

## **Mental Health and Human Rights: International Standards and Clinical Practice**

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## Introduction

This Handbook is part of the celebration of the 70th anniversary of the adoption of the Universal Declaration of Human Rights (UDHR) (UN, 1948). Not only was health not mentioned in the UDHR beyond a brief reference to “medical care” in the context of the right to an adequate standard of living, but mental health was not mentioned at all. Nevertheless, the UDHR inaugurated a process of normative expansion and practical application of human rights deemed essential for life with dignity and social participation. Recent decades witnessed an increased focus on mental health as an essential component of optimal living. The human rights framework is especially relevant for persons with mental disorders insofar as their vulnerabilities are addressed and protected within the meaning, scope and practical significance of human rights. In other words, the limitations on autonomy and agency associated with mental disabilities challenge the equality in dignity and rights of all human beings, which is the operating premise of human rights.

Mental health conditions can be broadly divided into two large categories: Common Mental Disorders (CMDs) which encompass depression, anxiety and somatoform disorders; and Severe Mental Disorders (SMDs), which include schizophrenia and other psychoses, and severe forms of mood and other disorders (e.g., bipolar, etc.) (WHO, 2018a). Although the discourse on human rights in mental health usually revolves around SMDs, where the most frequent and visible violations of human rights take place, other violations such as the right to health and health care are also relevant to CMDs.

Our purpose is to place issues pertinent to protection and promotion of the human rights of persons with mental disabilities within the context of the right to health and other human rights. To do so, we will examine, firstly, the challenges mental disability pose for the full enjoyment of human rights, and then the responses of the human rights framework as they have evolved. Our third section will explore the integration of a normative and practice-based approach to human rights and mental health. In conclusion, we will propose some guidelines for mental health practice and the application of human rights norms to mental health. We argue for new conceptual, methodological, programmatic, policy and legislative rights-based frameworks which espouse a new ecology of mental health, one that positions individual and societal mental health as inextricably linked.

## Human Rights Challenges of Mental Disabilities

Human rights to mental health are universal standards that protect and promote not only healthcare but the right to a standard of living that supports mental health and wellbeing. The stigma and discrimination associated with mental and psychosocial disabilities often marginalize people from their community, thereby affecting their ability to secure employment and livelihood, and exercise basic civil, political, social, economic and cultural rights. The fear and social exclusion that surrounds untreated mental illness can lead to different types of abuse and even torture, exploitation and humiliation that designate the person as “less than human.” These violations are well-known determinants of mental ill health, thereby triggering and exacerbating the person’s symptoms and functioning, and which in turn contribute to poverty and social disadvantage.

Specific rights of persons with mental disabilities are violated as a result of lack of access to appropriate care, including psychosocial interventions, rehabilitation and essential medicines, because they are unavailable, infeasible, or unaffordable. In 2017, community-based residential care facilities still remain sparse in low and middle-income countries

(LMICs) while the average number of mental health inpatient beds is 1.9 per 100,000 population. In contrast, in high-income countries, there are 23 residential care beds and 52.6 mental health inpatient beds per 100 000 population (Mental Health Atlas, 2017, WHO, 2018b, 36). In terms of mental health workforce, there were 0.1 psychiatrists per 100 000 in LMICs whereas 120 times more in high income countries (WHO, 2018b, 34). Nurses working in mental health are 0.3 per 100,000 population in low-income, 1.4 in lower middle-income and 6.8 in upper middle-income countries.

Failure to obtain informed consent results in forced inpatient admission and treatment in mental health facilities. As will be seen later in the chapter, involuntary hospitalization and court mandated treatment are perhaps the most controversial topics in human rights in mental health. Furthermore, some of the worse violations of human rights happen within psychiatric institutions, including inhumane treatments, prolonged and painful use of restrains, at times with rusting metal shackles, use of caged beds, filthy living conditions and lack of clothes, clean water, food, heating, and social/cognitive stimulation. Not only are people kept in seclusion for lengthy periods, but they are often detained in large institutions, isolated from society and far from families and loved ones.

Another disturbing trend is the incarceration of people with mental disorders because of a lack of mental health services or diagnosis and treatment of their condition, including in high-income countries (Fazel & Seewald, 2012). The disorders of these “prisoners” therefore continue to go unnoticed, undiagnosed and untreated (WHO, 2005). WHO and the International Committee of the Red Cross have formulated a series of ten steps that all countries—including LMICs—can take for the prevention, diagnosis and treatment of mental disorders within prisons, and diverting people with mental disorders towards the mental health system and “the adoption of mental health legislation that protects human rights” (World Health Organization (2005)).

