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Is Compulsory Detention and Involuntary Treatment of Mental Health Patients Always a Breach of Human Rights?

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IS COMPULSORY DETENTION AND INVOLUNTARY TREATMENT OF MENTAL HEALTH PATIENTS ALWAYS A BREACH OF HUMAN RIGHTS?

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I. ABSTRACT

The fundamental question this paper seeks to address is whether compulsory detention and involuntary treatment of mental health patients is a breach of international human rights provisions. Human rights are the basic rights and freedoms that belong to everyone and which are based on shared values like dignity, fairness, justice, and equality. These rights are not just abstract principles. As early as 1946, the World Health Organization described health as one of the fundamental rights of every human being. Their constitution asserts that "governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."[1]

Human rights law is important in the context of mental health because of two fundamental ideas unique to the protection of rights and freedoms. First, human rights law is the only source of law that legitimizes international scrutiny of mental health policies and practices within a sovereign country. Individuals have always had inherent rights and freedoms, however, recognizing this right is a new phenomenon and it is just in recent times that we have parties being held accountable for violations. Second, human rights law provides fundamental protections that cannot be taken away by the ordinary political process. People possess rights simply because of their being human. Thus, persons with mental disabilities need not prove that they deserve certain rights or can be trusted to exercise them in socially and culturally acceptable ways. This area of mental health has posed difficult questions for doctors such as when it is justifiable to treat patients against their will. Respect for autonomy is a central principle in contemporary healthcare ethics. Therefore, under normal circumstances, treatment should only be performed with the patient's consent. However, how does this work if the patient has been determined mentally incapable of making rational decisions and therefore unable or unwilling to give consent? The question then is should the doctor still proceed with what they believe to be in the best welfare of the patient or withhold treatment because the patient is unable or unwilling to give consent?

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[1] Constitution of the World Health Organization (Jul. 22, 1946) 14 U.N.T.S. 185.

This paper explores situations in which a mental health patient's human rights might need to be restricted for his own preservation or to protect others who may be affected by the patient's actions or behavior. When thinking about restricting rights, any such action should be proportionate. This means that mental health care practitioners must be able to show that they have taken the individual's rights into account and that any restriction is kept to the minimum possible and is never excessive. Restrictive policies should not adopt a blanket approach that affects all patients but should be assessed and applied on an individual and proportionate basis.

II. OVERVIEW OF THE HUMAN RIGHTS OF MENTAL HEALTH PATIENTS

Traditionally, disability had not been regarded as a human rights issue despite disabled people constituting one of the most marginalized and socially excluded groups in any society.[2] The issue of the human rights for persons with mental disabilities has been ignored for decades by national governments around the world and even by international agencies vested with the protection of mental health, resulting in poor access to care for mental health patients.[3] Disability was seen only as a medical problem of the individual requiring a treatment or cure in order to make the disabled individual a functioning member of society.[4] By viewing mental health as a human rights issue, however, we are required to address the inherent equality of all people, regardless of abilities, disabilities, or differences, and forced to break down barriers to equality and inclusion of people with disabilities.[5]

The stigmas associated with mental illness have fueled misperceptions and perpetuated enduring negative stereotypes both in real life and in the media.[6] As a result, these myths have become pervasive and influential on the public discourse surrounding mental disability and the right

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[2]Sophie Mitra, *The Capability Approach and Disability*, 16 J. DISABILITY POL'Y STUD. 236, 236-37 (2006).

[3] Laural Asher & M. J. De Silva, *A Little Could Go a Long Way: Financing for Mental Healthcare in Low and Middle-Income Countries*, 26 EPIDEMIOLOGY & PSYCH. SCI. 3, 248, 248 (2017).

[4] Anita Silvers, *A Fatal Attraction to Normalizing: Treating Disabilities as Deviations From "Species-Typical" Functioning*, GEO. UNIV. PRESS 95 (1998).

[5] PROMOTING INCLUSION THROUGH SOCIAL PROTECTION 63 (United Nations Publication, 2018).

[6] Otto F. Wahl, *Media Madness: Public Images of Mental Illness,* RUTGERS UNIV. PRESS (1995).

to mental health.[7] The first myth is that of incompetency, which relies on the false assumption that persons with mental disabilities cannot competently make decisions or grant consent.[8] In actuality, mental disabilities vary substantially. While some mentally disabled people lack competency, others have full competency or merely limited incapacity. The public is not aware of many people living with mental health problems because they are highly active and productive members of society. A person's right to mental health clearly may be undermined if he or she is erroneously assumed to be incompetent. A second destructive myth is the common misconception that persons with mental disabilities pose a threat to others. Extensive research shows that persons with mental disabilities have no greater propensity to commit violent acts than anyone else.[9] In fact, people with mental illness are far more frequently the victims of violence than the general population.[10] Nevertheless, the media often gives disproportionate attention to the rare cases when a mentally disabled person commits a violent crime.[11] Even a single high-profile incident of this nature can fuel public outrage and stigma against all persons with mental disabilities and may provide the motive to enact more severe mental health laws. These stigmas lead to further discriminatory behaviors. Persons with mental illness are less likely to gain employment,[12] less likely to find adequate housing,[13] and more likely to be arrested.[14]

For these reasons, applying international human rights laws to mental health is critical. The fundamental nature of human rights is that

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[7] Nicolas Rusch et al., *Mental Illness Stigma: Concepts, Consequences, and Initiatives to Reduce Stigma*, 20 EUR. PSYCH. 529 (2005).

[8] Peter Hayward & Jenifer A. Bright, *Stigma of Mental Illness: A Review and Critique*, 6 J. MENTAL HEALTH 4, 345 (1997).

[9] *Executive Summary*, MACARTHUR RSCH. NETWORK ON MENTAL HEALTH & L. (Apr. 1999), http:// www.macarthur.virginia.edu/risk.html.

[10] Seena Fazel & Martin Grann, *The Population Impact of Severe Mental Illness on Violent Crime*, 163 AM. J. PSYCH. 1397 (2006).

[11] Michael Smith, *Role of the Popular Media in Mental Illness*, 349 THE LANCET 1779, 1779 (1997).

[12]David E. Drehmer & James E. Bordieri, *Hiring Decisions for Disabled Workers: The Hidden Bias*, 16 J. APPLIED SOC. PSYCH. 197 (1986).

[13] Page Stewart, *Effects of the Mental Illness Label in Attempts to Obtain Accommodation*, 9 CAN. J. BEHAV. Sci. 85 (1977).

[14] Larry Sosowsky, *Explaining the Increased Arrest Rate Among Mental Patients: A Cautionary Note*, 137 AM. J. PSYCH. 1602 (1980).

human rights are rights inherent to all human beings without distinction.[15] Governments do not possess the power to grant or deny human rights and freedoms. They are instead obligated to promote and protect human rights and fundamental freedoms of individuals or groups and refrain from hindering and interfering with the enjoyment of such rights.[16] Persons have rights simply because they are human.[17] Thus, mental health patients do not have to prove that because they can act in socially and culturally acceptable ways, they deserve human rights.[18] International human rights law can therefore serve as a basis to challenge unjust treatment of people with mental disabilities, even in the face of popular or political objections.[19]

The World Health Organization (WHO) notes that globally, about 450 million people have some sort of neurological health condition.[20] People with mental illness, especially, encounter human rights violations and are usually less able to advocate for their basic rights.[21] Mental health services, which include community and hospital-based psychiatric care, housing, and access to medications, routinely receive inadequate funding from both public and private sources, potentially leaving people with mental illness with an absence of enforceable legal protections and life-saving services.[22]

For people with mental disabilities, in particular, the presence of human rights legislation may be even more significant than for people with other kinds of disabilities.[23] Violations of their basic human rights and freedoms are a common occurrence worldwide both within institutions and in their community, which violates Article 12 of the International Covenant

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[15] G.A. Res. 217 (III) A, Universal Declaration of Human Rights, at art. 2 (Dec. 10, 1948).

