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 disorders

Rationale: People with mental disorders 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 disorders. 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 disorders 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 disorders 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

A. INTRODUCTION

People with mental disorders around the world are exposed to a wide range of human rights violations. The stigma surrounding mental disorders 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 disorders. 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 disorders, 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.

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 disorders,

[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.

(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 them 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 in the way that 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 patients 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 to 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.

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 disorders 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 disorders 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]

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[2] Ibid.

[3] Ibid.

[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.

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 and creation 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]

C) HUMAN RIGHTS VIOLATIONS OF PEOPLE WITH MENTAL DISORDERS

As briefly outlined above, people with mental disorders are susceptible to having their rights violated on several fronts. Firstly, 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. 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 disorders 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 disorders are considered dangerous or contagious and are

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

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[10].

Many people living in psychiatric institutions fair 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.

"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."[11]

Many people living in psychiatric institutions are exposed inhumane or degrading treatment, including physical, sexual and mental abuse and neglect. Abusive use of seclusion and restraints are common practice in certain facilities; Patients 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]

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[10] 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

[11] 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

[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*

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

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 disorders face human rights violations and discrimination not only within the health care context but in all areas of their lives. Many, for example, are

d) : Behind Closed Doors: Human Rights Abuses in the Psychiatric Facilities, Orphanages and Rehabilitation Centers of Turkey, Mental Disability Rights International, 2005

[13] Ibid
[14] Ibid

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 disorders. 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 disorders are often inappropriately detained in prisons. Indeed in many countries the rate of mental disorders in prisons is disproportionately high. This is in large part due to the widespread misconception that all people with mental disorders are a danger to the public and to the general intolerance of many societies to difficult or disturbing behaviour. Consequently many people with mental disorders 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 disorders 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 disorders around the world.

The sections c and d below describe both the key UN and regional human rights instruments relevant to the rights of people with mental disorders 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]

Legally binding UN instruments

The major international human rights instruments within the UN system, known collectively as the International Bill of Rights, are: the Universal Declaration of Human Rights (UDHR)[18] adopted in 1948; the International Covenant on Economic,

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

[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)

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. Because of their special vulnerability, many of their provisions are especially relevant to people with mental disorders.

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 disorders. 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 disorders.

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. 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.[22] General Comment 5[23] of the ICESCR also provides advice on rights of persons with disabilities, including those with mental disabilities.

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

[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.

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 disorders. 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 familiy, 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 disorder 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 four other 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). In addition, a "Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities" is currently in the process of being drafted. Each of the six existing UN treaties has its own monitoring body established to oversee Member State compliance with the instrument.

In August, 2006 the General Assembly adopted the draft **UN Convention on Disability**. The ratification process for this legally binding convention begins in January, 2007. The convention contains several provisions directly relevant to people with mental disorders. It requires countries to ensure that people with disabilities, including mental disorders, 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.” This will act as an additional prohibition against involuntary committal to psychiatric situations except in extreme situations that are carefully and narrowly defined by law. The convention 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 disorders by ratifying governments, this convention also places several affirmative requirements on them. For example, it 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 requires governments to take steps to help people with disabilities remain integrated in their communities.

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**)[24] are a detailed international statement of the rights of persons with mental illness and comprise the most direct expression of human rights in the context of mental illness to date. The MI Principles include a wide range of commitments relating to standards of care and treatment, including the right to medication, 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.[25] The Principles also recognize the inherent problems of protecting human rights in an institutional setting and therefore state that care for persons with mental disorders 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[26].

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."* [27]

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.[28] 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.[29]

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[24] *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).

[25] See reference under footnote 37 at paragraph 25.

[26] 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/)

[27] 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.

[28] See reference under footnote 52 at 40.

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

Technical standards

In addition to the 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.

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 patients 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 patients' 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 disorders must safeguard their dignity and human rights, provide rational and appropriate treatment, and strive to maintain persons with mental disorders in their communities. It further states that mental health legislation must safeguard the human rights of persons with mental disorders, 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 disorders 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). Among other standards, the Declaration insists on treatment based on partnership with persons with mental disorders, and on enforcing involuntary treatment only under exceptional circumstances.

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 Disorders, which is a tool to help understand and interpret the MI Principles.

WHO is also currently in the process of developing an instrument to provide guidance to countries on setting human rights **monitoring mechanisms** for mental health, including review bodies to review cases of involuntary admission and treatment, and visiting boards to inspect mental health facilities. The WHO instrument will also contain practical tools for assessing whether the rights of people with mental disorders are being protected.