## **Human Rights Responses to Mental Health**

The human rights responses to these violations have involved both the normative expansion of the right to health to include mental disabilities and new approaches to mobilizing change in practices, primarily through the UN procedures and mechanisms.

### ***Normative expansion of human rights relating to mental health***

Two developments contributed to the expansion of standard-setting relating to the human rights of persons with mental disabilities: the interpretation of the right to health and the emergence of normative instruments relating to disabilities, mainly the Convention for the Rights of Persons with Disabilities (CRPD).

#### ***Mental health in the Normative Expansion of the Right to Health.***

At the time of the adoption of the UDHR, mental health was not perceived as a high public health priority. The drafting of the UDHR reflected a social model of health, the same model that influenced the language of the preamble of the WHO Constitution, where health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" and affirmed that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”

The intent of the WHO definition was to expand the concept of health from mere absence of disease to well-being rooted in the person's social ecology. This language clearly reflects the emerging focus on "social medicine" in the 1940s as opposed to a narrow biomedical model (Meier, 2010, p. 6). However, the various drafts and the final text of Article 25 of the UDHR ("Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services...") fails to include a specific reference to "mental" along with physical and social well-being as defining health and instead enumerated health as part of the right to an adequate standard of living. Its social model, however, has been reflected in the subsequent normative expansion of the right to health to include mental health--principally Article 12 of the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) ("the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"). Variations on this definition are found in most of the core UN and regional human rights treaties and declarations.

The other core UN human rights texts, prior to the CRPD, do not refer to mental health in the articles on the right to health, with two principal exceptions: The 1989 Convention of the Rights of the Child (CRC) and the 2007 Declaration on the Rights of Indigenous Peoples (UNDRIP).

The CRC addresses mental health in several articles, as analyzed in chapters 6, 10, 15 and 26 of this publication. Article 17 refers to the child's access to information aimed at the promotion, *inter alia*, of his or her mental health. Article 19 calls for measure to "protect the child from all forms of physical or mental violence," and Article 23 provides that "States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community." Article 25 mentions the right to periodic review of treatment of mental health of children placed in care facilities by the state. Article 27 mentions "the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development." Article 29 on education and Article 32 on economic exploitation refer to the development of the child's "personality, talents and mental and physical abilities" and to harm to the "child's health or physical, mental, spiritual, moral or social development" (UN, 1989).

The second exception to the absence of reference to mental health in UN texts is Article 24 of UNDRIP on the right to health. That article provides that "indigenous peoples have the right to their traditional medicines and to maintain their health practices, as well as the right to "the highest attainable standard of physical and mental health" (UN, 2007). The 2016 report of the Expert Mechanism on the Rights of Indigenous Peoples called on States to "promote health through the provision of culturally appropriate information concerning healthy lifestyles and nutrition, disease and illnesses (including mental illness), harmful traditional practices, and the availability of services." (UN, 2018b, para. 46).

The regional human rights treaties tend to include mental health in their provisions relating to the right to health, such as Article 16 of the African Charter on Human and Peoples' Rights of 1981, Article 14 of the African Charter on the Rights and Welfare of the Child of 1990, Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988, Article 39 of the Arab Charter on Human Rights of 2004, and Article 29 of the ASEAN Human Rights Declaration of 2012.

### *Mental Health in the Convention on the Rights of Persons with Disabilities (CRPD)*

The adoption of the CRPD in 2006 (UN, 2006), which entered into force in 2008, has been described as “the culmination of two and a half decades of development in international human rights law aimed at addressing human rights violation experienced by people with disabilities” (Gooding, 2017, p. 46). Significantly, Article 1 defines “persons with disabilities” as including “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others,” thus reflecting a social model, “which greatly influenced CRPD negotiations” and, building from that model, reflects the “human rights model of disability” (Gooding, 2017, p. 47). This model has been maintained by the CRPD Committee in interpreting the normative content of the Convention through its six General Comments covering Articles 5 (UN, 2018a), 6 (UN, 2016c), 9 (UN, 2014a), 12 (UN, 2014b), 19 (UN, 2017g), and 24 (UN, 2016d). A seventh is in preparation on Articles 4.3 and 33.3 (Participation with persons with disabilities in the implementation and monitoring of the Convention).

It is particularly significant to note that Article 8 of the CRPD mandates that State Parties adopt measures to organize human rights campaigns and training to increase public awareness of skills and merits of persons with disabilities. CRPD also mandates that these public campaigns address the obligations of governments to implement CRPD and establish legal and oversight mechanisms to protect the rights of persons with mental disabilities. However, it is rare that states have a well-defined independent judicial procedure that can be used by people who experience involuntary hospitalization and treatment in mental health facilities to contest that decision.