[16] *Id.* at art. 12-19.

[17] *Id.* at art. 1.

[18] Lawrence O. Gostin, *Human Rights of Persons with Mental Disabilities*, 23 INT'L J. LAW & PSYCH. 2, 125 (2000).

[19] *Id.*

[20] *Investing in Mental Health*, WORLD HEALTH ORGANIZATION [WHO] at 1 (2003).

[21] Wahl, *supra* note 7.

[22] *The Numbers Count – Mental Disorders in America*, NAT'L INST. MENTAL HEALTH, archived at https://web.archive.org/web/20131004192638/http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml.

[23] *WHO Resource Book on Mental Health, Human Rights and Legislation,* WHO 1, 83 (2005).

on Economic, Social and Cultural Rights (ICESCR),[24] which "recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." People with mental disabilities face stereotypes and prejudice which lead to deprivation.[25] In their communities, they often remain imprisoned by the social isolation they experience because they are unable to care for themselves. They also face denial of education and employment[26] because they have not received the education and training needed to obtain employment or because of discrimination based on unsubstantiated fears and prejudice leading to unfair access to services, health insurance, and housing.[27]

The core reason for mental health legislation is human rights. The right to health, as it exists in international human rights instruments, clearly encompasses both physical and mental health.[28] The promotion and protection of both mental and physical health are necessary to ensure one's ability to enjoy and benefit from other human rights. Thus, efforts to recognize and uphold a human right to mental health must also include the right to be free from interference, such as the right to be free from compulsory detention and involuntary medical treatments.[29] Establishing and upholding mental health rights will advance the dignity and welfare of persons with

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[24] G.A. Res. 2200A (XXI), International Covenant on Economic, Social and Cultural Rights (Dec. 16, 1966) 993 U.N.T.S. 14531.

[25] Jennifer Crocker et al., *Social Stigma*, 2 HANDBOOK PSYCH. 4, 504 (1998).

[26] PETER DAVID BLANCK & DAVID L. BRADDOCK, THE AMERICANS WITH DISABILITIES ACT AND THE EMERGING WORKFORCE: EMPLOYMENT OF PEOPLE WITH MENTAL RETARDATION, AM. ASS'N OF MENTAL RETARDATION (1998).

[27] *See e.g.*, Michael L. Perlin, "*What's Good Is Bad, What's Bad Is Good, You'll Find Out When You Reach the Top, You're on the Bottom:" Are the Americans with Disabilities Act (and Olmstead v. L.C.) Anything More than "Idiot Wind?*" 35 U. MICH. J. L. REFORM 235 (2001); Michael L. Perlin, "*I Ain't Gonna Work on Maggie's Farm No More:" Institutional Segregation, Community Treatment, the ADA, and the Promise of Olmstead v. L.C.,* 17 T.M. COOLEY L. REV. 53 (2000); Michael L. Perlin*, "For the Misdemeanor Outlaw:" The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities*, 52 ALA L. REV. 193 (2000); Michael L. Perlin*, "Their Promises of Paradise:" Will Olmstead v. L.C. Resuscitate the Constitutional Least Restrictive Alternative Principle in Mental Disability Law?,* 37 HOUS. L. REV. 4, 999 (2000) (all discussing the Americans with Disabilities Act, 42 U.S.C. §§ 12101 et seq.).

[28] *WHO Resource Book on Mental Health, Human Rights and Legislation, supra* note 24.

[29] U.N. Committee on Economic, Social and Cultural Rights, *General Comment no. 14: International Covenant on Civil and Political Rights (art. 7)* (Dec. 16, 1966).

mental disabilities[30] and at the same time ensure their access to quality health services.

An interdependent relationship exists between mental health and human rights. The preamble to the 1946 Constitution of the World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[31] However, some mental health policies violate the rights of mental health patients in an extremely abusive manner.[32] These policies usually involve the exercise of governmental power, that is, the power to restrain, to treat, and to deprive individuals of basic rights of citizenship.[33] There is an assumption that these policies are exercised beneficently for the welfare of the individual as well as family and society.[34] Unfortunately, governmental authority by its very nature affects a variety of personal interests such as autonomy, bodily integrity, privacy, property, and liberty.

Second, human rights violations adversely affect mental health.[35] The mental health effects of severe human rights violations, such as torture, rape, genocide, and inhuman and degrading treatment, are obvious and inherent. Yet, the duration and extent of associated mental health problems remain under-appreciated. Severe abuses of human rights result in serious life-long mental suffering not only by the individual, but often the family, community, and even future generations.[36] Even less drastic human rights violations, such as discrimination and invasion of privacy, can affect a person's dignity and self-worth.[37]

Third, mental health and human rights are inseparable.[38] Human rights are required for mental health because they provide security from harm or restraint and the freedom to form and express beliefs that are essential to

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[30] G.A. Res. 217 (III) A, *supra* note 16.

[31] *Preamble to the Constitution of the World Health Organization*, 2 OFF. REC. OF THE WHO, 100, 100 (July 22, 1946).

[32] *The Numbers Count – Mental Disorders in America, supra* note 23 at 4.

[33] U.S. CONST. amend. XIV.

[34] *Shackled Day and Night in Nigeria*, BBC NEWS (Jan. 16, 2021), http://news.bbc.co.uk/1/hi/world/africa/76130.stm.

[35] J. Arboleda-Florez, *Stigmatization and Human Rights Violations*, *in* MENTAL HEALTH: A CALL FOR ACTION BY WORLD HEALTH MINISTERS 57 (WHO, 2001).

[36] *Id*.

[37] Doron Shultziner & Itai Rabinovici, *Human Dignity, Self-Worth, and Humiliation: A Comparative Legal-Psychological Approach*, 18 PSYCH., PUB. POL'Y, & L. 1, 105 (2012).

[38] Pedro Anderson et al., *Physical and Mental Health: Joining Inseparable Fragments of a Universal Health Coverage*, INT'L FED'N MED. STUDENTS' ASSOC.

mental well-being.[39] The advancement of human rights thus benefits mental health. This, as well as moral and legal obligations, are reasons to advance the human rights of mental health patients.

A country that has in place mental health legislation reflects a society that respects and cares for its people.[40] However, some countries either do not have mental health legislation or have legislation that stems from a more repressive society. The danger of outdated laws is that the provisions do not conform to international human rights standards because initial mental health laws were drafted to protect the public from supposedly dangerous patients rather than for the promotion and protection of the human rights of persons with mental illness.[41] Consequentially, persons with mental disabilities may lack valuable legal protection rooted in human rights, or protection may be under-enforced, even where available under law.[42]

According to a WHO report, mental health spending represents less than five percent of general government health expenditures across all income groups.[43] Mental health simply does not enjoy parity with physical health in terms of budgeting and attention, thus creating a situation whereby a person's mental health is ranked below their physical health.[44] The only care made available for the protection of mental health patients is in psychiatric institutions, with many of them associated with significant human rights violations reflected in inhumane treatment and living conditions, such as shackling or locking up in confinement for extended periods of time.[45]

The Human Rights Council (HRC) was mandated in a resolution[46] by the Office of the High Commissioner for Human Rights (OHCHR) to prepare a report identifying some of the major challenges faced by users of mental health services, persons with mental health conditions, those with psychosocial disabilities, and to include a list of recommendations. The

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[39] G.A. Res. 2200 (XXI), International Covenant on Civil and Political Rights, art. 18 (Dec. 16, 1966).

[40] Wahl, *supra* note 7 at 1.

[41] *Id*.

[42] Lawrence Gostin & Lance Gable, *The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health*, 63 MD. L. REV. 1, 20 (2004).

[43] *Mental Health Atlas,* WHO (2015).

[44] *Id.*

[45] *Caged Beds: Inhuman and Degrading Treatment in Four EU Accession Countries*, Mental Disability Advocacy Center (2003).

