

## **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 the rights 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 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 disabilities
- g. Key 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 treatment practices as well as unhygienic and inhuman living conditions.

Another major human rights violation is that people are denied opportunities to exercise their legal capacity – to make decisions for themselves. This lack of legal capacity permeates every aspect of their lives and results in widespread violations with people all over the world facing discrimination in the fields of education, employment and housing. People in many countries are also denied civil and political rights including the right to vote, stand for public office as well as the right to marry and have children.

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 on an equal basis with others.

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 human rights framework and examine key human rights standards that are particularly pertinent to people with mental disabilities. 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<sup>1</sup>. 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 people with mental disabilities rather than highlighting the need to promote their rights. 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:

1. mental health policy affects human rights
2. human rights violations affect mental health
3. and positive promotion of mental health and human rights are mutually reinforcing.<sup>2</sup>

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 powers associated with these policies and laws can be exercised for the welfare of the individual, family and society, these powers can also give rise to human rights violations when they are exercised arbitrarily, discriminatorily or without procedural protections.<sup>3</sup>

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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<sup>1</sup> 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.

<sup>2</sup> Ibid.

<sup>3</sup> 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.<sup>4</sup> Unemployment, limited educational opportunities, lack of food, shelter and access to healthcare, including health insurance, restrict one's ability to be active 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.<sup>5</sup>

Restrictions in civil liberties such as the right to vote, to take part in public affairs, to participate in policy-making, 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.<sup>6</sup>

The third relationship is that mental health and human rights are inextricably linked.<sup>7</sup> A minimum level of both human rights and mental health are necessary for people to lead lives that enable 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 is almost impossible.<sup>8</sup>

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<sup>4</sup> *World Health Report*, Geneva, World Health Organization, 2001

<sup>5</sup> 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.

<sup>6</sup> 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.

<sup>7</sup> *Ibid.*

<sup>8</sup> *Ibid.*

## C) HUMAN RIGHTS VIOLATIONS OF PEOPLE WITH MENTAL DISABILITIES

People with mental disabilities experience wide ranging violations on several fronts. The low priority of mental health on national agendas means that people in many parts of the world do not have access to basic mental health care and social services. The absence of these community based services results in many people being locked away in psychiatric institutions, which in many countries are associated with gross human rights violations. Many institutions are more like human warehouses than places of care and treatment. The buildings are decrepit and filthy, lacking even basic sanitation and hygiene standards. People 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 be 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.<sup>9</sup>

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<sup>10</sup>. 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

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<sup>9</sup> 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

<sup>10</sup> Ibid

aimlessness, inactivity, and social isolation is not conducive to recovery, and is inhuman and degrading<sup>11</sup>.

People with mental disabilities also experience violations in their own communities. The stigma, myths and misconceptions associated with people with mental disabilities – that they are possessed by supernatural forces or evil spirits, that they are unintelligent, lazy, weak and dangerous – means they are isolated from society. In some countries, people are physically removed from their community, 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<sup>12</sup>.

It has been reported that in some parts of Somalia, people with severe mental health conditions can be subjected to a so-called 'hyena cure'. This village practice involves dropping a person with a mental health condition into a pit with one or more hyenas that have been starved of food. It is thought that the hyenas will scare away the djinns, or evil spirits, that inhabit the person. Family members of the person with the mental health conditions will pay the owner of the hyena for such 'treatment'.