### ***Mental Health Promotion by Human Rights Procedures and Mechanisms of the United Nations***

As the main organ of the UN consisting of all member states, the General Assembly may initiate studies and make recommendations for the purpose of “assisting in the realization of human rights,” according to article 13(1) of the UN Charter. Its initiatives relating to mental health and human rights are reviewed in the next section. The other UN mechanisms that have advanced this agenda are examined in the section which follows. We do not discuss the role of the Security Council (SC) although it too has been deeply involved in addressing mental health in the context of armed conflict. Recently the SC adopted a Resolution in which it recalled to “the need for persons with disabilities, including those with physical, intellectual, psychosocial and sensory disabilities and those marginalized on the basis of their disability, to be guaranteed [the] full enjoyment without discrimination [of all human rights and fundamental freedoms]” and called on states to take appropriate measures in the context of armed conflicts. (UN, 2019) This part will focus more on the role of the UN institutions that address human rights of persons with mental disabilities outside of the situation of armed conflict.

#### *UN General Assembly*

The UN system has not only expanded the normative basis for protecting the rights of persons with mental disabilities through the elaboration of treaties and declarations discussed above, but it has developed a wide range of action plans to address these concerns.

Nearly fifty years ago the UN General Assembly began a slow evolution in adapting and adopting specific standards relating to mental health. In 1971 the General Assembly adopted the UN Declaration on the Rights of Mentally Retarded Persons, (UN, 1971) the title

of which reflects the limited understanding of the nature of mental health prevailing at the time. In 1991, the GA adopted The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (MI Principles), a much more complete and improved text. (UN, 1991). At the end of the Decade of Disabled Persons (1982-1993) the GA adopted the Standard Rules on the Equalization of Opportunities for Persons with Disabilities. (UN, 1993).

### *Other UN Human Rights Mechanisms*

The human rights mechanisms of the UN have taken the lead in the paradigm shift from the paternalistic to a more inclusive approach to mental health as a human rights concern. The essential political body making all decisions on human rights is the Human Rights Council (HRC, successor to the Commission on Human Rights), which is supported by the secretariat through the Office of the UN High Commissioner for Human Rights (OHCHR). These bodies are reviewed in the first section below. The second section looks at the monitoring and interpretation of States' obligations by UN treaty bodies. The third section focuses on the special procedures of individuals and groups appointed to monitor specific countries or themes, the most relevant for present purposes being the special rapporteurs on the right to health and on the rights of persons with disabilities.

#### *Human Rights Council (HRC) and the Office of the High Commissioner (OHCHR)*

OHCHR has addressed human rights and mental health as part of the HRC's agenda on the right to health. In response to a request from the HRC (UN, 2016a), the High Commissioner submitted a report on the integration of a human rights perspective in mental health in 2017, stressing equal recognition before the law and an absolute ban on deprivation of liberty of the mentally impaired and forced treatment. (UN, 2017a, para. 22-33). He ended with a series of recommendations, including on data collection, creating "an enabling legal and policy environment," full participation of affected communities, allocation of adequate resources, and accountability in terms of monitoring, review, remedial measures and corrective action. (UN, 2017a, paras. 36-50)

The Council, in its resolution 36/13, urged "States to take active steps to fully integrate a human rights perspective into mental health and community services, and to adopt, implement, update, strengthen or monitor, as appropriate, all existing laws, policies and practices with a view to eliminating all forms of discrimination, stigma, prejudice, violence, abuse, social exclusion and segregation within that context, and to promote the right of persons with mental disorders to full inclusion and effective participation in society, on an equal basis with others." (UN, 2017b, para. 7)

In response to another request in that resolution, the High Commissioner organized a consultation to identify strategies to promote human rights in mental health, which took place on 14 – 15 May 2018 and expanded the engagement in the "new paradigm" to a broad range of intergovernmental, academic, and civil society institutions, but not yet to the vested interests he denounced as the "gatekeepers" in mental health systems, namely, biological psychiatry, and the pharmaceutical industry, which create the "power imbalances" responsible for the current "crisis." (UN, 2018b) The consultation recommended that States "ensure that all health care and services, including all mental health care and services, are based on the free and informed consent of the individual concerned, and that legal provisions and policies permitting the use of coercion and forced interventions, including involuntary hospitalization and

institutionalization, the use of restraints, psychosurgery, forced medication, and other forced measures aimed at correcting or fixing an actual or perceived impairment, including those allowing for consent or authorization by a third party, are repealed.” (UN, 2018b, para. 46).