[46] G.A. Res. 32/18 (July 1, 2016).

council, in its report before the United Nations General Assembly (UNGA),[47] identified systemic challenges to mental health that include stigma and discrimination; violations of economic, social, and other rights; and the denial of autonomy and legal capacity. A year later, the HRC in its thirty-sixth session, while reaffirming its report before UNGA, recognized that persons with psychosocial disabilities, persons with mental health conditions, and users of mental health services face widespread discrimination, stigma, prejudice, violence, abuse, social exclusion and segregation, unlawful or arbitrary institutionalization, over-medicalization and treatment practices that fail to respect their autonomy, will, and preferences.[48]

Lack of resources has also been indicated as a major challenge to the human rights of mental health patients. Despite the impact of mental health conditions on individuals, families, and communities, there is inadequate investment of both financial and human resources to mental health. Implications of this include inadequate provision of services, insufficiently trained mental health professionals, minimal accessibility to quality mental health services, and the inadequate delivery of services that meet human rights standards. This violates Article 2 (1) of the ICESCR, which states that:

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.[49]

The practices identified by the HRC above also undermine the provision of the International Bill of Human Rights,[50] which is made up of the ICESCR (1966),[51] the Universal Declaration of Human Rights (1948),[52] the UN Convention for the Prevention of Torture and Inhuman or Degrading

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[47] Hum. Rts. Council, Rep. of the Hum. Rts. Council on Its Thirty-Fourth Session, U.N. Doc. A/72/53 (Mar. 23, 2017).

[48] G.A. Res. 36/13, Mental Health and Human Rights (Sept. 28, 2017).

[49] G.A. Res. 2200A (XXI)*, supra* note 25.

[50] G. A. Res. 217 (III) A-E, International Bill of Human Rights (Dec. 10, 1948).

[51] *The Numbers Count – Mental Disorders in America, supra* note 23.

[52] G. A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948).

Treatment or Punishment (1987),[53] and the International Covenant on Civil and Political Rights (1966).[54]

III. COMPULSORY DETENTION AND INVOLUNTARY TREATMENT OF MENTAL HEALTH PATIENTS

A. Compulsory Detention and Involuntary Treatment under International Laws.

A person with mental disabilities' right to liberty and their right to make decisions regarding their own health may be infringed when, without appropriate due process, they are confined and treated against their will and without justification.[55] Even where such detention and treatment are warranted, they are usually not provided with humane living conditions. Various human rights treaties that tackle involuntary admission and treatment lack provisions that protect the liberty of mental health patients. Discussions on compulsory detention involve complex variables as on one hand, it infringes on the patient's right to personal liberty, however, on the other hand, compulsorily detaining a mental health patient can prevent harm to self and others in the society.[56] It is also a way to assist the patient in attaining access to mental health care which they ordinarily would not be able to manage on their own.

Various human rights treaties guarantee the right to liberty and security of the person.[57] Before proceeding to provide treatment and rehabilitation for a mental health patient, free and informed consent should be gathered.[58] Such consent must be obtained without any improper inducement,[59] and information about the proposed treatment and risks of side-effects should be discussed with the patient in a way that can be

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[53] Covenant for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, Dec. 10, 1984, 1465 U.N.T.S. 85.

[54] G.A. Res. 2200 (XXI), International Covenant on Civil and Political Rights (Dec. 16, 1966).

[55] *Id*. at art. 9 (provides for the right to liberty and security of person and the need for affirmative action to protect the rights of persons with mental disorders).

[56] *The Numbers Count – Mental Disorders in America, supra* note 23, at 5.

[57] G.A. Res. 46/119, Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, Principle 11 ¶ 1 (Dec. 17, 1991).

[58] *Id.*

[59] *Id.* at Principle 11 ¶ 1(b).

understood by the patient.[60] These rights to liberty allow a mental health patient the right to refuse mental health care and treatment.

The right to consent to treatment is well recognized under international law[61] and integral to the common law principle that a person is entitled to make autonomous decisions about medical treatment, provided they have the capacity to do so.[62] This right has been reinforced for people with mental illness by the provisions of the CPRD, which require that persons with disabilities must be able to exercise legal capacity on an equal basis with others.[63] A person will have the capacity to refuse medical treatment at common law if they are able to comprehend and retain information that is material to the decision and to use and weigh the information as part of the process of making the decision.[64]

However, these same documents, such as the MI Principles (1991)[65] and the accept the need for compulsory detention and treatment of people living with mental illness. A person will be said to lack the required mental capacity to make decisions about medical treatment for themselves if [66] she lacks the capacity to: (i) make reasoned choices about the treatment[67] or (ii) understand relevant information about the proposed treatment[68] or (iii) comprehend the risks and benefits of the treatment in question[69] or (iv) [70] To ensure that the human rights of mental health patients are adequately protected,[71]

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[60] *Id.* at Principle 11 ¶ 1(d).

[61] G.A. Res. 2200A (XXI), International Covenant on Economic, Social and Cultural Rights, art. 1 (Dec. 16, 1966).

[62] *Hunter and New England Area Health Service v A* [2009] NSWSC 761; 74 NSWLR 88 (Austl.).

[63] Convention on the Rights of Persons with Disabilities, art. 12 ¶ 2 (Dec. 13, 2006).

[64] *Hunter* [2009] NSWSC 761 at [25].

[65] G.A. Res. 46/119, *supra* note 58, at Principle 15 ¶ 1.

[66] Loren H. Roth, Alan Meisel & Charles W. Lidz, *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 3, 279 (1977).

[67] Paul S. Appelbaum & Thomas Grisso, *Assessing Patients' Capacities to Consent to Treatment*, 319 NEW. ENG. J. MED. 1635 (1988).

[68] *Id.*

[69] *Lane v. Candura*, 376 N.E.2d 1232,1236 (Mass. App. Ct. 1978).

[70] *Id.* at 1235.

[71] *See* Recommendation Rec(2004)10 of the Comm. of Ministers of the Council of Eur. To Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder, 11 EUR. J. HEALTH L. 407 (2004).

A person may be compulsorily detained for involuntary treatment in a mental health facility only after he or she has been examined by a qualified mental health practitioner.[72] The entire foundation of mental health law rests on a reliable diagnosis of mental disability without which there should be no confinement.[73] Depriving an individual of his liberty without first consulting a medical expert authorized by law for that purpose is unlawful.[74] The institution must establish that the patient, because of her mental illness, is likely to cause harm to herself or to other persons.[75] In such circumstances, the public's safety and the patient's best interests might prevail over the individual's right to liberty. The sort of mental illness must be of sufficient seriousness that would warrant compulsory detention. Where the mental illness is of a serious degree, the institution must show that failure to provide admission would likely lead to a further deterioration of the patient's mental condition, and the treatment can only be provided upon admission to the mental health facility.[76]

To protect the rights of mental health patients detained involuntarily when it is decided that a mentally ill individual is to be admitted involuntarily as a patient, a second mental health practitioner who is independent of the initial mental health expert should be consulted as soon as possible.[77] The reason for this is to ensure that the compulsory detention is lawful and where the second mental health practitioner disagrees, then the involuntary admission will not take place. The Principles do not state how many practitioners must examine a person before admission, nor do they provide guidance on practitioner qualifications. The review must examine whether the initial mental health expert acted in accordance with the criteria as set forth under the law. The institution must have followed all of the standards set in it, including the proscription against arbitrary detention and the requirement of independent medical evidence demonstrating that the person is, and continues to be, of unsound mind. Therefore, a review of the validity

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[72] G.A. Res. 46/119, *supra* note 58, at Principle 16 ¶ 1.

[73] Convention for the Protection of Human Rights and Fundamental Freedoms, art. 5, *amended by* Protocol Nos. 11, 14, Nov. 4, 1950, Europ.T.S. No. 5, 2061 U.N.T.S. 7.