Source: WHO Report on Mental Health and Development: targeting people with mental health conditions as a vulnerable group, World Health Organization, Geneva, 2010

Another major human rights violation is that people with mental disabilities are denied opportunities to exercise their legal capacity – to make decisions for themselves. This is due mainly to the false but common assumption that people with mental disabilities lack the capacity to assume responsibilities, manage their affairs, and make decisions about their lives. For example people in many countries are systematically admitted to facilities and given treatment without their express informed consent. The laws and practices of many countries confer far-reaching powers to guardians of people with mental disabilities which results in extensive restrictions on people's ability to make decisions concerning their place of residence, their personal and financial affairs and other aspects of their daily lives<sup>13</sup>. To compound this, in many places people with mental disabilities are not given access to legal

<sup>11</sup> Ibid

<sup>12</sup> 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](http://www.who.int/features/2005/mental_health/en/index.html)

<sup>13</sup> WHO Report on Mental Health and Development: targeting people with mental health conditions as a vulnerable group, World Health Organization, Geneva, 2010

mechanisms to contest violations and protect their rights despite the fact that they have been stripped of the fundamental rights to liberty and autonomy.

In many countries, people with mental disabilities are also denied civil and political rights such as the right to vote and to stand for public office. This contributes to their ongoing political marginalization, disenfranchisement, and invisibility. People also experience restrictions in the rights to marry and have a family. In many places, children are forcibly removed from a parent with a mental disability without any consideration of their abilities and capacity to be a parent. Also, having a mental disability is grounds for divorce in some countries<sup>14</sup>.

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 disability. In fact of all disabilities, psychosocial disabilities are associated with the highest rates of unemployment, with rates as high as 90%<sup>15</sup>. In low income countries many people for example are excluded from income-generating projects.

Many children and adolescents with mental disabilities also experience discrimination in access to education. In countries they are institutionalised in facilities that do not offer any kind of education. In other contexts, poverty-related constraints mean they are usually the first to be deprived of the possibility of going to school. If they are able to go to school, children in many countries are sent to segregated or so-called special schools that offer lower quality education, rather than being included in mainstream education with tailored support. Failure to provide appropriate support can result in poor academic performance, school failure, and high drop-out rates compared with other children and adolescents<sup>16</sup>.

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<sup>14</sup> WHO Report on Mental Health and Development: targeting people with mental health conditions as a vulnerable group, World Health Organization, Geneva, 2010

<sup>15</sup> Drew N., Funk M., Tang S., Lamichhane J., Chávez E., Katontoka S., Pathare S., Lewis O., Gostin L., Saraceno B. *Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis*. Lancet series on Global Mental Health 2011. The Lancet 2011

<sup>16</sup> Drew N., Funk M., Tang S., Lamichhane J., Chávez E., Katontoka S., Pathare S., Lewis O., Gostin L., Saraceno B. *Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis*. Lancet series on Global Mental Health 2011. The Lancet 2011

People with mental disabilities are often inappropriately detained in prisons. Indeed in many countries the rate of mental disabilities in prisons is 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<sup>17</sup>.

## **D) INTERNATIONAL (UN) AND REGIONAL HUMAN RIGHTS SYSTEMS**

The international human rights system, comprising 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**<sup>18</sup>

#### **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

<sup>17</sup> WHO and ICRC Information Sheet on Mental Health and Prisons.  
[http://www.who.int/mental\\_health/policy/mh\\_in\\_prison.pdf](http://www.who.int/mental_health/policy/mh_in_prison.pdf)

<sup>18</sup> 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**)<sup>19</sup> adopted in 1948; the International Covenant on Economic, Social and Cultural Rights (**ICESCR**)<sup>20</sup> and the International Covenant on Civil and Political Rights (**ICCPR**)<sup>21</sup> 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” and the right to education. 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.<sup>22</sup> 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.<sup>23</sup> General Comment 5 of the ICESCR also provides advice on rights of persons with disabilities, including those with mental disabilities.<sup>24</sup>

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<sup>19</sup> *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](http://www.unesco.org/shs/human_rights/hrbc.htm)

<sup>20</sup> *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](http://www.unhchr.ch/html/menu3/b/a_cescr.htm)

<sup>21</sup> *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](http://www.unhchr.ch/html/menu3/b/a_ccpr.htm)

<sup>22</sup> 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.

<sup>23</sup> 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).

<sup>24</sup> 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 take deliberate, concrete and targeted 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 take part in the conduct of public affairs, vote and stand for election, the right to marry and found a family, as well as freedom of thought, conscience and religion among others.