### *Treaty Monitoring Bodies*

Prior to the adoption of the CRPD in 2006 and the creation of the CRPD Committee, the treaty body responsible for monitoring compliance with the rights most relevant to persons with disabilities was the Committee on Economic, Social and Cultural Rights (CESCR). It drafted a General Comment on persons with disabilities, which reaffirmed MI Principles, and drew attention to the particular difficulties affecting persons with mental disabilities to enjoy the right to marry and create a family, the right to work, the right to participate in cultural life, and, notably, the right to health (UN, 1994a, paras. 21, 30, 34, 37).

In its General Comment on the Right to Health, CESCR analyzed the normative content of the right in terms of accessibility, affordability, appropriateness and of quality of care, and specified the duties of the state to respect, protect and provide this right (UN, 2000, paras. 34-37). With respect to mental health, the Committee interpreted paragraph 2 (d) of Article 12 of the Covenant (which refers to "conditions which would assure to all medical service and medical attention in the event of sickness") as covering “both physical and mental,” and including “appropriate mental health treatment and care.” (UN, 2000, para. 17, emphasis added).

The CESCR refers to mental disability as proscribed grounds of “discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement” (UN, 2000, para. 18). It also refers to access of children to mental health services (UN, 2000, para. 22) and stresses non-discrimination in access of persons with disabilities to both public and private health providers (UN, 2000, para. 26). The committee does recognize that “coercive medical treatments” may be applied as “an exceptional basis for the treatment of mental illness... subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the [MI] Principles” (UN, 2000, para. 34).

### *Special Procedures*

The first Special Rapporteur on the Right to Health, Paul Hunt, paid considerable attention to the human rights and mental health, noting soon after his appointment, “discrimination and stigma associated with particular health conditions such as mental disabilities..., tend to reinforce existing social divisions and inequalities.” (UN, 2003, para. 59.) He devoted his 2005 report to mental health, describing persons with mental disabilities as “a group that is among the most neglected, marginalized and vulnerable” (UN, 2005, summary). He addressed in particular intellectual disabilities, community integration and consent to treatment. (UN, 2005, paras. 76-90) He recommended “that States enhance and amplify policy and legal initiatives in the field of mental disability” and affirmed that “a human rights approach, including participation, autonomy, dignity, and inclusion, should guide all these actions” (UN, 2005, para. 93).

The second Special Rapporteur on the Right to Health, Anand Grover, addressed informed consent in 2009 (UN, 2009) and compulsory treatment for drug dependence in 2010 (UN, 2010), without, however, more than brief references to mental health.

The current mandate holder, Dainius Pūras, himself a mental health professional and professor of child psychiatry, submitted his 2017 report to the Human Rights Council on the topic of mental health (UN, 2017c), declaring at a press conference: “We need little short of a revolution in mental health care to end decades of neglect, abuse and violence” (UN, 2017d). Through strong language Pūras articulated a set of priorities and a rethinking that is echoed in the more diplomatic language of the High Commissioner and the HRC, whose pronouncements are politically significant. In his call for a “paradigm shift” away from the “reductionist biomedical model” of mental health and toward rights-based approach, he noted that the CRPD “laid the foundation... with the aim of leaving behind the legacy of human rights violations in mental health services” (UN, 2017c, para. 11). He identified the obstacles to the shift toward a psychosocial model based on human rights, drawing attention in particular to the dominance of the biomedical model, power asymmetries and biased use of evidence in mental health research and interventions. (UN, 2017c, paras. 18-29). He identified the components of a “right to mental health framework” as international cooperation—through meaningful and active participation of rights holders; non-discrimination, in particular in the misuse of mental health diagnoses to pathologize identities; accountability through monitoring, review, and remedies; rights-based mental health care as an essential aspect of health care; informed consent and non-coercive options; and concerted action to secure certain social determinants associated with mental health and reflected in healthy psychosocial environments. (UN, 2017c, para. 35-68.) Following his report and that of the OHCHR secretariat, the Council adopted a resolution in which it called on states to integrate a human rights lens into mental health care (UN, 2017b, para. 7).

Other special procedures, such as the Special rapporteur on the Rights of person with disabilities, the Special Rapporteur on extrajudicial, summary or arbitrary and the Special rapporteur on the rights of indigenous peoples have addressed mental health and the tension between the biomedical model and the social one.

Another example is the Special Rapporteur on Torture (SRT), Juan Mendez, who called on States to “[i]mpose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short- term application” and to “Replace forced treatment and commitment by services in the community” (UN, 2013, para. 89 (b)). However, in a letter to the leaders of APA and the World Psychiatric Association (WPA), Mendez clarified the above positions and wrote that he “did not mean to propose an absolute ban on nonconsensual interventions (including institutionalization and restraints) under any and all circumstances” (Levin, 2014).