[74] Recommendation Rec(2004)10 of the Comm. of Ministers of the Council of Eur. To Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder, *supra* note 72.

[75] G.A. Res. 46/119, *supra* note 58, at Principle 16 ¶ 1(a).

[76] *Id.* at Principle 16 ¶ 1(b).

[77] *Id.* at Principle 16 ¶ 2.

of the detention should not be done perfunctorily but must be done upon a serious examination on the merit of the particular case.

Mental health laws have imposed reasonably strong standards for the protection of mental health patients. For the detention of involuntarily admitted patients to be lawful, the mental health facility must have been designated to do so by a competent authority.[78] This is to ensure that the facility does not act arbitrarily and instead follows procedures as prescribed by domestic law.[79] The detention must be consistent with the purposes for which the facility is confining the patient.

An important element missing from international conventions is the right to appeal to judicial bodies.[80] All persons are entitled to a fair hearing by an impartial tribunal to decide rights recognized by law.[81] This right should be included in legislative sections setting out the process that needs to be followed by patients, their families, and legal representatives when appealing to a mental health review body or tribunal against the initial decision to compulsorily detain the patients. The tribunal would give patients the opportunity to state their opinions regarding the decision about whether they are wrongfully admitted. Their opinions should be taken into account when the tribunal makes its decisions. The tribunal would also need to hear statements from the patient's family members and the health practitioners involved. The tribunal should be made up of persons different from the individuals proposing the treatment while possessing the requisite skills and knowledge to judge the competence of the patient.

Compulsory treatment must not be given for longer than is necessary. There needs to be a provision for regular review of involuntary admissions by the treating health practitioner and by an independent review body. A mental health patient should be discharged from the facility when she no longer fulfills the criteria for involuntary admission. The procedure for discharge should be as flexible as possible to ensure that the patient is not confined longer than is necessary. A decision to continue detaining the patient will only be justified upon the persistence of the serious mental disorder that caused the patient to be compulsorily admitted in the first place.

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[78] *Id.* at Principle 16 ¶ 3.

[79] *Id.*

[80] Starson v. Swayze [2003] S.C.C. 722.

[81] G.A. Res. 217 (III) A, Universal Declaration of Human Rights, art. 10, (Dec. 10, 1948).

B. Compulsory Detention and Involuntary Treatment Before the Court.

An application of international human rights laws to mental health patients primarily focuses on their rights to liberty and dignity. However, international covenants also provide minimum standards to ensure that a mental health patient has the right to be treated in a therapeutic environment without too many restrictions and with the least intrusive treatment appropriate.[82] Article 5 of the American Convention[83] provides for a right to humane treatment. This is to protect mental health patients from being subjected to cruel conditions that may result in a further deterioration of their mental health. According to the United Nations Detention Principles,[84] inhumane treatment should be interpreted to extend the widest possible protection for patients against physical and mental abuses.[85] Therefore, mental health professionals who seclude or restrain patients may be in violation of the law[86] even if their purpose is to provide therapy for the patient or security for the institution. Since individuals with mental illness are ordinarily vulnerable by virtue of their mental state and depend on the government and the community for assistance, special scrutiny of their conditions of confinement is important.

The European Court of Human Rights has been highly active in protecting the human rights of persons with mental disabilities. *Keenan v. United Kingdom*[87] involved a petition alleging that Keenan's right to life, not to be tortured, and to have access to effective remedies under the European Convention on Human Rights (ECHR) were violated. Mark Keenan was a mentally ill man confined to a prison segregation cell after he assaulted two prison officers.[88] The deputy Governor extended the prisoner's sentence by twenty-eight days and placed the prisoner in segregation for seven days.[89] The next day Keenan hung himself.[90] The court found that a lack of effective

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[82] G.A. Res. 46/119, *supra* note 58, Principle 9 ¶ 1.

[83] Organization of American States, American Convention on Human Rights, Nov. 22, 1969, O.A.S.T.S. No. 36, 1144 U.N.T.S. 123.

[84] G.A. Res. 43/173, Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment (Dec. 9, 1988).

[85] *Id*. at Principle 6.

[86] G.A. Res. 46/119, *supra* note 58 at art. 3.

[87] Keenan v. United Kingdom, 33 Eur. Ct. H.R. 913 (2001).

[88] *Id.* at ¶¶ 20, 22.

[89] *Id.* at ¶ 37.

[90] *Id.* at ¶ 42.

monitoring and informed psychiatric input by prison officials showed significant defects in treatment.[91] Taking into account the prisoner's vulnerability and the authorities' obligation to protect his health, the court determined that extending his sentence due to the assault was not compatible with standard treatment for a mentally ill person. The court's decision was important as it made clear inadequate medical care, including mental health care, can rise to the level of inhuman and degrading punishment under the ECHR. The court upheld the violation of Article 3[92] because it found the standard of care with which Keenan was treated in the days before his death was inadequate, especially because he was mentally ill and known to be a suicide risk. This amounted to a failure on the part of the authorities to fulfill their obligations under Article 3[93] to protect Keenan from inhuman and degrading treatment and punishment.

In *Price v. United Kingdom*,[94] the European Court committed a woman with significant physical disabilities to prison for seven days for contempt of court.[95] During this period, the prison officials confined her to a regular cell that was not adapted to the needs of a person with disabilities. The applicant thus had no choice but to sleep in her wheelchair.[96] She also was unable to use the toilet facilities or access the light switches and emergency buttons because they were all out of her reach.[97] She experienced serious medical problems as a result of the conditions of her detention.[98] The court expressed that, in determining whether a treatment is degrading, it will consider whether the person's intent was to humiliate the victim concerned.[99] The court noted that even if it did not find a humiliating purpose, it would not automatically decide that there was no violation of Article 3.[100] In that case, the court did not find that the prison officials meant to embarrass the woman, but it nevertheless held that detaining a seriously disabled person under these circumstances constitutes degrading treatment in violation of Article 3.[101]

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[91] *Id.* at ¶ 49.
[92] Keenan v. United Kingdom, 33 Eur. Ct. H.R. 913 (2001).
[93] *Id.*
[94] Price v. United Kingdom, App. No. 33394/96, 34 Eur. H.R. Rep. 53 (2002).
[95] *Id.* at ¶ 7.
[96] *Id.* at ¶ 8.
[97] *Id.*
[98] *Id.* at ¶¶ 8-14.
[99] *Id.* at ¶ 24.
[100] G.A. Res. 217 (III) A, *supra* note 16.
[101] Keenan, 33 Eur. Ct. H.R. at ¶ 30.

Since the purpose of a compulsory detention on the grounds of unsoundness of mind is to heal the patient, such detention should take place only in a facility equipped to provide minimally adequate care and treatment.[102] The European Court in *Aerts v. Belgium*[103] stated that persons with mental illness must be confined in a minimally therapeutic environment. The court held that the detention of Aerts in a psychiatric wing of a prison rather than a hospital, clinic, or other appropriate institution was a violation of Article 5(1)(e) of the ECHR.[104] It established that while Article 5[105] was concerned with the legality rather than the conditions of detention, detention will be said to be arbitrary and in violation of Article 5(1)[106] if there was not a reasonable relationship between the grounds and the place and conditions of detention. It considered that the facilities Aerts was detained in were inappropriate to his condition and had little therapeutic benefit.

Minimally intrusive care and treatment should be a necessary pre-condition to involuntary detention on the grounds of mental disability.[107] If the government is depriving a person of her liberty because she needs therapy, then the government has a duty to provide minimally adequate treatment.[108] Such adequate standards of treatment would help assure that a person's mental health does not deteriorate but actually improves during confinement.

The American Commission[109] has adopted a more direct stance than the European Court in requiring governments to protect persons with mental disabilities from inhuman and degrading treatment. In *Victor Rosario Congo v. Ecuado*r,[110] the American Commission found Ecuador in violation of Article 5 of the American Convention,[111] which guarantees a right to humane

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[102] G.A. Res. 217 (III) A, *supra* note 16.