Governments that ratify human rights instruments 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 ratified 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 21<sup>st</sup> 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 20<sup>th</sup> 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.<sup>25</sup>

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.

An important set of standards are the **Standard Rules on the Equalization of Opportunities for Persons with Disabilities**. Prior to the CRPD, the Standard Rules was another the principal UN instrument identifying State obligations in the area of human rights and disability. The Standard rules set out rights

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<sup>25</sup> 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/>

in relation to, health care, rehabilitation, support services, education, employment, family life, The right to participation by people with disabilities in policies and laws that affect them. Many countries have based their national legislation on the Standard Rules. However unlike the CRPD they are not legally binding

The UN Principles for the Protection of Persons with Mental Illness (**MI Principles**)<sup>26</sup> 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, 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.<sup>27</sup> 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<sup>28</sup>.

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.”*<sup>29</sup> It is now widely accepted that that provisions of the CRPD supersede the MI Principles

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.<sup>30</sup> The **Standard Rules** on the

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<sup>26</sup> *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).

<sup>27</sup> See reference under footnote 37 at paragraph 25.

<sup>28</sup> *The 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/](http://www.who.int/mental_health/resources/policy_services/en/))

<sup>29</sup> 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.

<sup>30</sup> See reference under footnote 52 at 40.

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.<sup>31</sup> As non-binding instruments, these are also superseded by the CRPD.

### 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. 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.

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

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<sup>31</sup> See reference under footnote 37 at paragraph 25.

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 includes a Checklist for mental health law which enables countries to review their existing laws or draft Bills in order to determine compliance with international human rights standards. The 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. It is important to note that the Resource Book was developed prior to the coming into force of the CRPD and therefore an analysis of a law's compliance with the CRPD needs to be done alongside an analysis using the WHO document.

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, A major new publication is the WHO QualityRights Tool kit to assess and improve quality and human rights in mental health and social care facilities. The tool kit was prepared with input from international experts, including people with mental disabilities, and is based on the United Nations Convention on the Rights of Persons with Disabilities. Its aim is to give countries information on quality and human rights standards in facilities that must be respected, protected and fulfilled. It provides practical information and guidance on: the human rights and quality standards to be met in both inpatient and outpatient facilities; preparing for an assessment, including establishing a multidisciplinary assessment committee; conducting a comprehensive assessment of facilities, including conducting interviews, observing and reviewing documentation; and reporting the findings and making appropriate recommendations on the basis of the assessment. More information on the WHO QualityRights tool kit and project is available at: [http://www.who.int/mental\\_health/policy/quality\\_rights/en/index.html](http://www.who.int/mental_health/policy/quality_rights/en/index.html)

#### 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(also known as shadow report) 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.

#### 5. UN Human Rights Council

Another mechanism for monitoring human rights compliance in the United Nations system is UN Human Rights Council, created in 2006 as part of the overall UN reform. The 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.

**The HR Council conducts what is known as a Universal Periodic Review** of the human rights situation in all 192 member states of the UN every four year. It reviews reports by governments on what they are doing to fulfil their human rights obligations, and also considers reports from NGOs and also from the treaty monitoring bodies and the UN Specialised agencies. Summary report of the review by the Council is made public and then 'adopted' at the Council session.

The Human Rights Council also has a complaints procedure (procedure 1503) which gives it the authority to consider a complaints to address consistent patterns of gross human rights violations in anywhere in the world. A group

of 5 independent experts called the Working Group on Communications (WGC) (appointed by the advisory committee) determine whether complaints deserve investigation. If they determine that investigations are needed they pass it on to another group of 5 experts called the Working Group on Situations (WGS). The WGS then makes recommendations to the Council on the course of action it should take.

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 – see box below).