## **Integrating Normative Approaches to Human Rights and Mental Health**

The development of a human rights-based approach in mental health practice and in the normative framing by the UN and other international organizations has progressed considerably over the last thirty years and especially since the adoption of the CRPD. Drawing on these two streams of evolving approaches to mental health, this part will summarize the current state of human rights standards applicable in mental health.

Unlike the MI principles, the CRPD does not signal out mental disabilities but includes them in its comprehensive approach. Table 1 compares the rights defined in the MI Principles and those in the CRPD. The aim of this enumeration of rights defined in these two essential



documents on mental health and human rights is to underscore that the mental health-specific provisions of the MI Principles may be considered as adding to the normative content of the corresponding articles of the CRPD and the latter provide a legally-binding force to the corresponding non-binding pronouncement of the MI Principles.

The fact, for example, that the MI Principles do not mention the rights to life or to a nationality, freedom of movement, special physical and communication access, political rights, empowerment of women, or reproduction and family rights, does not mean that these rights are not protected for persons with mental disabilities; on the contrary, the CRPD clearly confirms that they apply and the silence of the MI principles on these matters in no way weakens their value. Similarly, the failure of the CRPD to reaffirm the right of persons with mental illness to protection from political interference in determining their health status, the standard of care that should prevail in mental health facilities, and the avoidance of forced treatment does not diminish these rights; rather, the MI Principles offer an interpretative guide to applying the CRPD to persons with mental illness. They were designed primarily to apply to rights of persons with mental illness under treatment, and are quite detailed in doing so, although they appropriately reaffirm that “Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights.” (Principle 1.5)

**Table 1: Comparison of rights in the MI principles and the CRPD**

<i>Rights defined</i>	<i>1991 MI Principles</i>	<i>2006 CRPD</i>
Rights to life and integrity		Article 10 (“Right to life”); Article 17 (“respect for ... physical and mental integrity”)
Right to health	Principle 1.1 (“All persons have the right to the best available mental health care, which shall be part of the health and social care system.”)	Art. 25 (detailed but no specific reference to mental health)
Respect for dignity	Principle 1.2 (“All persons with a mental illness... shall be treated with humanity and respect for the inherent dignity of the human person.”)	Article 3 (a) (“Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons”)
Non-discrimination	Principle 1.4	Articles 3 (b), 4 (e), 5, 6 (women and girls) and 25 (e)
Liberty of movement and nationality		Article 18 (“freedom to choose their residence and to a nationality”); Article 20 (“Personal mobility”)
Protection from exploitation and abuse	Principle 1 (“protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment”); Principle 8 (“patient shall be protected from harm,	Article 15 (“Freedom from torture or cruel, inhuman or degrading treatment or punishment.”); Article 16 (“Freedom from exploitation, violence and abuse”)

	including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort”)	
Freedom of expression, opinion and information	Principle 19 (“access to the information concerning the patient in his or her health and personal records”)	Article 21 (“Freedom of expression and opinion, and access to information (including “accessible formats and technologies ... augmentative and alternative communication, ... Internet”)
Community integration	Principle 3 (“...right to live and work, as far as possible, in the community.”); Principle 7 (“right to be treated and cared for, as far as possible, in the community in which he or she lives”)	Article 19 (“equal right ... to live in the community, ... and full inclusion and participation in the community, including by ensuring that: [they can]... choose their place of residence... access to ... support services... [and that] Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.”); Article 25(c)
Political interference	Principle 4 (Medical, not political, determination of illness)	
Protection of privacy and confidentiality of information	Principle 6 (“right of confidentiality of information concerning all [persons with mental disabilities]”); Principle 19 (patient’s “access to the information concerning the patient in his or her health and personal records” and any decision to withhold is “subject to judicial review”)	Article 22 (Respect for privacy, including “the privacy of personal, health and rehabilitation information.”)
Standard of care	Principle 8 (“protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.”)	

Least restrictive environment and least restrictive or intrusive treatment, in accordance with Principles of Medical Ethics	Principle 9 (“right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment ... directed towards preserving and enhancing personal autonomy.”)	
No compulsion	Principle 5 (“No person shall be compelled to undergo medical examination ... except in accordance with a procedure authorized by domestic law.”)	
Medication	Principle 10.1 (“Medication ... only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others.”)	
Free and informed consent	Principle 11 (“obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient.”)	Article 25(d) (“provide care ... on the basis of free and informed consent...”)
Right to refuse treatment	Principle 11 (“right to refuse or stop treatment” with exceptions ... Sterilization shall never be carried out as a treatment for mental illness.”)	
Notification of rights to patients in MH facility	Principle 12	
Protection of rights in MH facilities	Principle 13 (Respect for legal personhood, privacy, communication, religion, recreation, education, vocational rehabilitation, nor forced labor or exploitation.)	Article 12 (“Equal recognition before the law” in general but not specific to MH facilities)
Resources in MH facilities	Principle 14 (“same level of resources as any other health establishment” in terms of	