[103] Aerts v. Belgium, App. No. 25357/94, 29 Eur. H.R. Rep. 50 (1998).

[104] G.A. Res. 46/119, *supra* note 58.

[105] *Id.*

[106] *Id.*

[107] [107] G.A. Res. 46/119, *supra* note 82.

[108] Lawrence O. Gostin, *The Right to Health: A Right to the Highest Attainable Standard of Health*, 31 HASTINGS CTR REP. 2, 29, 30 (Jan. 1, 2001).

[109] The Inter-American Commission on Human Rights (IACHR) is an autonomous organ of the Organization of American States (OAS). Its mandate is found in the OAS Charter and the American Convention on Human Rights, *supra* note 84.

[110] Congo v. Ecuador, Case 11.427, Inter-Am. Comm'n H.R., Report No. 63/99, Report 63/99, OEA/Ser.L./V/II.106 doc. 6 rev. (1999).

[111] Organization of American States, American Convention on Human Rights, *supra* note 84.

treatment. Victor Rosario Congo was a person with mental disabilities placed in a detention center pending investigations into criminal charges.[112] While in custody, a guard struck him on the head because he was not cooperating with interrogations.[113] The Social Rehabilitation Center in Machala employees did not give him any medical treatment for the resulting injury, and they left him in his cell for forty days.[114] Eventually, authorities took him to a hospital to treat his severe dehydration, but Congo ended up dying in that hospital.[115] The American Commission acknowledged that the United Nations Mental Illness Principles[116] should act as guidance for determining whether the person received humane treatment since it concerns the protection of the human rights of persons with mental disabilities.[117] The Commission found that keeping a person in isolation itself can constitute inhuman and degrading treatment,[118] but when the person in isolation has a mental disability, then solitary confinement might amount to a more egregious violation of Article 5.[119] The Commission also found that Ecuador violated Mr. Congo's right to life under Article 4 of the Convention.[120] Basic measures necessary for Mr. Congo's survival, such as medical care to treat his physical injuries and mental care, were not provided by the State.[121]

This case is important and noteworthy for several reasons. This was the first time that the Inter-American Commission addressed the rights of persons with mental disabilities. The case set a strong precedent for the protection of the human rights of mental health patients under the American Convention, firmly establishing Article 5[122] as a powerful tool to help prevent harmful detention and inhumane treatment conditions in mental hospitals and facilities. The decision of the Commission brought to evidence a compelling connection between the right to humane treatment and the protection of

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[112] Congo v. Ecuador, at ¶ 6.
[113] *Id.* at ¶¶ 8, 9.
[114] *Id.* at ¶ ¶ 10-17,
[115] *Id.* at ¶ 19.
[116] G.A. Res. 46/119, *supra* note 58.
[117] Congo v. Ecuador, at ¶ 44.
[118] *Id.* at ¶¶ 56, 58.
[119] *Id.*
[120] Congo v. Ecuador, at ¶ 59.
[121] *Id.* at ¶ 82..
[122] Organization of American States, American Convention on Human Rights, *supra* note 84.

persons with mental disabilities under compulsory detention.[123] The American Commission also took into consideration prior decisions held by the European Court of Human Rights,[124] as well the provisions of the United Nations Mental Illness Principles,[125] due to the absence of precedent within its own system.[126] This recognition and acceptance of other related sources of international law bode well for the future development of the protection of mental health patients under the American System. The rights and protections of persons with mental disabilities will rapidly develop if the Commission continues to build on the jurisprudence of more established systems and laws.

IV. INTERNATIONAL CONVENTIONS FOR THE PROTECTION OF PERSONS WITH MENTAL DISABILITIES

The United Nations' work to protect persons living with a form of mental disability from stigma and discrimination has largely been concentrated on the right to health framework. The UN General Comment No. 14[127] asserts that the right to health as defined in Article 12.1[128] is an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of mental health.[129] This includes low socioeconomic status, violence and abuse, adverse childhood experiences, early childhood development, and whether there are supportive and tolerant relationships in the family, the workplace, and other settings. The right to health as included in frameworks such as Article 2(1) of the ICESCR;[130] Article 25 of the Convention on the Rights of Persons with Disabilities (CRPD);[131] and Articles 10, 11, 12, and 14 of the Convention on the

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[123] Congo v. Ecuador, Case 11.427, Inter-Am. Comm'n H.R., Report No. 63/99, Report 63/99, OEA/Ser.L./V/II.106 doc. 6 rev. (1999).

[124] The European Court of Human Rights has established that the state of health of a victim is an important factor in determining whether they have been subjected to inhumane or degrading punishment or treatment.

[125] Congo v. Ecuador, Case 11.427, Inter-Am. Comm'n H.R., Report No. 63/99, Report 63/99, OEA/Ser.L./V/II.106 doc. 6 rev. (1999).

[126] *Id.* at ¶ 82.

[127] U.N. Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (art. 12),* E/C. 12/2000/4 (Aug. 11, 2000).

[128] *Id.*

[129] *Id.* at ¶ 11.

[130] *The Numbers Count – Mental Disorders in America, supra* note 23.

[131] G. A. Res. 61/106, Convention on the Rights of Persons with Disabilities (Jan. 24, 2007).

Elimination of All Forms of Discrimination against Women;[132] contains freedoms, such as the right to a health system that provides equal access to quality treatment for everyone. These frameworks ensure through a human rights-based perspective that quality health services for mental health are available on the basis of non-discrimination. These efforts by the UN recognize the strong relationship between physical and mental health and emphasize support for the protection of mental health patients.

A. The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.

The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care[133] is the principal source of law within the United Nations system. It is commonly referred to as the MI Principles. These principles, while not formally binding, serve as influential aids in the interpretation of treaty obligations that promote the rights of mentally disabled persons in health care. The principles contain specific provisions on consent to mental health treatment,[134] confidentiality,[135] and to the standard of care and treatment of the mental health patient.[136] It further prohibits discrimination on the ground of mental disability.[137]

The MI Principles begins by enunciating the fundamental freedoms and basic rights to such things as the right to the best available mental health care,[138] humane treatment and respect for inherent dignity,[139] and protection from physical or other abuse and degrading treatment.[140] It acknowledges the hassle of protecting human rights in mental institutions by stating that care should, when possible, be administered in the community.[141] It also provides for a duty to treat patients in the least restrictive environment, and such

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[132] G. A. Res. 34/180, Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 28, 1979, 1249 U.N.T.S. 13.

[133] G.A. Res. 46/119, Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (Dec. 17, 1991).

[134] *Id.* at Principle 11.

[135] *Id.* at Principle 6.

[136] *Id.* at Principle 8.

[137] *Id.* at Principle 1 ¶ (4).

[138] *Id.* at Principle 1 ¶ (1).

[139] *Id.* at Principle 1 ¶ (2).

[140] *Id.* at Principle 1 ¶ (3).

