: The Convention on the Elimination of All Forms of Racial Discrimination (1963); the Convention on the Elimination of All Forms of Discrimination Against Women (1979); the Convention on the Rights of the Child (1989); the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1984); and the UN Convention on the Rights of Persons with Disabilities (2006) (discussed in detail below). Each of the legally binding UN treaties has its own monitoring body established to oversee Member State compliance with the instrument.

b. *The Convention on the Rights of Persons with Disabilities*

In August, 2006 the General Assembly adopted the first UN convention enshrining the rights of persons with disabilities through the **Convention on the Rights of Persons with Disabilities (CRPD).** The CRPD is the first human rights convention of the 21st century and the first legally binding instrument with comprehensive rights and protections for individuals with disabilities. The CRPD opened for signature on March 30, 2007 with a record

number of 82 member states signing on that day. After receiving the 20th ratification on April 3, 2008, the CRPD entered into force. Thirty days later, the Optional Protocol to the CRPD, the international treaty establishing the implementation and monitoring bodies for the CRPD, also came into force.[24]

The CRPD outlines the rights of persons with disabilities as well as the obligations of State parties to promote and protect these rights. The CRPD requires countries to ensure that people with disabilities, including mental disabilities, are granted equality under the law and freedom from discrimination. It also requires governments to prevent people with disabilities from being deprived of their liberty "unlawfully or arbitrarily." The CRPD also states that legal protections on freedom of expression and the right to privacy are extended to those with disabilities.

In addition to prohibiting active violation of the human rights of people with mental disabilities by ratifying governments, the CRPD also places several affirmative requirements on them. For example, it requires governments to promote access to health care and rehabilitation services. It also requires governments to "take all appropriate measures to promote the . . .recovery" of people with disabilities who become victims of exploitation, violence or abuse. It also puts an obligation on governments to take steps to help people with disabilities remain integrated in their communities. Specific articles will be discussed below.

2. Non- binding UN standards

The UN Covenants and Conventions mentioned above are legally binding upon states that sign up to them. In addition to these, there are a number of international instrument (discussed below) dealing specifically with disability and mental illness, which though not legally binding nevertheless represent a consensus of international opinion and can serve to guide the interpretation of treaties.

The UN Principles for the Protection of Persons with Mental Illness (**MI Principles**)[25] are a detailed international statement of the rights of persons with mental illness. The MI Principles include a wide range of commitments relating to standards of care and treatment, including the right to medication,

[24] For further information on the CRPD and up to date information regarding the ratification process, students should see the UN Enable website at http://www.un.org/disabilities/

[25] *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*. UN General Assembly Resolution 46/119 of 17 December 1991 (MI Principles).

the right to consent to treatment, the treatment of minors and criminal offenders, the review of involuntary admissions, access to medical information, complaints, monitoring and remedies for abuses.[26] The Principles also recognize the inherent problems of protecting human rights in an institutional setting and therefore state that care for persons with mental disabilities should, as far as possible, be in community-based and primary care settings. Many countries have used the MI principles as a basis for developing their national mental health strategies, including Mexico, Hungary, Costa Rica, Portugal and Australia[27].

The MI Principles have, however, been subject to some criticism. In 2003 the UN Secretary-General in a report to the General Assembly noted that the MI Principles *"offer in some cases a lesser degree of protection than that offered by existing human rights treaties, for example with regard to the requirement for prior informed consent to treatment. In this regard, some organizations of persons with disabilities, including the World Network of Users and Survivors of Psychiatry, have called into question the protection afforded by the Principles (and in particular, principles 11 and 16) and their consistency with existing human rights standards in the context of involuntary treatment and detention."* [28]
It is important to note that provisions of the CRPD supersede the MI Principles. The MI Principles will no longer be considered relevant to the extent that they conflict or are inconsistent with the more recent and legally binding CRPD articles. However, where the MI Principles are in agreement with the CRPD, these principles can be useful to achieve a more in-depth understanding of the human rights of individuals with mental illness.
The **Declaration on the Rights of Disabled Persons** outlines an extensive list of rights including the rights to "medical, psychological and functional treatment" and economic and social security.[29] The **Standard Rules** on the Equalization of Opportunities for Persons with Disabilities, adopted in 1993, contain a broad range of obligations to ensure that equal opportunities are available to persons with disabilities in all fields. The 22 provisions set out requirements in relation to health care, rehabilitation, support services, awareness-raising, education, employment, family life, policy-making and legislation.[30] As non-binding instruments, these are also superseded by the CRPD.

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[26] See reference under footnote 37 at paragraph 25.
[27] T*he Role of International Human Rights in National Mental Health Legislation.* World Health Organization, Geneva, 2001. (http://www.who.int/mental_health/resources/policy_services/en/)
[28] United Nations (2003). Progress of efforts to ensure the full recognition and enjoyment of the human rights of persons with disabilities. *Report of the Secretary-General, to the United Nations General Assembly* A/58/181, July 2003.

[29] See reference under footnote 52 at 40.
[30] See reference under footnote 37 at paragraph 25.

3. Technical standards

In addition to these UN human rights standards, UN agencies, world conferences, and professional groups meeting under UN auspices have adopted a broad array of technical guidelines and policy statements. These can be a valuable source of interpretation of international human rights conventions. It is important to note that these pre-date the CRPD and may not always be in agreement with the provisions of the CRPD. Again, where there is conflict, the CRPD will supersede these standards.

The **Declaration of Caracas** (1990), adopted as a resolution by legislators, mental health professionals, human rights leaders and disability activists convened by the Pan American Health Organization (PAHO/WHO), has major implications for the structure of mental health services (see Annex 4). It states that exclusive reliance on inpatient treatment in a psychiatric hospital isolates residents from their natural environment, thereby generating greater disability. The Declaration establishes a critical link between mental health services and human rights by concluding that outmoded mental health services put service users' human rights at risk. The Declaration aims to promote community-based and integrated mental health services by suggesting a restructuring of existing psychiatric care. It states that resources, care and treatment for persons with mental disabilities must safeguard their dignity and human rights, provide rational and appropriate treatment, and strive to maintain persons with mental disabilities in their communities. It further states that mental health legislation must safeguard the human rights of persons with mental disabilities, and services should be organized so as to provide for enforcement of those rights.

International associations of mental health professionals have also attempted to protect the human rights of persons with mental disabilities by issuing their own sets of guidelines for standards of professional behaviour and practice. An example of such guidelines is the **Declaration of Madrid** adopted by the General Assembly of the World Psychiatric Association (WPA) in 1996 (see Annex 5).

In 2005, WHO developed the **WHO Resource Book** on Mental Health, Human Rights and Legislation, which is a core text for this Diploma. The WHO Resource Book provides information to countries on key international human rights standards related to mental health. It also provides practical guidance on what needs to go into a mental health law, and strategies for developing and adopting mental health law as well as ensuring its effective implementation. The Resource Book has been translated into French, Spanish,

Arabic, Hindi, German, Portuguese and Chinese and is being used by countries around the world in the reform of their mental health law.