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**. 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 as part of the overall UN reform. The Council replaces the UN Human Rights Commission, previously 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. Widely criticised for being bureaucratic, excessively political and ineffectual and for being composed of several member countries with poor human rights records, the Commission was disestablished in March 2006. The new Human Rights Council conducts periodic reviews of the human rights records of all UN Member States, beginning with those elected to the Council. It has greater regional and local representation to facilitate stronger monitoring and there will be more systematic ongoing reporting by countries. The members of the Council, elected by the General Assembly of the UN, will meet more regularly than its predecessor (10 weeks rather than 6 weeks each year). The Council will retain some of the positive features of the Commission, including the appointment of Special Rapporteurs and other independent experts and working groups to monitor and report on thematic human rights issues (such as on health, disability and on torture).

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 Elimination of All Forms of Discrimination against Women	Committee on the Elimination of All Forms of Discrimination against Women (CEDAW)
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment	Committee Against Torture (CAT)
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)

Regional human rights systems[30]

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, 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

[30] 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)

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 patients, 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.

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 disorder. 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 disorder. 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 upcoming UN Disability Convention) 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 gives interpretation to the provision of the ECHR and also creates European human rights law.

Supported by a number of judgements by the European Court of Human Rights, mental health legislation in European States has to provide for safeguards against involuntary hospitalisation, based on three principles:- a) mental disorder is established by objective medical expertise; b) is of a nature and degree warranting compulsory confinement and c) for continued confinement it is necessary to prove persistence of the mental disorder[31].

Example of an action by the European Court of Human Rights

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.

http://www.mhg.ru/english/3AEC6AF

[31] Gostin L O. & Gable L. The Human Rights of persons with Mental disabilities: a Global perspective on the Application of Human Rights Principles to Mental Health. *Maryland Law Review* 63(20) 20-121.

D) KEY RIGHTS OF PEOPLE WITH MENTAL DISORDER 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 disorders. Many of the rights discussed below are also expanded upon in different Modules of the Diploma.

I. 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".

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 disorders:

Access to Appropriate and Professional Services: The right to health under Article 12 entails a right on the part 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. The MI Principles also elaborate extensively on the availability, accessibility, acceptability, and quality of services

Right to individualized treatment: The principle that people with mental disabilities have a right to individualized treatment is emphasized throughout the MI Principles. 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

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[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.

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 Principle 11.

Right to rehabilitation and treatment that enhances autonomy: Both the Declaration on the Rights of Mentally Retarded Persons (MR Declaration) and the MI Principles recognize that all treatment must be directed toward the enhancement of the autonomy and skills of each individual. 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." The profound importance of this principle – and the fact that it applies to "every patient" – 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 treatment that preserves or enhances his or her skills or develops maximum potential, the MI Principles and the MR Declaration raise expectations to a level that cannot be met by custodial care alone. General Comment 5 of the ICESCR also emphasises the right to have access to services which enable people to become independent and integrate into society.

Right to least restrictive alternative: The MI Principles 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." The right to treatment in the least restrictive environment is reinforced by the principle 9(4) requirement that "[t]he treatment of every patient shall be directed towards preserving and enhancing personal autonomy." The principle that treatment should be the least restrictive possible is built into protections against such practices as physical restraints or involuntary seclusion (MI Principle 11) and involuntary detention (MI Principle 16)

Right to community-based services: The MI Principles also recognize the right to community-based services and support systems necessary to promote this right. MI Principle 7(1) states that "[e]very patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives." 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.

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

Admission to these facilities is usually necessitated not so much by the clinical condition of the patient but by the absence of any other alternative. Once in the institution, the same lack of community alternatives serves to retain patients 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 patients who no longer clinically require this level of service 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 patients are confined for whom there are no bona fide diagnoses of mental illness but who remain simply due 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."

Children's right to services that promote community integration: The UN Convention on the Rights of the Child (CRC) provides the strongest convention-based statement of the right to services that promote community integration. While the right to grow up in a family or a family-like environment is emphasized throughout the CRC, Article 23 on the rights of children with disabilities particularly emphasizes these rights, stating that service systems be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's receiving the fullest possible social integration and individual development.