[141] *Id.* at Principle 13 ¶ (2)(d).

treatment is to be aimed at maintaining and improving their personal autonomy.[142]

The MI Principles makes available legal standards and procedures for involuntary admission to a mental health facility.[143] Involuntary admission of a mental health patient may take place only if: (1) a person has been diagnosed with a mental illness by a qualified mental health practitioner under internationally accepted medical standards;[144] (2) there is a serious possibility of immediate harm to the patient or to other persons;[145] or (3) the patient is severely mentally ill, has impaired judgment, and there will be a drastic deterioration of the patient's condition if not admitted to a mental health facility.[146] The institution must be one that has been designated by law and has the necessary authority to provide involuntary admission for individuals with mental illness.[147]

To ensure that the involuntary admission meets the prescribed standards, the patient has the right to receive a fair hearing by a judicial or other independent and impartial review body acting in accordance with the relevant authority.[148] The review body's decision on whether to involuntarily admit a patient is to be done immediately and should include a periodic review of their decision in accordance with the above standards.[149] The Principles provides procedural safeguards for the conduct of the hearing. The patient has the right to representation, can call independent experts, and can review all evidence given and the reasons for the review body's decision.[150]

B. United Nations Convention on the Rights of Persons with Disabilities (CRPD).

The UN Convention on the Rights of Persons with Disabilities[151] addresses the social, cultural, economic, and legal barriers that prevent persons with disabilities from fully participating in society and fulfilling their human rights. The Convention recognizes that people with disabilities continue to face various barriers to participation as equal members of society

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[142] *Id.* at Principle 9 ¶¶ (1)(4).
[143] *Id.* at Principle 16.
[144] *Id.* at Principle 16 ¶ (1).
[145] *Id.* at Principle 16 ¶ (1)(a).
[146] *Id.* at Principle 16 ¶ (1)(b).
[147] *Id.* at Principle 16 ¶ (3).
[148] *Id.* at Principle 17 ¶ (1).
[149] *Id.* at Principle 17 ¶¶ (2)(3).
[150] *Id.* at Principle 18.
[151] G. A. Res. 61/106, *supra* note 132, at 21.

and that their inherent and basic human rights continue to be violated.[152] It states as its purpose the promotion, protection, and advancement of the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities, as well as respect for their inherent human dignity.[153] This purpose extends to persons living with disabilities, which includes both physical and mental impairments, that may limit the way they participate with other members of society.[154]

The Convention was enacted to direct people away from treating those with disabilities as objects of management or care and shift toward treating others as subjects capable of their own decisions and equal protection of the law. Under the Convention, States Parties are obligated to prevent discrimination against, promote accessibility by, and work to achieve the full realization of economic, social, and cultural rights for persons with disabilities.[155] Its philosophy is "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity."[156]

The CRPD is noteworthy as it was the first international human rights treaty in recent times to be negotiated in a record time of five years. The *ad hoc* committee also ensured it received input from people living with disabilities who shared what they considered to be important to their own lives.[157] A year after being opened for signature, having been ratified by more than the requisite twenty nations, the CRPD became a legally enforceable treaty. One hundred and thirty-six countries are currently signed to the Convention.[158] The CRPD is also historic for bringing mental health issues more forcefully than ever before into the fold of international human rights

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[152] *Id.* at pmbl. (k).

[153] *Id.* at art. 1.

[154] *Id.*

[155] *Id.* at art. 4.

[156] *Id.* at art. 1.

[157] Nolan Quigley et al., *The United Nations Convention on the Rights of Persons with Disabilities: From the Perspective of Young People,* 29 DISABILITY STUD. Q. 1 (2009).

[158] On the date of the Convention, October 23, 2008, there were 136 signatories to the Convention, 79 signatories to the Optional Protocol, 41 ratifications of the Convention, and 25 ratifications of the Optional Protocol. https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&clang=_en; https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15-a&chapter=4&clang=_en.

law.[159] The United States has, however, chosen not to ratify the Convention even though it participated in the negotiating sessions due to the fact that the Convention has significant overlap with the Americans with Disability Act (ADA). However, the Convention changes the framework around which disability is defined in a more positive, inclusive manner. It also addresses the problems individuals with disabilities encounter in society in a more holistic manner, accounting for past discrimination and problems with the current built environment, as opposed to the discrete manner in which the ADA typically addresses problems.

An Optional Protocol accompanying the Convention establishes Committee procedures for addressing complaints of Convention violations made against particular State Parties by individuals or groups. Enforcement of the Convention's requirements occurs through the reporting and monitoring mechanisms created in Article 34, and responses to complaints directed to the Committee by individuals or groups if the State Party has signed the Optional Protocol.[160]

C. The Role of International Human Rights Conventions.

Ratification of international treaties creates legal accountability, thus establishing concrete obligations for government conduct that specifically address disability. A treaty will serve to define the specific application of human rights concepts to people with disabilities and assist governments by providing an anchor for, and informing the interpretation of, general human rights principles. In addition, a treaty will set concrete standards for government conduct according to which States will guarantee specific human rights for persons with disabilities and undertake to bring internal legislation and policies in line with applicable human rights standards. Where such obligations are not met, the treaty constitutes an invaluable tool for disability advocates to push for change. When advocates in their home countries face obstacles in their advocacy efforts, international standards can support them and may be used to demonstrate that governments have already committed to recognizing certain rights. The extent to which international human rights standards can serve to support and strengthen grassroots advocacy initiatives will depend, of course, on the ability of the international human rights system

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[159] Rosemary Kayess and Phillip French, *Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities* 8 HUM. RTS. L. REV. 1 (2008).

[160] G. A. Res. 61/106, *supra* note 132, at 34.

to engage grassroots groups and demonstrate the relevance of human rights standards and mechanisms to their work on the ground. A concerted effort must be made, therefore, to convey the application of a wide range of international human rights practices to domestic advocacy initiatives.

Persons with mental disabilities continue to face numerous violations of their human rights. Most often, these violations of human rights comprise four interrelated categories: liberty, dignity, equality, and entitlement. The liberty interests of persons with mental disabilities may be infringed through unwarranted detention. Without appropriate due process protections, people with mental disabilities may be confined against their will and often without justification. Even if involuntary confinement is warranted, persons with mental disabilities frequently are not provided with humane living conditions in institutional settings. A treaty would be significant in establishing beyond question that persons with disabilities are indeed subjects of international rights and protection. These principles are enshrined in international law in treaties and declarations that apply directly to the rights of persons with mental illness.[161] In so doing, these international instruments can act as a tool to enforce the welfare and human rights of persons with mental disabilities. Consequently, it is imperative that these human rights receive appropriate consideration and protection to guarantee justice and fairness for persons with mental disabilities.

A treaty specifically addressing the rights of people with disabilities provides an opportunity to identify specific practices that endanger the well-being and enjoyment of human rights by persons with disabilities. In the same way the 1993 World Conference on Human Rights recognized violence against women as a war crime[162], a treaty can serve to identify egregious practices against people with disabilities that have not attracted the attention of the international community. These practices include, for example, the institutionalization of people with disabilities in degrading and dehumanizing conditions, involuntary psychiatric procedures, and domestic violence

[161] For example, the MI Principles includes: a preference for community care; the right to the least restrictive environment; clear standards and natural justice for compulsory admission; legal representation; and the right to information. G.A. Res. 46/119, *supra* note 58.

[162] Agreement Regarding the Arrangements for the World Conference on Human Rights, May 18, 1993, 1722 U.N.T.S. 101.

against people with disabilities.[163] This lack of attention to egregious practices is significant given the virtual disappearance of people with disabilities from current human rights monitoring. A treaty on the rights of people with disabilities will provide a legal, as well as moral and political, basis for the wider recognition and protection of the rights of people with disabilities, thereby increasing the likelihood of the development of methodologies and indicators for measuring human rights violations, something that has not occurred with regard to the UN Standard Rules and other instruments relating to disability.[164]

In addition to contributing to the development of domestic legislation, an international treaty can inform the work of domestic courts. The provisions of the treaty can not only serve as a guide in the interpretation of any specific implementing legislation, but the principles embodied in the treaty can also encourage the judicial development of other areas of domestic law. An international treaty on the human rights of people with disabilities might, for instance, provide the basis for invoking international law in a disability case before a national court. International law is cited with increasing frequency and effect in national courts, both in the United States and abroad. The United States has a significant body of case law wherein international standards have been either expressly invoked by individuals seeking a remedy for human rights violations or relied on to guide the interpretation of both state and federal laws.[165]

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[163] For an account of international human rights reporting concerning involuntary psychiatric procedures, *see* World Network of Users and Survivors of Psychiatry, *Human Rights Position Paper* (2001) , http://wnusp.net/index.php/human-rights-position-paper-of-the-world-network-of-users-and-survivors-of-psychiatry.html

[164] *See, e.g.*, *The Limberg Principles on the Interpretation of the International Covenant on Economic, Social and Cultural Rights*, U.N. Doc. E/CN.4/1987/17, *reprinted in* 9 HUM. Rts. Q. 122 (1987).