	qualified staff, equipment, care and treatment.)	
Involuntary institutionalization	Principle 15 (“every effort shall be made to avoid involuntary admission.”) Principle 16 (Admitted or retained involuntarily only if qualified MH practitioner considers “serious likelihood of immediate or imminent harm to that person or to other persons” or “failure to admit or retain...is likely to lead to a serious deterioration of his or her condition or will prevent...treatment in accordance with the principle of the least restrictive alternative.”)	Article 14 (“Liberty and security of person ... the existence of a disability shall in no case justify a deprivation of liberty.”)
Accessibility		Article 9 (“...access ... to the physical environment, to transportation, to information and communications, ...”)
Access to justice and remedies	Principle 17 (“judicial or other independent and impartial body established by domestic law...[to assess if] criteria for involuntary admission are satisfied, ... right to appeal to a higher court”) Principle 18 (“Procedural safeguards”) Principle 21(patient’s right to make a complaint); Principle 22 (“Monitoring and remedies”)	Article 13 (“effective access to justice for persons with disabilities on an equal basis with others...”)
Political rights		Article 29 (“Participation in political and public life”)
Women and girls		Article 6 (“ensure full and equal enjoyment ... of all human rights and fundamental freedoms [for women and girls] ... ensure the full development, advancement and empowerment of women ...”)
Reproductive and family rights		Article 23 (right to “found a family ... decide freely ...

		number and spacing of ... children, ...access to...family planning... retain their fertility ... prevent concealment, abandonment, neglect and segregation of children with Disabilities ... alternative care [when necessary]”)
Children’s rights	Principle 2 (“Protection of minors”)	Article 7 (“best interest of the child”)
Inclusive education		Article 24
Right to work and employment	Principle 13.3 and 4 (No forced labour in a mental health facility. ... patient choice of type of work. “The labour of a patient shall not be exploited. ... right to ... same as would...be paid for such work to a non-patient.”)	Article 27 (“Right ... to work, [including a] work environment that is open, inclusive and accessible to persons with disabilities. [without] discrimination on the basis of disability equal remuneration for work of equal value, safe and healthy working conditions, including protection from harassment, and the redress of grievances...”)
Participation in cultural life, leisure and sports	Principle 7 (“treatment suited to his or her cultural background.”); Principle 13.2.a (“Facilities for recreational and leisure activities”[in mental health facilities]); Principle 13.2.d (“facilities, ... suited to his or her social and cultural background” [in mental health facilities])	Article 30 (“Participation in cultural life, recreation, leisure and sport ... in accessible formats ...”)
Awareness raising	Principle 23 (“States shall make the present Principles widely known by appropriate and active means.”)	Article 8 (“foster respect ... combat stereotypes ... [through] campaigns ... education ... media... training”)

The MI Principles have been used to interpret human rights treaties. In 1994 the CESCR general comment on persons with disabilities drew on MI Principle 13 (3) to determine that “‘therapeutical treatment’ in institutions which amounts to forced labour is also incompatible with the [ICESCR].” (UN, 1994b, para. 21). It also drew attention to the particular difficulties affecting persons with mental disabilities to enjoy the right to marry and have a family, the right to work, the right to participate in cultural life, and, of course, the right to health (UN, 1994b, para. 30, 34, 37).

Of course, “insanity” has long been an exception to the application of the death penalty where capital crimes have been committed (Wilson, 2016). The UN Committee on Crime Prevention and Control and the Special rapporteur on extrajudicial, summary, or arbitrary executions, among others, addressed “execution of the mentally handicapped” in the 1980s and 1990s (Schabas, 1998, p. 820, 824). As noted by the Secretary-General in his 2017 supplement to his quinquennial report on capital punishment, prohibition of the death penalty on persons suffering from any mental or intellectual disabilities “is firmly rooted in the customs and practices of most legal systems” (UN, 2017g, para. 50), although “in practice, many elements subjectively assessed can result in sentencing persons with mental disabilities to death, starting with the lack of a clear definition and understanding of ‘mental disability’ and other terms.” (UN, 2017g, para. 51). He recommends that “States should ensure that persons with mental or intellectual disabilities are not sentenced to death. Laws and sentencing guidelines must be developed or amended to prohibit the imposition of the death sentence and the execution of such persons” (UN, 2017g, para. 56.).