Another important WHO technical standard is the Mental Health Care Law: **Ten Basic Principles** (1996). This publication sets out a number of clear principles that should guide the development of mental health laws. In addition, WHO also developed Guidelines for the Promotion of Human Rights of Persons with Mental Disabilities, which is a tool to help understand and interpret the MI Principles.

WHO in collaboration with other partners, is also currently in the process of developing an instrument to provide guidance to countries on setting mechanisms to monitor human rights in mental health facilities. This instrument, which uses the CRPD as its framework, will also contain practical tools for assessing whether the rights of people with mental disabilities are being protected.

4. UN treaty monitoring bodies

The major UN human rights covenants and conventions which are legally binding, have treaty-based supervisory bodies. The body responsible for overseeing the ICESCR is the **Committee on Economic, Social and Cultural Rights** and the body responsible for the ICCPR is the **Human Rights Committee**. The CRPD will be monitored by the **Committee on the Rights of Persons with Disabilities.** Governments that ratify the covenants and conventions agree to submit progress reports on a regular basis to the treaty bodies on the steps that they have taken to implement the convention – through changes in legislation, policy, or practice. Non-governmental organizations can also submit information for review by supervisory bodies. Supervisory bodies review both the official and non-governmental reports and publish their findings, which may include a determination that governments have not met their international obligations under the convention. The international supervisory and reporting process thus provides an opportunity to educate the public about a specialized area of rights. This process can also be a powerful way to pressure governments to realize convention-based rights.

Another mechanism for monitoring human rights in the United Nations system is the newly established UN Human Rights Council, created in 2006 as part of the overall UN reform. This Council replaces the UN Human Rights Commission, which was the UN's principal mechanism for examining, monitoring and publicly reporting on human rights conditions in specific countries and on major phenomena of human rights violations worldwide.

The Commission was widely criticized for being excessively bureaucratic, political, and ineffective.

The new Human Rights Council is elected by the General Assembly of the UN and conducts periodic reviews of the human rights records of all UN Member States. The Council meet for 10 weeks of the year, which is almost twice the meeting time of its predecessor. It has greater regional and local representation to facilitate stronger monitoring and more systematic ongoing reporting by countries.

One of the positive features of the Commission retained by the Human Rights Council is the appointment of Special Rapporteurs and other independent experts and working groups to monitor and report on thematic human rights issues (including health, disability and torture).

What is the role of Special Rapporteurs in relation to mental health?

1. **The Special Rapporteur on the Right to Health**

In 2002, the UN Commission on Human Rights appointed a Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, including the right to the highest attainable standard of mental health.

The Human Rights Council, by its decision 1/102 of 30 June 2006, extended all mandates of the former Commission on Human Rights, including that of the Special Rapporteur. As such, the rapporteur's task is to work in cooperation with States, inter-governmental organizations and civil society; to report on the status of the right to health around the world; and to make recommendations on appropriate measures to promote and protect the right to health.

In 2005, the Special Rapporteur furnished a report on Mental Disability and Human Rights. In this report, the Rapporteur discussed, *inter alia*, the inadequate budgets that countries give to mental health services, inappropriate institutionalization of persons with mental disabilities, poor conditions and

abuse in psychiatric facilities, high rates of suicides in prisons, inappropriate admission and treatment of people without their consent and stigmatization of mental disabilities. To address this, the Special Rapporteur recommended increased attention for mental health by policy and lawmakers and that more resources, including a greater percentage of country's health budgets, go towards mental health. It was further suggested that there should be sustained and independent monitoring of mental health care. As an overall guiding principle, the Special Rapporteur recommended that a human rights approach, focused on participation, autonomy, dignity and inclusion, should guide all mental health matters and actions.

On a country level, the Special Rapporteur investigates mental health potential rights violations by inspecting psychiatric facilities. On the basis of recent investigations, the Special Rapporteur has observed obvious disparities between international and domestic human rights obligations and the reality of available mental health care. Very poor conditions have been observed in psychiatric hospitals, and there has been a noted lack of lack of rehabilitation and community-based mental health services. From these observations, a range of recommendations have been made, including involving people with mental disabilities and their families in the development and implementation of mental health policy, providing more resources for mental health care, making services more available and accessible, and making appropriate mental health services available to persons in detention.

From June 2008 Mr Anand Grover from India has taken on the function of UN Special Rapporteur on the Right to Health

2. The Special Rapporteur on Disability

The Special Rapporteur on Disability has the task of monitoring the implementation of the Standard Rules on Equalization of Opportunities for Persons with Disabilities (discussed above). The rapporteur reports annually to the UN Commission for Social Development, a functional commission of the UN Economic and Social Council. The reports present findings on the promotion and monitoring of the implementation of the Standard Rules and present recommendations, as requested by the Commission, on their further development. As such, the Rapporteur's work will have direct significance to the implementation of the CRPD since the content of the Standard Rules and the CRPD overlap.

For more information, see http://www.un.org/esa/socdev/enable/rapporteur.htm

Legally binding UN human rights instruments and the Committees that monitor them

UN human rights instruments	Committee
International Covenant on Civil and Political Rights (ICCPR)	Human Rights Committee (HRC)
International Covenant on Economic, Social and Cultural Rights (ICESCR)	Committee on Economic, Social and Cultural Rights (CESCR)
Convention on the Rights of Persons with Disabilities (CRPD)	Committee on the Rights of Persons with Disabilities.
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment	Committee Against Torture (CAT)
Convention on the Elimination of All Forms of Discrimination against Women	Committee on the Elimination of All Forms of Discrimination against Women (CEDAW)
Convention on the Rights of the Child	Committee on the Rights of the Child (CRC)
International Convention on the Elimination of All Forms of Racial Discrimination	Committee on the on the Elimination of All Forms of Racial Discrimination (CERD)

5. Regional human rights systems[31]

In a number of regions of the globe there are systems for promoting and enforcing human rights. People may bring complaints against governments in relation to provisions of regional conventions that they feel are being violated and regional commissions or courts established to oversee these conventions consider and rule accordingly. The paragraphs below describes these regional systems.

Africa

The **African Charter on Human and People's Rights** (Banjul Charter) which came into being in 1986 is a legally binding document supervised by the **African Commission** on Human and People's Rights. The Charter entitles everyone to a range of human rights (several of which are particularly relevant to people with mental disabilities) including the right to equality before the law; the right to human dignity and freedom from all forms of exploitation and degradation; the right to appeal and the right to defence,

[31] The paragraphs below are extracted from the draft WHO instrument for monitoring the protection and promotion of the human rights of people with mental disabilities (not yet published)

including the right to be defended by counsel of one's choice. Moreover, every person has the right to enjoy the best attainable state of physical and mental health and states are required to take the necessary steps to protect the health of their people and ensure that they receive medical attention when they are sick. In 2004, a protocol establishing the **African Court** on Human and People's Rights entered into force and in 2006 judges were appointed to the Court.