[165] *See, e.g.*, Filartiga v. Pena-Irala, 630 F.2d 876 (2d Cir. 1980); Lareau v. Manson, 507 F. Supp. 1177, 1193 n. 18 (D. Conn. 1980) (using the U.N. Standard Minimum Rules for the Treatment of Prisoners as a guide to the interpretation of U.S. law). For more on the role of international law in U.S. courts, *see generally* JORDAN J. Paust, International Law as Law of the United States (Carolina Acad. Press 1996); Ralph Steinhardt, *Recovering the Charming Betsy Principle*, 94 AM. SOC'Y. INT'L L. PROC. 49 (2000); Ralph Steinhardt, *Fulfilling the Promise of Filartiga: Litigating Human Rights Claims Against the Estate of Ferdinand Marcos*, 20 YALE J. INT'L L. 65 (1995).

D. Issues and Concerns with the Adoption of International Human Rights Convention for the Rights of People with Disabilities.

As discussed above, there are many advantages to a country ratifying and adopting the various legally binding obligations that protect the human rights of mental health patients. The most significant benefits include: (i) creating legal accountability regarding disability rights;[166] (ii) establishing a system of enforceable rights that protects mental health patients from discrimination and other human rights violations;[167] (iii) establishing an obligation for how the states can improve mental health services and promote and protect the human rights and mental well-being of its citizens; (iv) providing a legal framework for implementation and enforcement; (v) promoting access to mental health care; (vi) setting minimum qualifications and skills for accreditation of mental health professionals and for mental health facilities; and (vii) ensuring adequate and appropriate care and treatment, protection of human rights of people with mental disorders, and promotion of the mental health of populations.[168] There are, however, obstacles that may limit the application of these international principles for mental health patients. These challenges include the fact that: (i) the level of implementation is contingent on the governance structures of the particular nation; and (ii) the international treaties apply only to countries that have ratified it.

i. Level of Implementation Contingent on the Governance Structures of the State.

A measure of support for international agreements is the internalization of international legal norms and rules into domestic

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[166] The Charter of the United Nations, 24 October 1945, is a key legislation for the protection of the human rights of individuals with mental disabilities. U.N. Charter (Oct. 24, 1945).

[167] Organization of the American States, Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities, June 7, 1999, OAS, AG/RES. 1608.

[168] Elke Beermann, Magistrate, Patient's Advocacy Service, Graz, Austria, Patients' Rights Protections, Mental Health Legislation and Patients' Advocacy Services in Austria, presented at the Hungarian Civil Liberties Union International Workshop in Budapest (May 19-21, 2000).

legislations.[169] This is the most demanding form of compliance and therefore, where there are no frameworks in place at the local level for implementing these international treaties, it is likely that no solid progress will be made to promote and protect the human rights of individuals with mental disabilities.[170] The WHO observes that a lack of comprehensive domestic mental health legislations crucial for implementing and coordinating mental health care services is a key barrier to accessing quality mental health care.[171] In many low- and middle-income countries, failure to localize mental health care legislation has been cited as a key barrier to improving access to mental health care.[172] For example, although Uganda passed the Persons with Disabilities Act in 2006, to date, there have been no regulations passed for its subsequent implementation.[173]

Although the various provisions of human rights are expected to be placed on equal footing, the challenge is that, realistically, states with limited budgets cannot prioritize all human rights simultaneously for all individuals when it comes to the implementation phase. In developing nations where there is ordinarily a lack of resources, it is a question of deciding which of the said human rights amongst health, education, and security should prevail.[174] Thus, a lack of resources would affect which particular human rights will be implemented. For example, it would be easier for a developing nation to implement the provision of Article 7 of the ICCPR,[175] which prohibits torture and degrading treatment, compared to the implementation of the ICESCR, which provides for the human right to health.[176] To implement the former, the state mainly has to refrain from any act that subjects another to inhumane treatment,[177] while in order to respect the latter, governments would need to invest significant money into building a system

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[169] Mark A. Pollack, *Who Supports International Law, and Why?: The United States, the European Union, and the International Legal Order*, 13 Int'l J. of Const. L. 4, 873 (2015).

[170] BETH A. SIMMONS, MOBILIZING FOR HUMAN RIGHTS: INTERNATIONAL LAW IN DOMESTIC POLITICS (Cambridge University Press) (2009).

[171] *Investing in Mental Health*, WHO (2003).

[172] Benedetto Saraceno, et al., *Barriers to Improvement of Mental Health Services in Low-Income and Middle-Income Countries*, 370 LANCET, 1164 (2007).

[173] Raymond Lang, *The United Nations Convention on the Rights and Dignities of Persons with Disability: A Panacea for Ending Disability Discrimination?* 3 ALTER-EUROPEAN J. OF DISABILITY RSCH., 266 (2009).

[174] Amitai Etzioni, *A Right above All Others*, 5768 AZURE 33, 31, 32 (2008).

[175] Appelbaum& Grisso, *supra* note 68.

[176] Shultziner & Rabinovici, *supra* note 38.

[177] G.A. Res. 2200 (XXI), *supra* note 40, at art 5.

of health that provides the opportunity for everyone to enjoy the highest attainable level of health.[178]

ii. International Conventions Apply Only to Countries That Ratify It.

Ratification is a challenge to advocates of mental health who might need to secure the participation of the domestic justice system in protecting the rights of people with disabilities. International human rights conventions are binding only on countries that have chosen to ratify the agreements reached. Lack of ratification demonstrates a state's unwillingness to be bound by the provisions of the treaty because, generally, signing and ratifying creates an obligation on the state to refrain from acts that would defeat the object and purpose of the treaty.[179] The United States, for example, has a poor record of ratifying international treaties. Out of the twenty-six international human rights treaties on which the United States is a signatory, it has only ratified three.[180] It is a fact that the United States is in a position of international leadership. Thus, the rest of the world has much to gain by the meaningful participation of American disability groups and policymakers in supporting a human rights treaty that will help foster domestic law changes around the world, similar to what the ADA has done to shape disability law and policy in the United States since the twenty years of its passing.[181] Signature and ratification of the various international treaties on human rights, which would require member states to share best practices and technical assistance, would also signify the commitment of the United States to providing critical global leadership on disability rights issues.[182] It would ensure that the United States promotes disability-inclusive development

[178] G.A. Res. 2200A (XXI), *supra* note 25.

[179] Off. of the High Comm'r for Hum. Rts., Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities, Chapter 4, HR/PUB/07/6 (2007).

[180] Manfred Elsig et al., *Who is in Love with Multilateralism? Treaty Commitment in the Post-Cold War Era*, 12 EUR. UNION POL. 529 (2011).

[181] Howard Karger & Steven R. Rose, *Revisiting the Americans with Disabilities Act After Two Decades*, J. SOC. WORK IN DISABILITY & REHAB., 73 (2010).