Informed consent and the right to refuse treatment: MI Principle 11 establishes that "no treatment shall be given to a patient without his or her informed consent...." Implicit in the formulation of Principle 11 is the concept of a right to refuse treatment since a person may choose to withhold consent. The MI Principles have been criticized for the lack of a more explicit and affirmative statement of the right to refuse treatment.[35] The Principles further protect the patient's autonomy by creating a due process procedure before a patient can be determined to lack legal capacity, thus empowering a personal representative to represent the patient's interest or exercise the patient's rights (Principle 1). The common practice in many countries of permitting family members to consent on behalf of the patient, without any formal process for determining the legal incapacity of the patient consistent with these requirements, violates the human rights of dignity and autonomy as recognized in the Universal Declaration of Human Rights as elaborated upon in these Principles. Article 7 of the ICCPR provides stronger protections for the right to refuse treatment as part of the protection against inhuman and degrading treatment. The protection against treatment

[35] For further details on MI Principle 11 and criticism of this Principle with respect to informed consent see WHO's *The Role of International Human Rights in National Mental Health Legislation.* Geneva, World Health Organization, Department of Mental Health and Substance Dependence.

without consent in the area of human experimentation is clearly greater under Article 7 of the ICCPR than it is under the MI Principles.

Protection of Human Dignity: The mandate of General Comment 5 that health services should be provided in such a way as to protect the "rights and dignity" of individuals with disabilities places 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 permeates the MI Principles. MI Principle 13(2) recognizes that "[t]he environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age" including facilities for education, leisure, "active occupation," and "vocational rehabilitation measures to promote reintegration in the community." MI Principle 13(1) (b) recognizes the right of people within mental health facilities to privacy - perhaps the most widely violated right of people in institutions. As part of this right, the MI Principle 13 recognizes a right to "uncensored private communications" with the outside world. This includes freedom to receive visitors as well as access to telephones, newspapers, radio and television.

II. **Freedom from Discrimination**

A fundamental human rights obligation is the protection against discrimination. This right, which is recognized both in the UN Charter itself (articles 55-56) and the Universal Declaration of Human Rights, which protects "everyone," is further protected under the ICESCR and the ICCPR and it is recognized by the major UN human rights standards concerning people with mental or physical disabilities.

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, as well.

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. Under the ICCPR, special protections or "affirmative action" is permissible – and at times required – to bring about equal protection under the law.[36] The MI Principles also affirm that, in the context of mental health care, "[s]pecial measures to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed discriminatory."

III. **Freedom from Inhuman & Degrading Treatment**

The Article 7 protection in the ICCPR against "inhuman and degrading treatment" is 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.

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."

The MI Principles establish a broad array of minimum standards for treatment within psychiatric institutions that needs to be protected. Principle 1 of the MI Principles explicitly states that "All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment".

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 patients 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 are inhuman and degrading and detrimental to both the physical and mental well-being of patients 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 should be seen as constituting inhuman and degrading treatment in violation of Article 7 of the ICCPR in addition to a violation of many of the rights outlined in the MI Principles.

Medical and scientific experimentation: The second clause of Article 7 of the ICCPR states that "no one shall be subjected without his free consent to medical or scientific experimentation." It is very unusual that the ICCPR would contain such specific language, and it is clear that the drafters of the convention intended to link the protection against torture, inhuman and degrading treatment with protections against coercive and potentially dangerous medical practices.

This provision of Article 7 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.[37] 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 patients recruited for the trial; but others may involve medications of no direct benefit to the patient while also posing a significant degree of risk. At a minimum, Article 7 would require that before a patient is permitted to enroll in experimental treatment, a clinical determination must be made by a qualified professional that the patient is competent to consent and does in fact provide consent based on a full disclosure of the risks and benefits. Article 7 does not provide for surrogate consent to experimentation upon an individual not capable of informed consent, and the concerns of the United Nations 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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[37] Clarence J. Sundram, *In Harm's Way: Research Subjects Who Are Decisionally Impaired*, J. HEALTH CARE L. & POLICY, Vol. 1, 36-65 (1998)

However, this is another area in which the language of the MI Principles appears to offer a lesser degree of protection than that contained the ICCPR. Principle 11 states: "Clinical trials and experimental treatment shall never be carried out on any patient without informed consent" but then proceeds to carve out an exception that swallows the rule by stating that "a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose." There is no prohibition against non-therapeutic experimentation. The issue of medical and scientific research is also discussed in Module 7 of the Diploma.

Involuntary treatment: As discussed above, many people with mental disorders 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.