Example of a ruling by the African Commission on Human and People's Rights on human rights and mental health

The Gambia

Purohit and Moore brought a case to the African Commission on Human and People's Rights claiming that the law on Mental health in the Gambia was outdated, that there were no provisions or requirements establishing safeguards during diagnosis, certification and detention of service users, that there was overcrowding in the psychiatric unit and that there was no requirement of consent to treatment or subsequent review of continued treatment.

The commission found the Republic of the Gambia in violation of a number of its Articles and strongly urged the Gambia to:-

- Repeal the Lunatics Detention Act and replace it with new human rights oriented legislation
- Create an expert body to review cases of all persons detained under the legislation
- Provide adequate medical and material care for persons with mental disabilities.

The Commission requested the Gambia to report back to the African Commission on measures taken to comply with the recommendations.

Source: Purohit and Moore/The Gambia 241/2001, Sixteenth Annual Activity report on the African Commission of Human and People's Rights, 2002-2003

The Americas

There are a number of treaties and conventions in the region of the Americas which protect and promote human rights, including the rights of people with mental disabilities. For example, the American Declaration of the Rights and Duties of Man (1948), the American Convention on Human Rights (1978), the Additional Protocol to the American Convention on Human Rights in the field of Economic, Social and Cultural Rights (1986) and the Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities (2001) all protect human rights including the rights of people with mental disabilities. The **Inter-American Convention on the Elimination**

of all Forms of Discrimination against Persons with Disabilities, which was adopted in 1999, is the first international convention (prior to the CRPD) that specifically addresses the rights of people with mental disabilities. The Inter-American Commission on Human Rights (IACHR) and the Inter-American Court of Human Rights are responsible for overseeing the Inter American Convention on Human Rights.

Example of an action by the Inter-American Commission on Human Rights (IACHR)

In 2003 the Mental Disability Rights International (MDRI) brought a petition before the Inter-American Commission on Human Rights (IACHR) challenging ongoing abuses in Paraguay's Neuro Psychiatric Hospital.

The IACHR ruled that emergency measures had to be taken to protect the lives and dignity of those living in the institution. This was the first time that the IACHR taken an emergency measure to protect the lives of people detained in a psychiatric institution. (MDRI, 2004). Following this ruling in 2005 MDRI signed an accord with the Paraguayan government on a plan, timetable and funding for a process of deinstitutionalization and WHO/PAHO is providing technical assistance for this reform.

The Inter-American Commission has since ruled for mental health changes in Panama, Ecuador and Brazil.
Example of a ruling by the Inter-American Court of Human Rights.

Damião Ximenes Lopes vs. Brazil

In 1999 a Brazilian citizen submitted a petition to the American Commission on Human Rights against the Federal Republic of Brazil alleging violations of the American Convention on Human Rights committed against her brother, who died after being admitted for psychiatric treatment. It was alleged that Mr Damiao Ximenes Lopes was tortured and physically maltreated before his death. In 2002 it was agreed that all domestic remedies for resolving the case had been exhausted and all other criteria for the Inter-American Court of Human Rights hearing the case had been met. The case was duly heard and in 2006 the Inter-American Court ruled in favour of the deceased victim and his family.

Europe

Europe too, has a number of human rights conventions. For example the Convention for Protection of Human Rights and Fundamental Freedoms – the ECHR (1953): the Convention on Human Rights and Biomedicine (1997); The Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment; European Social Charter (1996) The European

Court of Human Rights oversees the ECHR, provides interpretation to its provisions and also hears and rules on cases brought before it.

Example of an action by the European Court of Human Rights

1. *Rakevich vs. Russia*

In 2003, the European Court of Human Rights found that elements of Russian law and practice were in contravention of Article 5 (the right to liberty and security of person) of the ECHR. In the case of Rakevich vs. Russia, the claimant charged, among other things, that while being involuntarily detained, she lacked the right of appeal and that her case was not speedily determined before a court.

The Court found in her favour on these counts, and stated that the Russian Law on Psychiatric Care does not adequately integrate the right of appeal in the case of involuntary detention to a mental health facility.

Source: Moscow Helsinki Group, The First Legal Action of the European Court on Human Rights on a Case of Involuntary Hospitalization in Russia and its Impact on the Russian Justice, 2003. http://www.mhg.ru/english/3AEC6AF

2. *Shtukaturov v. Russia*

On March 27, 2008, the European Court of Human Rights held Russia in violation of numerous articles of the ECHR in the case of a young man with mental health disabilities. The applicant, Mr. Shtukaturov, was deprived of legal capacity in 2004 following a request from his mother, and was eventually detained in hospital.

In its judgment, the European Court of Human Rights found several violations of the ECHR, including the following:

- deprivation of legal capacity constitutes a "very serious" interference of a person's private life, since it is applied indefinitely and cannot be challenged by the person under guardianship (Article 8)
- a mental illness cannot be the sole reason to justify stripping someone of legal capacity and Russian law is disproportionate in allowing this to happen without making provision for a tailor-made response (Article 8)
- the guardianship proceedings were unfair because they wholly excluded Mr Shtukaturov (Article 6)
- deprivation of legal capacity is not a ground to deprive a person of their liberty (Article 5(1))
- every person who is detained, including those who have been deprived of their legal capacity, should have the right to pursue independently a legal review to challenge their detention (Article 5(4))

Source: Mental Disability Advocacy Center, European Court of Human Rights First Section Case of Shtukaturov v. Russia Judgment, 2008. http://www.mdac.info/en/node/145.

D) KEY RIGHTS OF PEOPLE WITH MENTAL DISABILITIES AND INTERNATIONAL HUMAN RIGHTS PROVISIONS TO PROTECT THEM[32]

The section below highlights some of the key rights contained in international human rights instruments that are of particular relevance to people with mental disabilities. Many of the rights discussed below are also expanded upon in different Modules of the Diploma.

1. Right to the highest attainable standard of physical and mental health

Article 12 of the ICESCR establishes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". Article 25 of the CRPD expands this, stating that "persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability".

The right to health requires countries to take specific steps to protect and promote health. The *right to health* or *to mental health* is also enshrined in the MI Principles and other human rights instruments and contains several dimensions that are particularly pertinent to people with mental disabilities:

<u>Access to Appropriate and Professional Services</u>: The right to health under Article 12 of the ICESCR entails a right of people with mental disabilities to services that are (a) available (b) accessible (c) acceptable and of (d) appropriate and good quality[33]. To be appropriately available, services must be provided in "sufficient quantity" by "trained medical and professional personnel." The concept of accessibility goes beyond physical access – it also requires that services be affordable and available in a non-discriminatory manner. The requirement that services be "acceptable" means that they must be provided in a manner that is culturally appropriate and respectful of medical ethics. For services to be of appropriate quality, they must also be culturally acceptable, medically appropriate, and provided in a safe and clean environment.

[32] The paragraphs below are extracted from WHO's *The Role of International Human Rights in National Mental Health Legislation.* Geneva, World Health Organization, Department of Mental Health and Substance Dependence.

