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THE RIGHTS OF PERSONS WITH MENTAL DISABILITIES TO ACCESS MENTAL HEALTH CARE AND THEIR HUMAN RIGHTS CONDITIONS IN PSYCHIATRIC FACILITIES IN ETHIOPIA

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January 2013

THE RIGHTS OF PERSONS WITH MENTAL DISABILITIES TO ACCESS MENTAL HEALTH CARE AND THEIR HUMAN RIGHTS CONDITIONS IN PSYCHIATRIC FACILITIES IN ETHIOPIA

SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE LLM DEGREE IN HUMAN RIGHTS LAW

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January 2013

Declaration

I, Aytenew Debebe, hereby declare that this work is an original work and has not been presented in any other institution before. All referred materials are duly acknowledged.

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Acknowledgments

First and foremost, praise is to the Almighty God without whom I would not have accomplished this work. I am grateful to my supervisor Dr Benyam Dawit who helped me in many ways in writing this research. I have immensely benefited from his selfless commitment at all stages of the research work. His critical and constructive comments have so much contributed to see this work like this. However, the responsibility for any remaining mistakes is solely mine. Finally, I would like to thank my families and friends who helped me one way or another for the successful completion of the research.

Thank you all!

List of Acronyms

ACHPR: African Charter on Human and Peoples' Rights

ACHPR: African Commission on Human and Peoples' Rights

ACHR: American Convention on Human Rights

ACRWC: African Charter on the Rights and Welfare of the Child

ACtHPR: African Court on Human and Peoples' Rights

ADA: American Disabilities Act

CAT: Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

CED: Convention for the Protection of all Persons from Enforced Disappearance

CEDAW: Convention on the Elimination of All Forms of Discrimination against Women

CESR: Committee on Economic, Social and Cultural Rights

CERD: Convention on the Elimination of All Forms of Racial Discrimination

CPT: European Committee for the Prevention of Torture and Inhuman and Degrading Treatment

CRC: Convention on the Rights of the Child

CRPD: Convention on the Rights of Persons with Disabilities

CSOs: Civil Society Organizations

EC: Ethiopian Calendar

ECHR: European Convention on the Protection of Human Rights and Fundamental Freedoms

ECtHR: European Court of Human Rights

FDRE:	Federal Democratic Republic of Ethiopia
HSDP:	Health Sector Strategic Development Plan (Ethiopia)
IACtHR:	Inter-American Court Of Human Rights
ICCPR :	International Covenant on Civil and Political Rights
ICESCR:	International Covenant on Economic, Social and Cultural Rights
ICF:	International Classification of Functioning, Disability and Health
MDAC:	Mental Disabilities Advocacy Center
MDRI:	Mental Disabilities Rights International
NGO:	Non-Governmental Organization
PWDs:	Persons with Disabilities
PWMDs:	Persons with Mental Disabilities
SER:	Socio-economic Rights
UDHR :	Universal Declaration of Human Rights
UN:	United Nations
WHO:	World Health Organization
WHO-AIMS:	WHO-Assessment Instrument for Mental Health Systems

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CHAPTER ONE

1. INTRODUCTION

1.1 Abstract

The standardization and undertakings for recognition and respect of human rights dates back to 1948 with the adoption of the UDHR. The understanding towards the universality of human rights is reached relatively later at the third World Human Rights Conference in Vienna in 1993. Despite this, until recently, little attention has been afforded to addressing the serious human rights violations suffered by PWDs. In response to the long reigned neglect and the advocacy works by different caucus of the disabilities movement, in 2006, a separate Convention was agreed at the UN level, the CRPD, which culminated the efforts of many stakeholders to bring about a new dawn for PWDs.

PWMDs are among this group of people who are vulnerable groups and have been victims of human rights violations based on their disabilities. The grossly inadequate budget allocated to mental health compared to the burden it caused on the global burden of disease and disability evidences how these group of people are forgotten globally and at a national level. This has far reaching implications on their human rights. The institutions extending care for PWMDs have been places of perpetration of various human rights violations.

In the above respect, Ethiopia is not a different country. With 15-17% of the total burden of diseases is caused by mental illness, it is seriously a concern to allocate an insignificant budget to the field. This is exacerbated due to the lack of neither any mental health law nor a policy for the protection of the rights of PWMDs, either any body to safeguard their conditions in psychiatric facilities. These people are thus suffering from various forms of human rights violations behind closed doors in addition to the lack of access to mental health services.

This study is therefore an effort to show the right of PWMDs to access mental health services and to show the human rights implications of the situation, in Ethiopia on the rights of PWMDs. Moreover, the human rights conditions at the psychiatric settings are also addressed in this study.