*UN Special Rapporteurs whose work is important in relation to the rights of persons with mental disabilities.*

#### **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 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. <http://www.ifhhro.org/information-centre/documents-un-special-rapporteur>

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. In 2009 he issued a report on informed consent which discusses the duties and obligations required of States and health-care providers in guaranteeing informed consent in clinical practice, public health and medical research. <http://unsrhealth.org/reports>

## **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.

## **3. The Special Rapporteur on Torture**

In 2008 the UN Special Rapporteur on Torture devoted an important report related to the rights of persons with disabilities covering issues such as poor conditions of detention, the use of restraints and seclusion, medical and scientific experimentation, medical interventions, abortion and sterilization, electroconvulsive therapy, forced psychiatric interventions, involuntary commitment, violence including sexual violence against persons with disabilities. <http://www2.ohchr.org/english/issues/torture/rapporteur/>

*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)

### 6. Regional human rights systems<sup>32</sup>

In a number of regions of the globe there are systems for promoting and enforcing human rights. These are:

- The African Human Rights System - created by the Organisation of African Unity (OAU) which is now the African union
- The Inter-American Human Rights System - created by the Organisation of American States (OAS)
- The European Human Rights System – created by the Council of Europe

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.

One of the strengths of the regional systems and perhaps in particular the European system as opposed to the UN system is that individual complaints

<sup>32</sup> 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)

are made by courts whose judgments are legally binding on states and which include explicit decision on reparations and reparations/compensations.

### *Africa*

The **African Charter on Human and People's Rights** (Banjul Charter) is the key human rights treaty for the African region and includes a number of rights which are particularly relevant to people with mental disabilities: 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; and the right to enjoy the best attainable state of physical and mental health.

The Banjul Charter is supervised by the **African Commission** on Human and People's Rights and the African court on Human and People's Rights. The **Commission** is a quasi-judicial body which is mandated to collect documents, undertake studies and researches on human rights in Africa and organise symposia and conferences, disseminate information on human rights, provide guidance to countries on the interpretation of the Banjul Charter, and until recently, to consider cases of human rights violations by states.

In 2006 the African Court on Human and People's Rights was established. The court now acts as the judicial body for the African human rights system and considers cases of human rights violations referred to it by the African Commission. Eleven judges sit at the African Court. Unlike the African Commission, the African Court possesses the authority to issue a binding and enforceable decision on cases brought before it.

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

##### *The Gambia*

In 2002 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. The Inter-American Court of Human Rights (comprising 7 judges) has a judicial role, and hears and rules on the specific cases of human rights violations referred to it by the Inter American Commission. It also advises and issues opinions on matters of legal interpretation related to the regions human rights instruments. The Inter-American Commission and Court have considered a number of cases related to the rights of people with mental disabilities (see box below).

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

In 2008 for example the Commission issued a precautionary measure in relation to Paraguay to improve the human rights conditions for people with mental disabilities in the State run psychiatric institution (people being held in abject conditions including two boys in solitary confinement for 4 years) – A precautionary measure is an emergency measure to prevent irreparable harm to persons in connection with a pending petition or case. As a result, the government of Paraguay requested support from WHO PAHO to put in place measures to stop violations including the drafting of a new mental health law

**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. Judges are elected by the parliamentary assembly of the Council of Europe and the number of judges is the same as the number of countries who are a member of Council of Europe.

Issues that the Court has ruled upon in relation to mental disability include issues related the right to a fair trial and legal representation for people with mental disabilities, review of detention, incapacity, ill-treatment, psychiatric assessment and many other relevant issues . All countries must examine both the Convention's provisions and the European Court Caselaw very closely, as

they are required to ensure that national laws are in conformity with the provisions of the Instrument **and** the judgments, decisions and opinions of the European Court.

### **Example of 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. Shtukaturv 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. Shtukaturv, 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 Shtukaturv (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. <a href="http://www.mdac.info/en/node/145">http://www.mdac.info/en/node/145</a> .
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## D) KEY RIGHTS OF PEOPLE WITH MENTAL DISABILITIES AND INTERNATIONAL HUMAN RIGHTS PROVISIONS TO PROTECT THEM<sup>33</sup>

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. 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 on the basis of disability which has the purpose or effect of impairing the recognition or exercise of all human rights and fundamental freedoms.