Clearly, the greatest progress in affirming the rights of person with mental disabilities between the MI Principles and the CRPD is the trend away from forced institutionalization and treatment in violation of patient autonomy and freedom from arbitrary arrest and detention. Before a patient can be admitted or retained involuntarily, it should be determined that there is “serious likelihood of immediate or imminent harm to that person or to other persons” or “failure to admit or retain... is likely to lead to a serious deterioration of his or her condition or will prevent... treatment in accordance with the principle of the least restrictive alternative.” It is generally accepted that the CRPD supersedes Principles 16 pertaining to involuntary hospitalization and treatment (Minkowitz, 2014, p. 233).

The potential tension is particularly true with respect to MI Principle 16 relating to a person’s lacking legal capacity “by reason of his or her mental illness, [as determined by] a fair hearing by an independent and impartial tribunal established by domestic law.” To set in motion an involuntary admission or treatment, MI Principle 16 requires a qualified mental health practitioner authorized by law, and if need persists, followed by consultation with another independent mental health practitioner and a judicial review body. The mental health facility should be legally authorized to receive such an admission.

Gooding (2017) points out that the formulation in the CRPD is a large deviation from the conceptualization of legal capacity in MI Principle 16. Mahomed, Stein, and Patel (2018) discuss the implications of legal capacity and the right to equal recognition before the law of CRPD Article 12. Its interpretation is consistent with General Comment 1 (GC1) on Article 12, which asserts the equality of all people in decision-making competency at all times. In periods of compromised legal capacity, the person’s will and preference should determine treatment. When this is not possible, the clinician should use a standard of the “best interpretation of the individual’s will and preference,” implying prior knowledge of or ability to communicate with the person, which may not always be feasible. In such cases, advanced directives, legal proxies or ombuds, could serve as remedies.

Many clinicians and family members feel that this directive is simply unattainable and does not take into consideration the realities of situations involving imminent or long-term risk to self or others. There seems to be increasing consensus about the need for continued discussion on the interpretation and practical applications of GC1. The dialogue should include a wide range of mental health professionals, service users and their families.

More recently, legislation has sought to balance safety of patients and others with the social model of disability. Mental health legislation can “prevent human rights violations and

discrimination; promote autonomy and liberty of people with mental disorders; promote access to mental health care and community integration; protect the rights of mentally ill offenders; legally enforce the goals and objectives of a mental health policy; establish independent review and monitoring mechanisms; and promote and protect human rights more generally” (Freeman & Pathare, 2005).

Notably, 43% of countries do not have any mental health legislation (Mental Health Atlas, 2017). Of course, legislation is not enough to ensure accountability; legal remedies are being implemented by NGOs and agencies providing services and advocacy for people with disabilities. In the absence of legal remedies and effective regulatory and oversight mechanisms within the domestic sphere, many people in LMICs have relied on international and regional human rights systems and organizations for justice and redress. Access to oversight mechanisms, judicial review, and access to legal remedies should be feasible for all persons with mental disabilities.

## **Conclusion**

We have outlined the main human rights challenges of mental health and the responses in standard-setting and institutional practice to those challenges, as well as proposed an integrated approach to applying the emerging norms to controversial issues of mental health in practice. In conclusion, we propose guidelines for mental health practice and assess the gap between human rights law and mental health practice.

### ***Guidelines for Mental Health Professionals***

The year 2012 was a turning point in human rights in mental health. In May 2012, the Sixty-fifth World Health Assembly adopted the Mental Health Action Plan (2013-2020), a comprehensive action plan developed through consultations with Member States, civil society and international partners (WHO, 2013). It emphasizes coordinated services from the health and social sectors for promotion, prevention, treatment, rehabilitation, care and recovery. Its objectives are “to strengthen effective leadership and governance for mental health; to provide comprehensive, integrated and responsive mental health and social care services in community-based settings; to implement strategies for promotion and prevention in mental health; to strengthen information systems, evidence and research for mental health” (WHO 2013, p. 10). A strong cross cutting theme of the Plan is human rights of persons with mental disorders, with a focus on respect for individual autonomy and the protection of dignity. The Plan clearly states that “Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.” The human rights theme is integrated with other themes such as universal health coverage, multisectoral approach, evidence-based practices, empowerment of persons with mental disorders, and a life course approach. This integration underscores that human rights are inextricably linked to other rights in the person’s ecology.