[33] General Comment 14 of the ICESCR. One of the most important sources of interpretation of human rights conventions is the guidelines, known as General Comments, produced by human rights oversight bodies (also referred to as treaty-based committees) to guide governments in the preparation of their official reports. General comments are non-binding, but they represent the official view as to the proper interpretation of the convention by the human rights oversight body. For more information on these four aspects, see Module 10 and the 2005 report of the UN Special Rapporteur on the right to health.

The CRPD also requires that State Parties provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health (Article 25(a)). The inclusion of this provision is very important, requiring positive action from State Parties since it mandates the creation of these mental health services.

These services must be delivered without discrimination on the basis of disability. Discrimination of this type in regards to the provision of health and life insurance must also be prohibited.

Right to individualized treatment: Article 25 of the CRPD emphasizes the right to individualized treatment. In particular, State Parties are required to ensure access for persons with disabilities to health services that are gender sensitive, and also to provide services specifically because of these individuals' disabilities, including early identification and intervention, and services designed to minimize and prevent further disabilities. Article 26 also states that habilitation and rehabilitation services must be based on a multidisciplinary assessment of individual needs and strengths.

The MI Principles can be useful in further elaborating this right. Principle 9(2) states that "[t]he treatment and care of every patient shall be based on an individually prescribed plan discussed with the patient, reviewed regularly, revised as necessary and provided by professional staff." MI Principle 8 recognizes that, within health care systems, a person with mental disabilities "shall have the right to receive such health and social care as is appropriate to his or her health needs." Medication "shall meet the best health needs of the patient...." In addition to treatment that is individualized to meet a particular person's health needs, the treatment of every person must also be "suited to his or her cultural background."[34]

The right to individualized treatment entails an obligation on governments to provide professional services tailored to individual needs (a) in the best judgment of professionals but also (b) respecting the preferences of the individual receiving services. Thus, one of the goals and requirements of individualized treatment is respect for individual choice in treatment. This is a key principle underlying the right to informed consent to treatment as established in Article 25(d) of the CRPD.

[34] General Comment 14, ¶ 47, *see also* note 21, MI Principle 7(3).

Right to habiliation and rehabilitation: In Article 26 of the CRPD, State Parties are obligated to take measures to enable persons with disabilities to attain and maintain their maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. In particular, habilitation and rehabilitation services must begin at the earliest possible stage, be voluntary, and be available to persons with disabilities as close as possible to their own communities, including in rural areas. Under Article 3, respect for autonomy is stated as a General Principle of the CRPD. The profound importance of this principle cannot be overemphasized. As discussed above, throughout the world people are placed in custodial facilities where the mental health or social services system functions to keep a person alive but essentially gives up on the hope that a person has any potential to develop his or her skills or return to the community. By recognizing a right of every person to services that maximize independence and full inclusion in all aspects of life, the CRPD raises expectations to a level that cannot be met by custodial care alone.

General Comment 5 of the ICESCR also emphasizes the right to have access to services which enable people to become independent and integrate into society. Furthermore, this right recognized in both the Declaration on the Rights of Mentally Retarded Persons (MR Declaration) and the MI Principles. The MR Declaration recognizes a right of each person to the medical care, therapy, education, and training "as will enable him to develop his ability and maximum potential" and "to care and treatment in accordance with the same standards as other ill persons." MI Principle 9(4) recognizes that "[t]he treatment of every patient shall be directed towards preserving and enhancing personal autonomy."

Right to community-based services: The major emphasis throughout the CPRD is on ensuring that people with disabilities are able to enjoy their rights of autonomy, liberty, and self-determination. As such, the CRPD emphasizes the right to community-based services and the systems necessary to promote and maintain this right. Article 19 recognizes the right of all persons with disabilities to live in the community, and requires State Parties to facilitate disabled individuals' full inclusion and participation in the community. In particular, Article 19 of the CRPD recognizes the right of all disabled individuals to choose their place of residence and to have access to "in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community". The ability of people with disabilities to live in the community must be facilitated by making community and health services and facilities available on an equal basis to people with disabilities as to others (Article 19(c); Article 25). Health services

in particular should be as close as possible to the communities in which people live (Article 25(c)).

As mentioned above, Article 26 requires that all habilitation and rehabilitation services support inclusion in the community. These services also must be provided as close as possible to people's own communities, including in rural areas.

In many countries, the absence of adequate community programs and services for persons with mental illness leads to an unnecessary reliance on institutions to provide care and treatment. Admission to these facilities is usually necessitated not so much by the clinical condition of the person but by the absence of any other alternative. Once in the institution, the same lack of community alternatives serves to retain people in the institution long after their psychiatric condition has stabilized and they could function in the community if adequate services and supports were available. This common condition, in which people who no longer clinically require this level of service still occupy institutional beds, also makes mental health care inaccessible to many who need it because the available beds are full. In some institutions, long-term service users for whom there are no bona fide diagnoses of mental illness remain confined due simply to an absence of other alternatives. The doctrine of the least restrictive environment is meaningless unless States take affirmative steps to create less restrictive alternatives in the community to meet a range of needs that can be predicted. As General Comment 14 to the ICESCR recognizes, States can address the need for a range of community services needed to serve people with mental disabilities in their planning and budget development processes. "Such steps must be deliberate, concrete and targeted towards the full realization of the right to health."

The MI Principles also have a number of provisions that promote the right to the least restrictive type of services. Under MI Principle 9(1), every individual "shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others." While MI Principle 9(1) is controversial for its paternalistic tone and emphasis on the physical safety of others rather than the rights of people with mental disabilities, the right to treatment in the least restrictive environment is still considered important in the rights-based model for mental health legislation and policy. The principle of the least restrictive treatment is reinforced by the principle 9(4) requirement that "[t]he treatment of every patient shall be directed towards preserving and enhancing personal autonomy."

For more information on the least restrictive principle and community based treatment, see module 5; for more information on the right to live in the community, see module 10.

Protection of Human Dignity: Respect and protection of the right to dignity is pervasive throughout the CRPD. Indeed, in Article 1, the purpose of the present Convention includes to promote respect for the inherent dignity of persons with disabilities. Under Article 3, respect for inherent dignity is stated as a General Principle of the CRPD. Under Article 8, State Parties have an obligation to foster respect for the dignity of persons with disabilities. This general right to dignity can also be seen in the articles on freedom from torture or cruel, inhumane or degrading treatment or punishment (Article 15), freedom from exploitation, violence and abuse (Article 16), and protecting integrity of the person (Article 17).

Furthermore, the mandate of General Comment 5 to the ICESCR states that health services should be provided in such a way as to protect the "rights and dignity" of individuals with disabilities, placing a broad range of rights within institutions within the ambit of the right to health. The right to dignity is protected under the International Covenant on Civil and Political Rights (ICCPR) as well, reflecting the central importance of the concept of human dignity as a cornerstone from which all other rights proceed. There are a number of specific rights within mental health services that are particularly essential to this principle including the right to be treated as an individual. This recognition also permeates the MI Principles, particularly Principle 13.