MI Principle 11 states that "no treatment shall be given to a patient without his or her informed consent..." but the MI Principles create many exceptions to this protection, and they do not recognize an affirmative right to refuse treatment. It is likely that Article 7 of the ICCPR provides greater protections. The exact protections of Article 7 with regard to non-experimental treatment have not been fully clarified by the UN Human Rights Committee, but coerced treatment would meet the general definition of inhuman and degrading treatment when it causes great suffering or degradation. The issue of involuntary treatment is also discussed in Module 7 of the Diploma.

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. 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. The issue of involuntary treatment is also discussed in Module 7 of the Diploma.

Protection against Punishment: Like Article 7 of the ICCPR, Article 5 of the UDHR provides, "No one shall be subjected to torture or cruel, inhuman or degrading treatment or 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. The use of "unmodified ECT" without anesthesia or muscle relaxants

creates a serious risk of harm to patients, including fractures and other injuries. In some institutions, untrained and unsupervised ward staff have been known to use medications as a form of control over patients, 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.

Right to privacy: One of the most pervasive violations of human rights in psychiatric facilities is the violation of the right to privacy. People may be forced to live for years in dormitory-like wards where they are never able to have a moment of solitude. They may have no secure place in which to place 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. MI Principle 13(1) protects the right to privacy, freedom of communication, and private visits. 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, which states that "[n]o one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence..." Article 17 specifies that "[e]veryone has the right to the protection of the law against such interference...."

IV. **Right to Liberty & Security of the Person**

Article 9 of the ICCPR establishes that "[e]veryone has the right to liberty and security of the person. No one shall be subjected to arbitrary...detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law." UDHR Articles 3 and 9 provide similar protections. The MI Principles contain detailed guidelines that are helpful in interpreting the protections against improper detention in a psychiatric facility. The MI Principles establish both substantive standards and procedural protections necessary to protect against arbitrary detention in a psychiatric facility.

The MI Principles limit involuntary commitment to a psychiatric facility to people who have been diagnosed with a mental illness "in accordance with internationally accepted medical standards." On account of this mental illness a person must be found to meet one of two additional criteria. The first criterion is that the person must present a "serious likelihood of immediate or imminent harm to that person or other persons…." Principle 16(1) (a).

Alternatively, a person can be subject to involuntary commitment if his or "judgment is impaired" and "failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility…." This second criterion for commitment is much broader than the first, and it creates a risk of opening up psychiatric commitment to anyone who is determined to "need treatment." Thus, it is extremely important that the second criterion is linked with the "principle of the least restrictive alternative," *i.e.* – a person cannot be involuntarily committed unless he or she could not receive appropriate services in the community.

The MI Principles also establish **procedural protections for psychiatric commitment**: They permit detention only for a "short period" which must be specified by domestic law "for observation and preliminary treatment pending review" by an independent body. Any involuntary commitment after this time can only be ordered by "a judicial or other independent and impartial body established by domestic law in accordance with procedures laid down by domestic law." The review body determines whether the individual subject to detention meets the substantive criteria discussed above. Thus, the determination as to whether the person should be committed, while initially a medical or psychiatric determination, is ultimately subject to judicial review to ensure that the determination is consistent with legal standards. The review body shall have at its disposal one or more qualified mental health practitioners, but they must also be independent of the institution seeking to commit the individual. A person subject to involuntary commitment "shall have the right to appeal to a higher court…."

Other rights within the MI Principles include (but are not limited to) the rights of individuals subject to involuntary commitment to choose and appoint counsel to represent them, including representation in any complaint procedure or appeal. An individual and his or her personal representative or counsel have the right to attend and participate in any hearing concerning them. The MI Principles also set forth procedures for making a patient's records available to the patient or counsel.

Importantly also, the MI Principles require that people subject to involuntary admission have a right to periodic review of their case. The issue of involuntary admission is also discussed in Module 7 of the Diploma.