In 2012, WHO also launched the QualityRights Tool Kit, a paradigm-shifting tool that offers countries practical information and guidance on the full range of human rights standards pertaining to living conditions and quality of treatment in mental health facilities and staff treatment of service users (WHO, 2012). The tool kit draws upon specific articles of the CRPD grouped under five human rights themes operationalized clearly through specific criteria and standards: “the right to an adequate standard of living and social protection; the right to enjoyment of the highest attainable standard of physical and mental health; the right to exercise

legal capacity and to personal liberty and the security of person; freedom from torture or cruel, inhuman or degrading treatment or punishment; from exploitation, violence and abuse; and the right to live independently and be included in the community.” The tool kit provides practical guidance on standards to be respected and protected in mental health facilities, and on preparation and implementation of assessment of facilities including drafting the report with recommendations.

As part of its QualityRights campaign to end violations against persons with mental disabilities, WHO has created MiNDBank, an online, free-of-cost, globally accessible platform that adopts a data-driven approach, consolidating over 7500 regional/national resources, to help policy makers, researchers, and practitioners evaluate the situation, identify legal and policy gaps to inform decision making for better health and human rights outcomes (WHO, 2014).

Among the critical tools to promote access to optimal care are access to knowledge and evidence-based clinical practices and tools, and a clearly articulated system of accessible and coordinated community care in primary care centers and, when needed, specialist care. The practitioner should be attentive to the person’s experience of the condition and provide respectful explanations of treatment approaches to the person and the person’s support system, including a discussion of treatment options, listening to and addressing disagreements to the care plan, and problem-solving around undesirable aspects of treatment (such as side effects or need for hospitalization). The approach has to emphasize the person’s strengths and abilities and support autonomy and maximum participation in life. Finally, the clinician needs to address advance directives, legal rights and proxy when the person is receptive and willing.

In clinical practice, one of the major controversies involves clinicians faced with lack of consent for treatment in cases when the decision-making ability is compromised, such as during episodes of psychosis, or when the person refuses admission to an inpatient unit or refuses to accept treatment while inpatient or wishes to be discharged against medical advice. The clinician is faced with the complexity of balancing the person’s freedoms to refuse treatment and right to appropriate treatment, on the one hand, and the clinical, family, and social demands for protection from the consequences of untreated mental disorders, on the other. There is some evidence that the application of a human rights-based approach to mental health interventions may contribute to positive therapeutic outcomes. Although limited by uneven quality in methods, a review of studies using a human-rights approach to service delivery showed widespread benefits, such as clinical improvements and potentially cost-savings (Mann, Bradley, & Sahakian, 2016).

### ***Emerging Trends in Applying Human Rights Law to Mental Health***

From “lunatics” to “mad” to “mentally retarded” to “mentally ill” to “persons with mental health conditions or psychosocial disabilities,” the terminology reflects changing attitudes toward mental health and indirectly toward the sensitivity to human rights concerns. It echoes the evolution of perception from “deranged” to “victim” to “person with rights.” This change is also evident in the shift from the medical to the social model in addressing mental health. A clear example is the application of a biomedical model in the 1991 MI Principles, replaced by a social model in the 2006 CRPD. The normative language adapted to most current terms reflecting the language of mental health professionals that is the most respectful to people with mental disabilities. So, one conclusion from the human rights perspective is that the shift in attitudes of health professionals is reflected in the normative evolution of human rights as applied to mental health.



The increasing involvement of OHCHR, treaty bodies, special procedures, courts of law and other human rights mechanism with mental health, including cases against countries whose policies and practices lag behind the evolving normative framework of mental health and human rights, is further evidence of the mutually reinforcing frameworks of mental health and human rights.

While consent to treatment is a critical human rights concern, a disproportional focus on it perpetuates the perception of persons with mental disorders as risky and “out of control.” Part of the solution to this dilemma is to move from a reactive approach, when the person is already too compromised to consent, to a preventive and proactive approach, which is community-based, emphasizing alliance, rather than compliance. Care should go hand-in-hand with community education on mental health and human rights, as well as opportunities for participation in community common goals and involvement with other persons with lived experience.

The decades ahead will provide ample opportunity to pursue the radical shifts that mental health and human rights professionals have proposed. We have entered a stage of greater normative clarity regarding the rights applicable to persons with mental disabilities, but we also face enormous challenges to bring practice into conformity with this emerging understanding of a human rights approach to mental health.

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The practices reported above undermine the right to health that is recognized in the Covenant as well as in article 25 of the UDHR. The International Covenant on Economic, Social and Cultural Rights (1966), together with the Universal Declaration of Human Rights (1948) and the International Covenant on Civil and Political Rights (1966), make up the International Bill of Human Rights. The Covenant was adopted by the UN General Assembly (UNGA) in its resolution 2200A (XXI) of 16 December 1966.Â The meeting focused on identifying strategies to promote human rights in mental health and it was opened to all interested stakeholders.