2. Legal Capacity and Informed Consent

Free and informed consent forms the cornerstone of treatment for mental disabilities and is central to mental health legislation and the CRPD provides strong protections of this right. Under Article 5.1 of the CRPD, "all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law". Article 25(d) of the CRPD specifically "requires health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent." Article 12.2 provides that "State Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life", which relates to the provision in Article 12.1 that "persons with disabilities have the right to recognition everywhere as persons before the law." Therefore, all people with mental disabilities must be recognized as people with rights and responsibilities. Legal capacity is foundational to many of the rights guaranteed under the

CRPD; without it, individuals would not be able to exercise rights such as living in the community (Article 19) or participating in political and public life (Article 29).

Some disability rights groups have interpreted the CRPD as preventing State Parties from declaring individuals incapable of making legally effective decisions.[35] Certainly, the CRPD has brought about a paradigm shift away from the assumption that people with mental disabilities are incapable of making decisions into the presumption that they are capable.

This can be seen as an affirmation of support for supported decision making, rather than substitute decision making. The primary difference between these models is that supported decision making does not involve a loss of legal capacity on the part of the affected adult; instead, the individual retains his or her status as a juridical person. As such, this model more fully recognizes the protection of rights of people with disabilities. However, after lengthy debate on this issue during the negotiation of the CRPD, it was decided to leave the document silent by neither prohibiting nor endorsing substitute decision making. The CRPD has left the issue, and the related issues of informed consent and involuntary treatment and admission, open for interpretation and without regulation.[36] Formal guidance from the **Committee on the Rights of Persons with Disabilities** is needed to clarify this issue.

While the MI Principles are considered to be superseded by the CRPD and have long been considered problematic and subject to much controversy, they nevertheless provide useful guidance on the meaning of informed consent. Below are a number of key aspects of informed consent outlined in MI Principles 11:

a) Consent must be obtained freely, without threats or improper inducements.

b) There should be appropriate and adequate disclosure of information. Information must be provided on the purpose, method, likely duration and expected benefits of the proposed treatment.

c) Possible pain or discomfort and risks of the proposed treatment, and likely side-effects, should be adequately discussed with the patient.

d) Choices should be offered, if available, in accordance with good clinical practice; alternative modes of treatment, especially those that are less intrusive, should be discussed and offered to the patient.

e) Information should be provided in a language and form that is understandable to the patient.

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[35] See the position papers of the International Disability Alliance entitled "IDA CRPD Forum: Principles for Implementation of CRPD Article 12" and "Position Paper on the Convention on the Rights of Persons with Disabilities (CRPD) and Other Instruments". These are discussed in the article, *infra* note 37.

[36] Dhanda, A. Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future? *Syracuse Journal of International Law and Commerce,* 34(2007) 429-462.

f) The patient should have the right to refuse or stop treatment.
g) Consequences of refusing treatment, which may include discharge from the hospital, should be explained to the patient.
h) The consent should be documented in the patient's medical records

An important component of free and informed consent is access to information about health records. Free and informed consent can only be provided when a person has free and full access to their clinic records. This issue is discussed in more detail, below.

Advanced directives and proxy consent are discussed in detail in the WHO resource book on Mental Health Legislation and Human Rights at page 56.

3. Right to Liberty & Security of the Person

According to Article 14.1 of the CRPD, individuals with disabilities must be granted the right to liberty and security on an equal basis with others. In very clear and unambiguous terms, the CRPD states that "the existence of a disability shall in no case justify a deprivation of liberty".

As such, this can be understood to mean that the existence of a mental disorder on its own will never provide adequate grounds for detention, whether in a prison, hospital or other institution and that laws of each country will be required to specify additional criteria for deprivation of liberty. Often, this involves an assessment of risk or harm to self or others, or the commission of a crime. The detention itself must be carried out in compliance with such laws and procedural protections, such as judicial or other independent review, must be in place. Furthermore, Article 19.2 may require States to provide reasonable accommodation during detention in order for the protection of human rights to be on an equal basis with all others.

The International Disability Alliance (IDA) [37] has a different position on this matter, stating that *"Liberty is a fundamental right that must be recognized and enforced without discrimination. When separate standards or procedures are used to deprive people with disabilities of their liberty (such as compulsory institutionalization or hospitalization) this violates the equal enjoyment of human rights. CRPD Articles 3, 14, 19 and 25 are relevant… CRPD Article 14…requires states parties to ensure that "the existence of a disability shall in no case justify a deprivation of liberty" and by CRPD Article 19, which guarantees the right to live in the community and to choose where and with whom to live, on an equal basis with others.*[38] Thus the IDA position is that disability must under no circumstances form the basis for deprivation of liberty, either on its own or with other criteria such as risk or harm to self or others, or the commission of a crime.

While formal guidance from the **Committee on the Rights of Persons with Disabilities** is needed to clarify this issue, it is clear that involuntary admissions and treatment impinge on the right to liberty and to self-determination. Independent judicial mechanisms need to be established to safeguard against arbitrary involuntary detention and treatment, and complaints and formal appeals mechanisms should also be in place. Involuntary treatment is discussed in more detail as it relates to the right of persons with mental disabilities to be free from inhuman and degrading treatment, below.

4. **Freedom from discrimination**

The fundamental right to be free from discrimination cuts across all areas of mental health legislation and is recognized both in the UN Charter itself (articles 55-56) and the Universal Declaration of Human Rights, which protects "everyone". The right to be free from discrimination is also specifically invoked in the ICESCR, the ICCPR and the CRPD. Article 5.2 of the CRPD requires State Parties to "prohibit all discrimination on the basis of disability". Such discrimination is defined in Article 2 as any distinction, exclusion or restriction the basis of disability which has the purpose of effect of impairing the recognition or exercise of all human rights and fundamental freedoms.

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[37] The International Disability Alliance (IDA) is an international network representing several organizations working in the area of disability. IDA were actively involved in the drafting of the UN Convention on the Rights of Persons with Disabilities - **http://www.internationaldisabilityalliance.org/**

[38] See the position papers of the International Disability Alliance entitled "IDA CRPD Forum: Principles for Implementation of CRPD Article 12" and "Position Paper on the Convention on the Rights of Persons with Disabilities (CRPD) and Other Instruments".

The concept of non-discrimination is closely linked with the concept of equality stated in Article 1 of the Universal Declaration of Human Rights: "[a]ll human beings are born free and equal in dignity and rights." The protection against discrimination is, first and foremost, a promise that people with disabilities will enjoy the same legal rights as all other individuals. Article 26 of the ICCPR establishes that all persons are equal before the law and are entitled without any discrimination to equal protection from the law.

The UN Committee on Economic, Social, and Cultural Rights has made clear that the protection against discrimination on the basis of "other status" under article 2(2) of the ICESCR "clearly applies to discrimination on the grounds of disability." It is important to note that, unlike many of the "positive rights" created by the ICESCR, which are subject to "progressive realization," non-discrimination on the basis of disability is an obligation that is effective immediately. In the context of health care, the Human Rights Committee has emphasized a positive right to access services. Examples of the negative right to protections against discrimination include protections against restrictions on marriage and raising children, forced sterilization, exclusion from employment, using mental illness as grounds for divorce, limitations on voting rights, and other limitations on civil rights.