[182] Michael Ashley Stein, *A Quick Overview of the United Nations Convention on the Rights of Persons with Disabilities and Its Implications for Americans with Disabilities*, 31 MENTAL & PHYSICAL DISABILITY L. REP. 679, 679 (2007).

practices at home and abroad, helping to increase equality for persons with disabilities throughout the world.[183]

V. THE FUTURE OF HUMAN RIGHTS AND MENTAL DISABILITIES

An important way to improve the lives of mental health patients is through the implementation of policies and programs that lead to better health care. Human rights cannot be protected in societies without a strong rule of law. "The rule of law is the implementation mechanism for human rights, turning them from a principle into a reality."[184] This requires legislation that complements the standards and good practices of international human rights laws which would serve to reinforce the protection of the lives, health, and dignity of persons.[185] Mental health patients are vulnerable members of society; they need special regulatory protections due to the psychiatric symptoms of their illness that affect their decision-making capacity.[186] This is why it is necessary to have mental health legislation in place for protecting the rights of persons with mental disorders in institutional settings and in the community. In accordance with the objectives of the United Nations Charter,[187] a fundamental basis for mental health legislation is human rights. Mental health legislation provides the legal framework for providing mental health services that promote access to care, rehabilitation, and the integration of people with mental health disorders into different sectors of society.[188] For there to be effective mental health law reform, the following principles must drive the initiative:

i. Obtain information about mental disorders and barriers to mental health care by conducting community-based epidemiological surveys. This will assist in getting a clearer understanding of how barriers such as stigma

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[183] Michael Ashley Stein & Penelope J.S. Stein, *Beyond Disability Civil Rights*, 58 HASTINGS L. J. 1203, 1240 (2007).

[184] *Rule of Law and Human Rights*, U.N. https://www.un.org/ruleoflaw/rule-of-law-and-human-rights/ (last visited 03/20/2021).

[185] *Id.*

[186] Carol Levine et al., *The Limitations of 'Vulnerability' as a Protection for Human Research Participants*, 4 AM. J. BIOETHICS 44, (2004).

[187] *Supra* note 163.

[188] Michelle Funk et al., *A Framework For Mental Health Policy, Legislation and Service Development: Addressing Needs and Improving Services,* HARV. HEALTH POL'Y REV. 57, (2005).

and discrimination can limit access to mental health care.[189] Data derived from surveying various subgroups can also provide a rough estimate of the level of need for mental health services and the prevalence of mental disorders.[190] Different ethnic groups may have different histories and experiences with the health care system, and therefore, certain barriers may be more prevalent among individuals of different ethnic groups.[191] For example, negative experiences of coercion in mental health care may be more prevalent among ethnic minorities.[192]

ii. Map out and carefully examine existing mental health legislation and existing laws that are likely to affect mental health as a basis for the new legislation. Mapping mental-health-related legislation is very helpful in providing an overview of the different laws that can contribute to achieving the objectives of mental health policies and programs and for assessing which laws may need to be changed. A systematic and critical review of existing legislation can help identify legal aspects that are lacking or in need of reform in order to protect the rights or ensure access to treatment of persons with mental disorders, as well as to facilitate promotion and prevention in the mental health field.[193]

iii. Study and thoroughly review the various international human rights conventions when drafting the new mental health legislation. Various international standards represent an international consensus on accepted good-practice standards and provide a useful framework for developing and implementing legislation and policy on mental health. International human rights documents should form the framework for drafting national legislation that concerns people with mental disorders or regulates mental health and social service systems. These documents include the MI Principles, the

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[189] Patrick W. Corrigan et al., *Structural Levels of Mental Illness Stigma and Discrimination,* 30 SCHIZOPHR. BULL. 3, 481, (2004).

[190] *Module on Planning and Budgeting Services for Mental Health*, WHO (2003).

[191] Lee Knifton et al., *Community Conversation: Addressing Mental Health Stigma with Ethnic Minority Communities,* 45 SOC. PSYCHIATRY AND PSYCHIATRIC EPIDEMIOL., 497, (2010).

[192] Jonathan Bindman et al., *Perceived Coercion at Admission to Psychiatric Hospital and Engagement with Follow-up*, 40 SOC. PSYCHIATRY AND PSYCHIATRIC EPIDEMIOL., 160, (2005).

[193] *See* Michelle Funk et al., *WHO Resource Book on Mental Health*, app. WHO Checklist on Mental Health Legislation (2005).

Standard Rules,[194] the Declaration of Caracas,[195] and the WHO Mental Health Care Law: Ten Basic Principles.[196]

iv. Review mental health legislation in other countries that have enacted progressive legislation that reflects international human rights standards and current knowledge in the area of mental health treatment and care.[197] When examining another country's mental health law, there may be social, economic, and cultural variables or factors specific to that country. Certain provisions may therefore not be applicable in one's own country. For example, a country may restrict guardianship to members of a person's immediate family. This would, however, be inappropriate in a country where an extended family has culturally determined rights with respect to a person. Thus, there may be a need to modify and adapt the provisions to suit the social, economic, and cultural situation of that particular country.

v. Consult with key stakeholders while drafting the new legislation. Their involvement will bring about consensus and negotiations about the issues surrounding the rights of mental health patients that will not only have an important role during the drafting phase of the legislation but also in ensuring that the legislation is implemented once it is adopted. Through the consultation process, potential weaknesses of the proposed legislation can be ironed out, conflicts with existing legislation and local customary practices rectified, issues that have been inadvertently left out can be added, and solutions to practical difficulties in implementation can be corrected.[198] A broad consensus is also necessary because mental health legislation cannot be embraced by any society unless misconceptions, misapprehensions, and fears relating to mental disorders are addressed. The stakeholders include politicians and parliamentarians, policymakers, government ministries, mental health professionals, family members of those with mental disorders, users and user groups, advocacy organizations, service providers,

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[194] G.A. Res. 48/9, Standard Rules on the Equalization of Opportunities for Persons with Disabilities(Dec. 20, 1993)**.**

[195] Pan-American Health Organization [PAHO]/WHO, Caracas Declaration, (Nov. 14, 1990).

[196] *Global Action for the Improvement of Mental Health Care: Policies and* Strategies, WHO (1996).

[197] A useful resource for accessing legislation from different countries is the WHO International Digest of Health Legislation (IDHL).

[198] *Mental Health Policy and Service Guidance Package: Advocacy for Mental Health*, WHO, (2003).

nongovernmental organizations, civil rights groups, religious organizations, and congregations of particular communities. In some African communities, it may be necessary to also include community leaders and traditional healers in the legislative process.[199]

vi. Educate the general public on the burden of stigma and discrimination faced by those with mental disorders. Cultural and social values, beliefs, attitudes, and traditions of a particular society influence attitudes about mental health, mental disorders, and the people who experience them. Stigma, myths, and misconceptions associated with mental disorders lead to discrimination and limitations on human rights and can represent obstacles to effective implementation of human rights-oriented legislation. Hence, changing public attitude constitutes an important component in implementing mental health legislation.[200] Disseminating information about mental health, including information about the rights provided in new legislation, can help change public attitudes towards people with mental disorders. Public awareness programs need to highlight special provisions in legislation and provide explanations for their inclusion, such as why sections regarding access to mental health care and protecting the human rights of persons with mental disorders have been included. The media can play a useful role in this process. They can highlight the importance of respecting the human rights of persons with mental disorders and assist in educating the public about advances in the treatment of mental disorders, especially the effectiveness of community-based rehabilitation programs.

VI. CONCLUSION

Although there exists a robust global human rights system, people with disabilities still face substantial barriers to the full enjoyment of their human rights due to the absence or inadequacies of mental health laws in most countries. These policies are critical to improving conditions for people with mental disabilities. There are positive transformative effects to be gained from the implementation of international standards into domestic legislation. An international convention on the human rights of people with disabilities not only sets out a wide range of steps that states must take to

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[199] Freddie Samuelson Khunou *Traditional Leadership and Governance: Legislative Environment and Policy Development in a Democratic South Africa,* 1 INT'L J. HUMAN. SOC. SCIENCES, 278, (2011).

[200] J. Arboleda-Florez, *Stigmatization and Human Rights Violations*, *in* MENTAL HEALTH: A CALL FOR ACTION BY WORLD HEALTH MINISTERS 57 (WHO, 2001).

create an enabling environment so that persons with disabilities can enjoy real equality in society but also establishes an institutional framework to monitor the global human rights condition of people with disabilities. In addition, constructive engagement with key stakeholders in mental health and the human rights communities will ensure that those who have an impact on the lives of people with mental disabilities possess the necessary training to understand the human rights of mental health patients and apply these in practice by improving the quality of care and promote human rights in mental health facilities.