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

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<sup>33</sup> 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.

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.<sup>34</sup> 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.

## **2. Right to the highest attainable standard of physical and mental health and to habilitation and rehabilitation**

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:

Access to Appropriate and Professional Services: 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<sup>35</sup>. To be appropriately available, services must

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<sup>35</sup> 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

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 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.

Right to habilitation 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

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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.

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.

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.

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.

### **3. 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 of the CRPD focuses specifically on legal capacity, stating that people with disabilities have the **right to recognition everywhere as persons before the law**. This means that people with disabilities must be allowed to enjoy the same protection afforded by the legal system as everybody else. For example, they have the right to start proceedings before courts in cases where their rights have been violated.

Furthermore, by contrast with traditional but rights restricting models of plenary guardianship, the CRPD requires that State Parties recognise the right of people with disabilities to enjoy legal capacity on an equal basis with others in all aspects of life. Additionally, the CRPD puts forward a supported decision-making model. This model enables people to retain their legal capacity and at the same time choose to receive support in exercising this right when they desire it and when it is needed. The person remains at the centre of decision making on issues that affect him or her, and when necessary, support can be on-hand to explain relevant issues and interpret and communicate the signs and preferences of the individual. Types of support might include advocates, a personal ombudsperson, community services, personal assistants, peer supports, and advance planning<sup>36</sup>.

#### **4. Right to Liberty & Security of the Person**

According to Article 14.1 of the CRPD, people with disabilities must be granted the right to liberty and security on an equal basis with others. The article further states that “the existence of a disability shall in no case justify a deprivation of liberty”.

Some controversy exists around the interpretation of this article. Some understand it to mean that the existence of a (mental) disability 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

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<sup>36</sup> Drew N., Funk M., Tang S., Lamichhane J., Chávez E., Katontoka S., Pathare S., Lewis O., Gostin L., Saraceno B. *Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis*. Lancet series on Global Mental Health 2011. The Lancet 2011

procedural protections, such as judicial or other independent review, must be in place.

Others disagree with this viewpoint. The International Disability Alliance (IDA), a consortium of disabled people's organizations involved in the drafting of the CRPD, have has stated 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.*<sup>37</sup> 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.

## **5. Freedom from torture or cruel, inhuman or degrading treatment or punishment**

Article 7 in the ICCPR and Article 15.1 in the CRPD provide protection against torture or cruel,inhuman or degrading treatment or punishment. 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 Report of the UN Special Rapporteur on Torture on disability in relation to freedom from torture (see above) highlights several different ways in

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<sup>37</sup> 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".

which the way people with mental disabilities are treated can amount to torture and cruel, inhuman or degrading treatment and punishment<sup>38</sup>.

In many countries for example, residents of institutions are used in scientific experimentation including experimentation involving new medications, without their consent. Both Article 15 of the CRPD and Article 7 of the ICCPR state that “no-one shall be subjected without his or her free consent to medical or scientific experimentation. In addition, certain intrusive and irreversible medical interventions undertaken without informed consent, such as psychosurgery or lobotomies, Electroconvulsive therapy, abortions or sterilizations, which many people with mental disabilities have experienced, can amount to torture. In relation to ECT, the Special Rapporteur notes that unmodified ECT (i.e. without anaesthesia, muscle relaxant or oxygenation), which is used in many parts of the world, inflicts severe pain and suffering and often leads to medical consequences, including bone, ligament and spinal fractures and possible loss of memory. Consequently it cannot be considered as an acceptable medical practice and may constitute torture or ill-treatment.