Protections against discrimination under international law go much further than simply outlawing laws that explicitly or purposefully exclude or deny opportunities to people with disabilities. Legislation that has the *effect* of denying rights and freedoms is discriminatory must be prohibited as well.

Article 5 of the CRPD focuses on non-discrimination. Article 5.1 states that State Parties should recognize that all persons are equal before the law and are entitled without discrimination to equal protection and equal benefit of the law. Article 5.2 puts a responsibility on State Parties to actively prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds. State law should therefore contain provisions for prohibiting discrimination on the grounds of mental disability. For example, mental health legislation and other legislation should:

a) ensure that there is no discrimination in the provision of health services to persons with disabilities as compared to persons without disabilities. This includes non discrimination in the quantity, access, and quality of services provided to persons with mental disabilities;

b) provide for penalties when there is discrimination against persons with mental disabilities by any service providers, in particular by health services providers;

c) protect against de facto and de jure discrimination; and

d) include provisions allowing persons with mental disabilities a right to appeal to the courts when there is such discrimination.

Reasonable Accommodation: The definition of discrimination provided in Article 2 of the CRPD includes "denial of reasonable accommodation". Reasonable accommodation is defined in Article 2 as "necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and freedoms." As such, there is a positive obligation on State Parties to identify any barriers to disabled individuals' exercise of human rights and take action to remove them, subject to the defence of disproportionate or undue burden. The reasonable accommodation duty will thus likely require State Parties to provide supports in the form of equipment and services, but will vary greatly between countries.

Affirmative Action: For people with mental or physical disabilities, the protection against discrimination would be of limited value if it only meant that people situated similarly are treated equally. Affirmative action measures differ from reasonable accommodation in that these are positive steps taken to enhance the status of certain minority groups, such as people with disabilities, to correct past injustices, rather than changes for disabled people that are meant to provide them with equal opportunities to those without disabilities. Under the ICCPR, special protections or "affirmative action" is permissible – and at times required – to bring about equal protection under the law.[39] Under the CRPD, "[s]pecial measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention" (article 5.4). As such, affirmative action measures that protect the rights of individuals with mental disabilities, such as quotas designed to increase representation of disabled persons in the workplace, are not prohibited.

Note that the coursework notes for Module 10 outline a number of additional rights outside of the health context that need to be protected in law in order to prevent discrimination against, and promote equality of opportunity for, people with mental disabilities.

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5. **Freedom from Inhuman and Degrading Treatment**

Article 7 in the ICCPR and Article 15.1 in the CRPD provide protection against inhuman or degrading treatment. This protection constitutes one of the most important protections under international human rights law for people with mental disabilities. Article 7 is such an important part of the ICCPR, it is designated as one of the provisions that is "non-derogable" – it can never be limited even under conditions of national emergency. Under the CRPD, States must take "all effective legislative, administrative, judicial or other measures" to prevent disabled people from being subjected to such treatment.

In recent years, the UN Human Rights Committee has taken a strong stand on the application of Article 7 of the ICCPR to all people in detention, including individuals in psychiatric facilities. When governments report on their actions to implement Article 7, the UN Human Rights Committee encourages governments to "address the conditions and procedures for providing medical and particularly psychiatric care. Information should be provided on detention in psychiatric hospitals, on measures to prevent abuses in this field, on appeals available to persons interned in a psychiatric institution and on any complaints registered during the reporting period."

We have seen how many people living in institutions are exposed to physical, mental or sexual abuse. Such treatment constitutes inhuman and degrading treatment and requires immediate action and remedy by governments. Similarly, the practice in some institutions, in which people are forced to perform institution maintenance labour without pay or in exchange for minor privileges (often due to a shortage of staff) also constitutes inhuman and degrading treatment and needs to be prevented as a matter of urgency.

Similarly, any individual who is forced to subject himself or herself to unsafe or unsanitary conditions just to be able to receive mental health treatment also requires protection. Some institutions may lack adequate food and clothing for all the residents; may be unable to provide adequate heat or warm clothing in the winter, leading to illness or death of residents, or may lack adequate health care and facilities to prevent the spread of contagious diseases. Such conditions can be considered inhuman and degrading and detrimental to both the physical and mental well-being of residents and require not only measures to prevent these abuses, but also measures that will ensure the provision of a safe and hygienic environment.

When abuses cause great suffering or personal degradation, they can constitute inhuman and degrading treatment in violation of Article 7 of the ICCPR and Article 15.1 of the CRPD.

Right to safe and hygienic environment: Persons with mental disabilities residing in mental health facilities are often subject to poor living conditions due to many factors, including among other things an unsafe or unhygienic environment due to poor sanitation, poor quality or unavailability of cleaning facilities, and rooms that are too warm or too cold. Such conditions violate internationally agreed norms for rights and conditions in mental health facilities. MI Principle 12 states that the environment in mental health facilities must be as close as possible to those of normal life.

Medical and scientific experimentation: In similar language to that of the second clause of Article 7 of the ICCPR , Article 15.1 of the CRPD goes on to state that "no-one shall be subjected without his or her free consent to medical or scientific experimentation." Such clear and strong language demonstrates that the drafters of the CRPD intended to link the protection against torture, inhuman and degrading treatment with protections against coercive and potentially dangerous medical practices.[40]

This provision of Article 15.1 is of great significance and widespread applicability. It has been a common and customary practice in many countries to use residents of institutions in scientific experimentation that requires the use of human subjects.[41] This is especially true in the area of experimentation involving new medications. Some of the drug trials may involve medications that are potentially beneficial to the person recruited for the trial; but others may involve medications of no direct benefit to the person while also posing a significant degree of risk or strong side effects. At a minimum, Article 15.1 would require that before a person is permitted to enroll in experimental treatment, a clinical determination must be made by a qualified professional that the person is competent to consent and does in fact provide consent based on a full disclosure of the risks and benefits. Article 15.1 does not provide for surrogate consent to experimentation upon an individual not capable of informed consent, and the concerns of the UN Human Rights Committee also argue strongly against consensual participation in non-therapeutic research due to the inherently coercive environment experienced by the institutionalized person.

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[40] The issue of medical and scientific research is also discussed in Module 7 of the Diploma.

[41] Clarence J. Sundram, *In Harm's Way: Research Subjects Who Are Decisionally Impaired*, J. HEALTH CARE L. & POLICY, Vol. 1, 36-65 (1998)

Involuntary treatment: Many people with mental disabilities are inappropriately treated against their will, as issues concerning consent for treatment are ignored, and independent assessments of incapacity to consent are not always undertaken. As discussed above, there is currently controversy regarding the CRPD's protection against involuntary treatment in relation to legal capacity and informed consent. The International Disability Alliance (IDA) an international network representing a number of different disability organizations, actively involved in the negotiations related to the drafting the CRPD, argue that forced psychiatric interventions violate the universal prohibition against torture, and that this prohibition, along with the CRPD's recognition of equal legal capacity and free and informed consent of persons with disabilities, require immediate cessation of forced psychiatric intervention. As such, the position of the IDA is that typical mental health legislation which sets out criteria for the imposition of forced psychiatric intervention is now unlawful.[42]

As discussed above, these are difficult questions, and the reality that forced psychiatric treatment and involuntary admissions are occurring and will continue to occur needs to be addressed. In many countries, the use of compulsory treatment is authorized where mental illness is considered to have rendered a person at risk to themselves or others (see Module 7 for more information on this issue). Indeed, some argue that governments have a duty to protect citizens from themselves or the larger community in exceptional situations such as these. Again the Committee on the Rights of Persons with Disabilities may need to provide guidance and clarification on this matter in the future.