Key words: persons with mental disabilities, human rights and mental health, access to mental health and psychiatric care, human rights conditions in psychiatric facilities in Ethiopia

1.2 Background

Since time immemorial, PWDs have been considered negatively; victimized by segregation, marginalized treatment in every aspect of life including education, health and family life often removed from normal social life.[1] This is due to prejudices that see disability as an illness and society can help them by extending charity. With the evolution of disability and society, this attitude has been modified towards social and human rights-based approaches that see disability as a social construct and that PWDs undergo the limitations created by society.[2]

The ICF confirms the change in approach when it emphasizes that disability depends on the interaction between environmental, social and personal factors.[3] Therefore, the more society embraces people's different characteristics and develops their abilities, the more it is able to remove barriers, obstacles and prejudices. The human rights-based approach is thus a response to the lack of equal opportunities and the unjustified differential treatments which have been continually causing violations of human rights.[4]

Concerns about the neglect of PWDs have been raised since the 1970s, prompted largely by the self-organization of PWDs[5] and by the growing tendency to see disability as a human rights

[1] Whiteneck, G. Conceptual models of disability: Past, present and future**,** in Field, M., *et al* (eds.) Workshop on disability in America: A New Look Summary and Background Papers. Washington, DC: The National Academies Press, (2006). pp 50-64; Luke, S. 'Public perceptions of disabled people evidence from the British social attitudes survey', (2009); Au, K., and Man, D., 'Attitudes toward people with disabilities: a comparison between health care professionals and students', International journal of rehabilitation research, Vol. 29, No. 2, (2006), pp 155-160.

[2] United Nations Convention on the Rights of Persons with Disabilities(CRPD), adopted by General Assembly resolution 61/106 of 13 December 2006, available at www.un.org/disabilities/default.asp?id=150,accessed on January 15, 2012, Preamble, Para (e)

[3] World Health Organization(WHO), International Classification of Functioning, Disability and Health(ICF), Geneva, , available at www.who.int/icidh/, accessed on January 26, 2012 (2001)

[4] Hisayo, K., and Richard W. 'Human rights-based approach to disability and health in development cooperation: Perspectives from the South', (2009), available at www.sylff.org/wordpress/wp-content/.../05/jip_1_final-report3.pdf, accessed on January 21, 2012; Kumpuvuori, J. and Katsui, H., "Disability, human rights and human security: case study on human rights advocacy activities of organizations of persons with disabilities in Uganda and Finland", Spanda foundation quarterly newsletter. Vol. 3, No.1 available at, http://www.spanda.org/publications.html ,accessed on January 21, 2012; Anna L., 'The EU rights based approach to disability: Some strategies for shaping an inclusive society', School of Law and Centre for Disability Studies, University of Leeds, Handicap International, available at www.handicap-international.fr/bibliographie.../RBA**Disability**.pdf , accessed on January 21, 2012

[5] Campbell, J., and Oliver M. Disability politics: understanding our past, changing our future, London, Routledge, (1996), as cited in World report on disability, (2011).

issue.[6] Disability rights as human rights have finally come after series of advocacy by various human right activists, family members etc. It has been submitted that the bitter experiences of discrimination has unified PWDs to fight for disability rights to be recognized as human rights.[7]

In 1982, the General Assembly of the UN adopted the World Programme of Action concerning Disabled Persons, which promotes the full participation and equality of PWDs in social life and development in all countries, regardless of their level of development. The General Assembly also proclaimed the decade from 1983 to 1992 "the UN Decade of Disabled Persons" and encouraged Member States to implement the Programme of Action. This was followed with a move for a separate international instrument tailored for PWDs engendering special obligations on States Parties. In response, the UN has adopted the CRDP by a unanimous vote in December 2006. The advent of the CRPD is the culmination of years of struggles by different arrays of the world community for equal opportunities for PWDs. The CRPD aims to ensure the protection of human rights of PWDs by committing all the sectors and responsible institutions of the states that ratify it to acting using suitable policies, legislation and resources.[8] This is an initiative which members of the disability movement have worked so hard over decades, to achieve. The movement towards the adoption of the CRPD has witnessed

> "how the global movement of PWDs has set aside their individual issues in favor of uniting to speak with one common voice to demonstrate their commonality of issues, including the day-to-day experience of discrimination which many PWDs are subjected to." [9]

The CRPD recognizes the need for promotion and protection of the human rights of PWDs in civil, cultural, economic, political and social life, with the appropriate measures of implementation.[10] It has also been marked as making a paradigm shift in attitudes and

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[6] Quinn, G, and Degener, T. 'A survey of international, comparative and regional disability law reform, in Breslin, M., and Yee, S, (eds). Disability rights law and policy- international and national perspectives, Ardsley, Transnational, (2002).