Also according to the report of the Special Rapporteur, the administering of psychiatric medication more generally (including neuroleptics and other mind-altering drugs) without informed consent and under coercion, can in certain circumstances amount to torture or inhuman treatment. For example, in a case of *Acosta v. Uruguay* presented to the Human Rights Committee of the ICCPR, the complainant had been subject to psychiatric experiments and forced injection of tranquillizers against his will, and the Committee found that this constituted inhuman treatment.

People in psychiatric institutions are sometimes exposed to violence by other patients as well as by the staff of the institution and this too can be considered as a violation of the right to be free from torture and ill treatment. For example in the case of *Ximenes Lopes v. Brasil* (see above) it was found that the culture of violence, regular beatings and restraints imposed on the patients, along with the poor conditions of detention violated the right to be free from torture and ill-treatment under American Convention on Human Rights.

The UN Special Rapporteur on Torture also notes that prolonged solitary confinement could constitute torture or ill treatment. Indeed in a case taken to the Inter-American Commission, the case of *Congo versus Ecuador*, the Commission found that the prolonged confinement of Mr Congo (who died

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<sup>38</sup> UN General Assembly. Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. United Nations, 2008; A/63/175.

as a consequence of the way he was treated) amounted to inhuman and degrading treatment.

## **6. Independent living in the community**

The right to live independently and be included in the community is enshrined in Article 19 of the CRPD. It states that people with disabilities have the right to live in the community and that governments must take effective and appropriate measures to facilitate their full inclusion and participation in society. It further states that people have the right to decide where and with whom they live and that they must not be obliged to live in a particular living arrangement.

Significantly also, article 19 states that people must be given access to a range of 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. This has important implications as it clearly promotes the closing down of psychiatric institutions (which isolate and segregate people) and the development of community based mental health services, social services and other necessary services to enable people to live in the community.

## **6. Education, employment, social support and housing**

The ICESCR protects and promotes a full range of rights related to education, health, employment and social support. The CRPD also elaborates on these rights in relation to people with disabilities to whom they are routinely denied. Article 24 of the CRPD on education states that people with disabilities must have access to inclusive, quality and free primary education and secondary education on an equal basis with others.

Article 27 on Work and employment states that discrimination on the basis of disability must be prohibited and that people with disabilities must have equal opportunities for employment, equal remuneration and have access to vocational training and placement services. Finally, article 28 on adequate standard of living and social protection states that people with disabilities must have access to social protection benefits and poverty reduction and public housing programmes.

## **7. Civil and political rights**

The ICCPR covers a full range of civil and political rights which must be respected, protected and fulfilled by governments. In an effort to redress the historical marginalisation and disenfranchisement of people with disabilities, Article 19 of the requires that governments put in place measures to ensure that people with disabilities are able to effectively and fully participate in political and public life on an equal basis with others. They must also be afforded the right to vote, stand for elections and fully participate in the conduct of public affairs, without discrimination and on an equal basis with others. Furthermore, these rights must be encouraged through the establishment and strengthening of organizations of persons with disabilities to represent their interests at international, national, regional and local levels.

## **8. Families and Caregivers**

Though the CRPD does not explicitly outline rights for families and caregivers of persons with disabilities, they must nevertheless be afforded a number of rights by virtue of the fact that in many cases they provide crucial support and care for people with mental disabilities. Family members and caregivers for example, should be provided with information about mental health, human rights, legal mechanisms for complaints and appeals, and other information that enables them to better support their family member. Of course this right to information needs to take into account the right of the person concerned to confidentiality and privacy.

Access to training, counselling and financial assistance is also important for families and caregivers. 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 of families and carers in policy, planning, legislation and service development is also important as very often they have first-hand experience

of the mental health and social care systems and are in a key position to advise on ways to ensure services that meet the needs of people with mental disabilities 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.