Seclusion and Restraints: The seclusion and restraint of people in psychiatric facilities are common practices that may cause great degradation or suffering. The UN Human Rights Committee specifically mentions "prolonged solitary confinement" as a practice that may amount to a violation of Article 7 of the ICCPR. As such, this can logically be extended to constitute a violation of Article 15.1 of the CRPD as well.

The UN Special Rapporteur on Torture notes in his 2008 Interim report that poor conditions in institutions are often coupled with severe forms of restraint and seclusion and concludes that the prolonged use of restraints and of

[42] International Disability Alliance (IDA) Position Paper on the Convention on the Rights of Persons with Disabilities (CRPD) and Other Instruments, April 25, 2008
See also Minkowitz, T. The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Consensual Psychiatric Interventions. *Syracuse Journal of International Law and Commerce,* 34(2007) 405-428.

solitary confinement and seclusion, may amount to torture or ill-treatment in violation of the UN Convention on Torture and of Article 15 of the CRPD[43]. (See Module 7 for further discussion on this)

In addition to the protection offered by the prohibition against torture, Article 16 of the CRPD requires State Parties to take measures to protect disabled people from "all forms of exploitation, violence and abuse" which may occur within or outside of the home. Article 17 of the CRPD ensures that every "person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others."

The MI Principles state that "[p]hysical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facilities and only when it is the only means available to prevent *immediate or imminent harm* to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose." The MI Principles create a number of important standard that provide additional safeguards against the abusive use of seclusion and restraints. For example, they state that all cases must be recorded in the patient's medical record. Patients must also be kept under humane conditions and receive close and regular supervision by qualified members of staff. Furthermore, the patient's personal representative must receive prompt notification of the seclusion or restraint.

For an example of an action being undertaken in countries to protect and promote human rights for individuals with mental disabilities, see the box on the "Chain Free Initiative" below.

The Chain Free Initiative

The "Chain Free Initiative" is an example of a concrete action being undertaken in countries to protect and promote human rights for individuals with mental disabilities. A program started by the WHO Regional Office for the Eastern Mediterranean Region (EMRO), the objective of the Chain Free Initiative is to improve the dignity and rights of people with mental disabilities in psychiatric hospitals, in communities and in their homes.

Recognizing that restraints take different shapes, the initiative aims to put an end to the use of physical chains as means of restraining people with mental disabilities, and to move towards removing "invisible chains" such as stigma and discrimination. It aims to provide technical and financial support for: hospital reform (chain-free hospitals); enabling families and

[43] Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, July 2008 (A /63/175)

communities to provide improved domestic conditions for people with mental illness (chain-free homes); and the development of community care programmes, raising mental health literacy in the community and among health workers, and ensuring that basic rights are monitored and guaranteed (chain-free environment).
This initiative is currently a pilot project in Somalia and Afghanistan.
Http://www.emro.who.int/mnh/cfi_phases.htm Source: Behind Closed Doors: Human Rights Abuses in the Psychiatric Facilities, Orphanages and Rehabilitation Centers of Turkey, Mental Disability Rights International, 2005

Protection against Punishment: Like Article 7 of the ICCPR, Article 15.1 of the CRPD provides protection against not only inhuman or degrading treatment, but inhuman or degrading punishment. It is an unfortunate reality that, on occasion, methods of treatment may also be used as forms of punishment. These include electro-convulsive therapy (ECT) and the most common form of psychiatric treatment, psychotropic medications.

Indeed in some institutions, untrained and unsupervised ward staff have been known to use medications as a form of control over service users, to punish them for transgressions by sedating them to make them more manageable and reduce the demands upon limited staff to provide supervision or offer therapeutic programs. Principle 10 of the MI Principles prohibits the use of medication as a punishment or for the convenience of others.

In relation to ECT, the World Health Organization specifically states that this form of treatment should "be administered only after obtaining informed consent." [44] Furthermore, the use of "unmodified" ECT without anesthesia or muscle relaxants can create a serious risk of harm to people, including fractures and other injuries. This form of ECT should be prohibited in order to comply with the CRPD.

Right to privacy: Privacy is a broad concept limiting how far society can intrude into a person's affairs. It includes information privacy (confidentiality) bodily privacy, communication privacy (discussed above) and territorial (space) privacy. One of the most pervasive violations of human rights in psychiatric facilities is the violation of the right to territorial privacy, or the right to private space. People may be forced to live for years in dormitory-like wards with inadequate or no private space, where they are never able to have a moment of solitude. Where residents have a single or double room it may be that staff or other residents are easily able to enter into

[44] *Supra* note 9.

and violate the personal space. Residents may also have no secure place in which to keep their personal possessions or their clothing. Intimate meetings with friends, family, or even a spouse may be restricted. Communication with family or friends is often monitored, and letters are opened.

CRPD Article 22 provides strong protection for the right to privacy of people with mental disabilities, stating that "[n]o person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence…." The right to privacy is also protected as a right in and of itself under Article 12 of the UDHR and Article 17 of the ICCPR. CPRD Article 22 also protects against restrictions on communication or unlawful interferences with communications by persons with mental disabilities. All service users have the right to communication with the outside world without restriction with only exceptional circumstances, for example, when a person makes repeated unpleasant phone calls. It should be noted, however, that in many jurisdictions it is illegal for all people – not just people with mental disabilities – to make repeated unpleasant phone calls. In such a case the restriction on the right to communication (I.e. disallowing repeated unpleasant phone calls) is a general one that is applied equally to the whole population and whether or not there is an infringement on the right to privacy is not only an issue for people with mental disabilities.

Right to Confidentiality: In addition to a general right to privacy is the more specific right to confidentiality of medical records. Persons with mental disabilities have the right to expect that information about themselves, about their mental health problems and treatment will be kept confidential and not revealed to other third parties, including their carers and families, without their consent. The right to confidentiality applies to all information, including stored information whether physical or digital storage.

MI Principle 6 specifically protects the right to confidentiality of information. Also, Professional Codes of Conduct applicable to mental health professionals and others involved in care and treatment often contain rules relating to confidentiality of medical information and other information obtained in the clinical context. Other service providers who may obtain or store information should also have rules and systems in place to ensure that confidentiality is maintained. In particular, service providers should ensure that their physical and digital data systems are secure so that breaches of confidentiality – accidental or intentional – are avoided.