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

Key human rights related to mental health	Instruments safeguarding the human right
People with mental disorders are entitled to the enjoyment and protection of their fundamental human rights.	• International Covenant on Economic, Social and Cultural Rights (ICESCR) • International Covenant on Civil and Political Rights (ICCPR) • UN Declaration of Human Rights • African (Banjul) Charter on Human and Peoples' Rights • Convention for the Protection of Human Rights and Fundamental Freedoms • American Declaration of the Rights and Duties of Man • American Convention on Human Rights • UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (MI Principles) • Standard Rules on Equalization of Opportunities for Persons with Disabilities • Declaration of Caracas • Recommendation of the Inter-American Commission on Human Rights for the Promotion and Protection of the Rights of the Mentally Ill
Right to the highest attainable standard of health care – including mental health	• International Covenant on Economic, Social and Cultural Rights (ICESCR) • African (Banjul) Charter on Human and Peoples' Rights • UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles) • Standard Rules on Equalization of Opportunities for Persons with Disabilities • European Social Charter • Declaration of Caracas • International Convention on the Elimination of All Forms of Racial Discrimination • Convention on the Elimination of All Forms of Discrimination Against Women • Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights
Protection against discrimination	• International Covenant on Economic, Social and Cultural Rights (ICESCR) • International Covenant on Civil and Political Rights (ICCPR) • Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities • UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles) • Standard Rules on Equalization of Opportunities for Persons with Disabilities • Recommendation of the Inter-American Commission on Human Rights for the Promotion and Protection of the

	Rights of the Mentally Ill • Convention on the Elimination of All Forms of Discrimination Against Women
Children with mental disabilities have the right to enjoy a full and decent life	• UN Convention on the Rights of the Child • The Salamanca Statement and Framework for Action on Special Needs Education • UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles)
People with mental disorders should be protected against torture, cruel, inhuman or degrading treatment or punishment	• UN Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment • African (Banjul) Charter on Human and Peoples' Rights • UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles) • Declaration of Caracas • International Covenant on Civil and Political Rights (ICCPR) • European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment • Recommendation of the Inter-American Commission on Human Rights for the Promotion and Protection of the Mentally Ill
Standards for involuntary care and treatment	• UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles • Council of Europe Recommendation 1235 on Psychiatry and Human Rights • Declaration of Caracas • World Psychiatric Association's Declaration of Madrid

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 disorders in institutions and community
3. International and regional human rights systems
4. Key international human rights standards related to people with mental disorders

4. Teaching Methods and Time Allocated

This module will be taught online/distance learning over a period of one month

Type	Number	Time allocation
Online Lectures	3	3 hours
Case study exercises/essays/ assignments	To be determined	To be determined
Online group discussion	1	To be determined

5. List of Lectures and homework assignments

1. Lectures (40 to 60 mins each)
    g. Lecture 1: Understanding the interaction between human rights and mental health
    h. Lecture 2: International (UN) and Regional Human Rights Systems
    i. Lecture 3: Key rights of people with mental disorders and international human rights provisions to protect them

6. Homework assignments

See Homework assignments for Module 3 document, which contains several different types of homework assignments:

a) 2 Short exercises (all students to complete both exercises)
b) 3 Case Studies (all students to chose and complete 2 case study exercises)
c) 2 essays (all students to chose and complete 1 essay question)

Core reading

Chapter 1 of the WHO Resource Book on Mental Health, Human Rights and Legislation. (2005) World Health Organisation, Geneva.

WHO (2001). The Role of International Human Rights in National Mental Health Legislation. Geneva, World Health Organization, Department of Mental Health and Substance Dependence. (http://www.who.int/mental_health/resources/policy_services/en/)

WHO (2007) Mental Health and Human Right; Health and Human Rights Publication Series Issue No. 6

http://www.upliftinternational.org/25_questions_hhr.pdf#search=%2225%20questions%20and%20answers%20right%20to%20health%22

Gostin LO (2000). Human rights of persons with mental disabilities. The European Convention of Human Rights. International Journal of Law and Psychiatry, 23(2):125-159.

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, 63(1):20-121

WHO Photo essay on human rights violations. WHO website: http://www.who.int/features/2005/mental_health/en/index.html

World Health Organisation (2002) 25 Questions and Answers on health and Human Rights. Health and Human Rights Publication Series No 1 Geneva.

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*

Additional reading

Gostin L. (2001). Beyond moral claims: a human rights approach in mental health. Camb Q Healthc Ethics 10(3):264-74

Corrigan, P (2004). How stigma interferes with mental health care. Am Psychol. 59(7):614-25

Cresswell, M. (2005). Psychiatric "survivors" and testimonies of self-harm. Soc Sci Med. 2005; 61(8):1668-77

Human Rights Branch, Attorney General's Department, Canberra (Australia) (1996). *Report on A Rights Analysis Instrument for Use in Evaluating Mental Health Legislation.* Prepared for the Australian Health Minister's Advisory Council National Mental Health Working Group, December 1996.

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