**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**

WHO Report on Mental Health and Development: targeting people with mental health conditions as a vulnerable group, World Health Organization, Geneva, 2010, ([http://www.who.int/mental\\_health/policy/mhtargeting/en/index.html](http://www.who.int/mental_health/policy/mhtargeting/en/index.html) )

Drew N., Funk M., Tang S., Lamichhane J., Chávez E., Katontoka S., Pathare S., Lewis O., Gostin L., Saraceno B. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. Lancet series on Global Mental Health 2011. The Lancet 2011

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)61458-X/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61458-X/abstract)

***Reports of UN Special Rapporteurs:***

- 2005, UN Special Rapporteur on the Right to Health - Report on Mental Disability <http://www.ifhhro.org/information-centre/documents-un-special-rapporteur>
- 2009, UN Special Rapporteur on the Right to Health Report on Informed Consent <http://unsrhealth.org/reports>

- 2008 UN Special Rapporteur on Torture Report related to the rights of persons with disabilities <http://www2.ohchr.org/english/issues/torture/rapporteur/>

G. Quinn. Submission on Legal Capacity the Oireachtas Committee on Justice, Defence & Equality Centre for Disability Law & Policy NUI Galway.  
<http://www.nuigalway.ie/cdlp/submissions.html>

Dhanda, A (2007). 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.

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Human Rights Position Paper of the World Network of Users and Survivors of Psychiatry <http://www.wnusp.net/wnusp%20evas/Dokumenter/Human%20Rights%20Position%20Paper.html>

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

International Disability Alliance (IDA) CRPD Forum, Principles for Implementation of CRPD Article 12.

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**

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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.

WHO Photo essay on human rights violations. WHO website:

[http://www.who.int/features/2005/mental\\_health/en/index.html](http://www.who.int/features/2005/mental_health/en/index.html)

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[http://www.aifo.it/english/resources/online/books/cbr/manual\\_human\\_rights-disability-eng07.pdf](http://www.aifo.it/english/resources/online/books/cbr/manual_human_rights-disability-eng07.pdf)

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*Additional Protocol to the American Convention on Human Rights in the Area of Economic Social and Cultural Rights* (1988). Organization of American States, Treaty Series No. 69 (1988) signed 17 November 1988. ([www.cidh.oas.org/Basicos/basic5.htm](http://www.cidh.oas.org/Basicos/basic5.htm))

*African [Banjul] Charter on Human and Peoples' Rights* (1982) adopted 27 June 1981. Organization of African Unity, doc., CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force 21 October 1986. [http://www.achpr.org/english/\\_info/charter\\_en.html](http://www.achpr.org/english/_info/charter_en.html)

*American Convention on Human Rights* (1978). Adopted at the Inter-American Specialized Conference on Human Rights, San José, Costa Rica, 22 November 1969. (<http://www.cidh.oas.org/Basicos/basic3.htm>)

*American Declaration of the Rights and Duties of Man* (1948). Approved by the Ninth International Conference of American States, Bogotá, Colombia, 1948. (<http://www.iachr.org/Basicos/basic2.htm>)

*Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*. Adopted by United Nations General Assembly resolution 43/173 of 9 December 1988. ([http://www.unhchr.ch/html/menu3/b/h\\_comp36.htm](http://www.unhchr.ch/html/menu3/b/h_comp36.htm))

*Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. United Nations General Assembly resolution 39/46, annex, 39 UN GAOR Supp. (No. 51) at 197, UN Doc. A/39/51 (1984). Entered into force 26 June 1987. ([http://www.unhchr.ch/html/menu3/b/h\\_cat39.htm](http://www.unhchr.ch/html/menu3/b/h_cat39.htm))

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*Convention on the Rights of the Child* (1989). Adopted by United Nations General Assembly resolution 44/25 of 20 November, 1989. (<http://www.unhchr.ch/html/menu2/6/crc/treaties/crc.htm>)

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*Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4 (1985). United Nations Sub- Commission on Prevention of Discrimination and Protection of Minorities, United Nations, Economic and Social Council. ([www1.umn.edu/humanrts/instatee/siracusaprinciples.html](http://www1.umn.edu/humanrts/instatee/siracusaprinciples.html))

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