Many jurisdictions allow exceptions to breaches of confidentiality when there are life-threatening emergencies or a high likelihood of imminent harm to

others. Another exception is the release of clinical information to a court of law, usually in a criminal case, where the specific information is pertinent to the case. State Parties have the positive obligation to protect the privacy of personal, health and rehabilitation information of persons with disabilities; Article 12 of the UDHR and Article 17 of the ICCPR both recognize the right to privacy. In such circumstances the State must have laws in place to limit the release of information to only what is immediately relevant, and not a general release of all confidential information. Legislation should also have provisions to allow persons with mental disabilities and/or their personal representatives to ask the courts for a judicial review or to appeal any release of confidential information.

Right of Access to Information: Persons with mental disabilities have the right to free and full access to their clinical records. Some jurisdictions outline certain exceptional situations when withholding such information is allowed, for example in a situation when it is deemed that revealing clinical records of a person may put his/her safety or that of others at risk. Laws may also specify the right of the person concerned to be allowed to insert their comments in the medical records.

Article 21 of the CRPD states that States Parties are responsible for facilitating access to information for persons with disabilities in general: "Providing information intended for the general public to persons with disabilities in accessible formats and technologies appropriate to different kinds of disabilities in a timely manner and without additional cost." This entails that service users must have access to information about their treatment and care, including the different forms of treatment available to them as well as possible side-effects of these treatments. This is a requirement if people are to be able to make an informed decision about their care.

It is also essential that people with mental disabilities have access to information about their human rights
in order to be able to exercise them. Although legislation may promote and protect a number of rights of persons with mental disabilities, in many cases people are not informed of these rights. Law and policy must ensure that people are informed of and understand their rights. For instance, people should be given information about their rights as soon as possible on admission to a mental health facility or prior to administration of any treatment. This information should include an explanation of what the rights mean and how they may be exercised, and should be conveyed in such a way that people are able to understand it. In countries where several languages are spoken, the rights should be communicated in the person's language of choice.

Right to protection from forced labour and adequate remuneration for work: People have a right to be protected from forced labour. In some cases residents of psychiatric facilities are not given the choice to refuse work while in other cases they are not appropriately and adequately remunerated for work performed. A pervasive and abusive practice in mental health institutions is of staff making service users do their personal work in return for minor privileges.

For more information on the right to work, see module 10

6. **Families and Caregivers**

In many countries, families and carers assume many responsibilities for looking after persons with mental disabilities and often face similar stigma and discrimination. Affording explicit rights to family members and caregivers must be balanced with the right of a person with mental disabilities. When this balance is successfully achieved, the rights held by families and caregivers can increase the quality of community and home life of people with mental disabilities, can empower people with mental disabilities and their families, and can decrease stigma.

Access to information about mental illness: Family members and caregivers need information to be able to better able to care for people with mental disabilities where such care is necessary. This information should be provided in a language and manner that understandable to them. The right of family members and caregivers must be balanced against the right of the person with mental disabilities to confidentiality and privacy.

Access to training, counselling and financial assistance: Providing care for a person with mental disabilities can be financially as well as emotionally demanding. In some cases, caregivers and family members provide housing and food, and may also pay for expenses such as health insurance, medication, or counselling. A caregiver or family members may also have to take time from work to provide transportation to medical appointments, or prolonged emotional support or supervision, as necessary. Article 28 of the CRPD recognises the right of persons with disabilities *and their families* to social protection including measures to ensure access to State assistance for including adequate training, counselling, financial assistance and respite care.

Participation in Treatment Planning : Family members and caregivers should be given the authority to appeal against involuntary admission and treatment decisions on behalf of their relative, as well as to submit complaints to appropriate judicial bodies in instances in cases of human rights violations. Family members should, with the consent of the service user, also participate in the development of the treatment plan for their family member. Being involved in this way can increase families' and carers' understanding of mental health issues, treatment and care regimens, side effects etc. which can positively impact on the recovery of the person concerned.

Participation of families and carers in policy, planning, legislation and service development: Family members and carers very often have first hand experience of the mental health system and are in a key position to advise on ways to ensure services that meet the needs of service users and their families/carers. As such they have a fundamental role to play in the design of policies, plans, laws and services in this area.

Summary of the major provisions and international instruments related to the rights of people with mental disabilities

Human Right	International Instruments that govern this right
I) Freedom from torture or cruel, inhuman or degrading treatment or punishment	▪ International Covenant on Civil and Political Rights (ICCPR) ▪ Convention on the Rights of Persons with Disabilities (CRPD) ▪ Convention against torture and other Cruel, Inhuman or Degrading treatment or Punishment.
II) Right to an adequate standard of living for health	▪ CRPD ▪ International Covenant on Economic, Social and Cultural Rights (ICESCR)
III) Right to the enjoyment of the highest attainable standard of physical and mental health.	▪ ICESCR ▪ CRPD ▪ Convention on the Elimination of All Forms of Racial Discrimination; ▪ Convention on the Elimination of All Forms of Discrimination Against Women ▪ International Convention on the Rights of the Child
IV) Right to personal liberty and the security of person.	▪ ICCPR ▪ CRPD
V) Enjoyment of civil, cultural, economic, political and social rights.	▪ ICCPR ▪ ICESCR ▪ CRPD

Expected Outcomes:
At the end of the module, it is expected that students will have developed an understanding of the following:

1. The link between mental health and human rights
2. Human rights violations of persons with mental disabilities in institutions and community
3. International and regional human rights systems
4. Key international human rights standards related to people with mental disabilities

Core reading

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WNUSP position paper on the UN Principles for the Protection of People with Mental Illness http://www.wnusp.net/wnusp%20evas/Dokumenter/positionpaper.html

International Disability Alliance (IDA) Position Paper on the Convention on the Rights of Persons with Disabilities (CRPD) and Other Instruments, April 25, 2008

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Graham Thornicroft et. al. Reducing stigma and discrimination: candidate interventions. *International Journal of Mental Health Systems* 2008, 2:3 doi:10.1186/1752-4458-2-3 http://www.ijmhs.com/content/2/1/3

In addition, students should review reports of international non-governmental organizations including Mental Disability Rights International *http://www.mdri.org/and* Mental Disability Advocacy Center (*http://www.mdac.info/*) Reports include:

- Mental Disability Advocacy Center (MDAC) (2003). *Caged Beds: Inhuman and Degrading Treatment in Four EU Accession Countries*, Budapest, Mental Disability Advocacy Center.
- Mental Disability Rights International (2005) *Behind Closed Doors: Human Rights Abuses in the Psychiatric Facilities, Orphanages and Rehabilitation Centers of Turkey*
- Mental Disability Rights International (2004) *Human Rights and Mental Health in Peru*
- Mental Disability Rights International (2005) *Behind Closed Doors: Human Rights Abuses in the Psychiatric Facilities, Orphanages and Rehabilitation Centers of Turkey*

Further reading
Peter Lehmann and Peter Stastny (eds). Alternatives Beyond Psychiatry

Additional reading

Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, July 2008 (A /63/175)

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