[7] Giampiero, G. and Francesca, O. (eds.), Training manual on the human rights of persons with disabilities, Ulaanbaatar, (2007); Doris F., Disability rights movement: from charity to confrontation, Temple University Press, (2000); Joseph, P., People with disabilities forging a new civil rights movement, Three Rivers Press, (1994)

[8] CRPD, Supra at note 2, Preamble Para(f)

[9] Giampiero, G. and Francesca, O. (eds.), Supra at note 8; Joseph P., Supra at note 8; Jerry, A., 'The Development of the disability rights movement as a social problem solver', Disability studies quarterly, Volume 23, No. 1, (2003); Charlton, J., Nothing About Us Without Us, Berkeley, Los Angeles, London: University of California Press, (1998)

[10] Article 4 of the CRPD lists down the measures that should be taken by the states parties inter alia, adoption of legislative and administrative measures and to undertake researches to ensure persons with disabilities are able to

approaches to PWDs from objectivizing them to be subjects of rights.[11] By this, the paternal attitude towards PWDs is addressed by the Convention; implying PWDs should be assisted but not deprived of their individual human rights.[12]

Especially, the Principles of the Convention have important values to the PWDs which include:

> "i. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
>
> ii. Non-discrimination;
>
> iii. Full and effective participation and inclusion in society;
>
> iv. Respect for difference and acceptance of disability as part of human diversity and humanity; equality of opportunity;
>
> iv. Accessibility;
>
> vi. Equality between men and women; and
>
> v. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.[13]"

These principles have addressed the human rights that have been indiscriminately violated for long time which should be protected with a vital attitudinal change and commitment.

Moreover, to strengthen the implementation of the Convention, an Optional Protocol which introduces two procedures, an individual communications procedure and an inquiry procedure, is adopted in 2006. The individual communications procedure allows individuals and groups of individuals in a State party to the Optional Protocol to complain to the Committee that the State has breached one of its obligations under the Convention.[14] By the inquiry procedure on the other hand, if the Committee receives reliable information indicating grave or systematic violations of

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access to the physical environment, to transportation, to information and communications, on an equal basis with others.

[11] Marrianne, S., A Hand book on the human rights of persons with disabilities, understanding the UNCRDP, July, 2010

[12] Ibid

[13] CRPD, supra at note 8, article 3

[14] Optional Protocol to the CRPD, adopted by General Assembly resolution 61/106 of 13 December 2006, article 1(1)

the provisions of the Convention by a State party, it may invite the State to cooperate in the examination of the information by submitting observations.[15]

Against all these commitments, it is observed that all over the world PWDs face human right violation being denied of basic rights of equal participation and routine discrimination at all front of their life (legal capacity, freedom of expression, voting rights, access to health, education, employment etc).[16] As a result, many are found thrown to streets and some others being institutionalized thereby making a direct breach of various human rights.[17]

PWMDs are not exception to this; they are rather largely prone to grave human right violations as mental disability is an invisible disability and associated with myths and superstitions. By the 2011 WHO report, more than 450 million people throughout the world have mental, neurological or behavioural problems. Yet, the majority of these people do not receive human rights protection or appropriate mental health treatment and care because of the low priority given to mental health. 62% of countries do not have yet any mental health legislation or that which exists is out-of-date or does not protect them well. 30% of countries lack a specified budget for mental health, 20% spend less than 1% of their total health budget on mental health.[18]

Due to the stigma they face, they can not receive the health and social care they require. In some communities, they are evicted to the edge of town where they are left to live in horrible conditions. Patients in many mental hospitals live under degrading conditions and are subject unjustified medications. They also face discrimination in the fields of education, employment and housing. Some countries even prohibit them from voting, marrying or having children.[19]

PWMDs have been thus routinely deprived of their rights in a way no other disability group has seen. Even earlier within the disability rights movement, mental disabilities were marginalized

[15] Ibid. Article 6(1)
[16] World Report on Disability, supra at note 5, WHO, (2011)
[17] Andrew, B. *et al*, From exclusion to equality, Handbook for parliamentarians on the CRPD and its Optional Protocol, United Nations Office Of The High Commissioner for Human Rights, (2007), Geneva, pp 13
[18] End human rights violations against people with mental health disorders, December 10, (2006), International human rights day, Geneva, available at, www.who.int/mediacentre/news/releases/2005/pr68/en/index.html, accessed on January 23, 2102.

[19] Marrianne, S., Supra at note 11

while the focus remained on physical disabilities.[20] Human rights oversight bodies that monitor the mainstream conventions and established reporting guidelines have dedicated little attention to the rights of PWMDs.[21] Additionally, most efforts targeting human rights violations related to PWMDs addressed infringements on civil and political rights. But their rights to access health, education, employment and adequate standard of living on an equal basis with others are overlooked in many of the advocacy works. Given appropriate supports and protection of their civil rights, the great majority of PWMDs are quite able to become fully productive and creative members of mainstream society. But those simple supports and protections are rarely provided.[22]

In respect of all the above problems, Ethiopia is not an exception. Prejudices and stigma surrounding mental disabilities are widespread. There is yet extensive discrimination against PWMDs among all sections of the society. Welansa, A. asserts that

> "although the negative stigma associated with mental illness is prevalent throughout the world, it remains particularly relevant in Ethiopian culture where it is believed to be a sign of weakness or a result of possession by evil spirits… due to the unacceptability of such a stigma, many Ethiopians deny their mental suffering and do not get the necessary treatment, which can then result in disastrous outcomes such as suicides or homicides."[23]

Despite the existence of effective treatments for mental illnesses, there is a belief that they are untreatable or that PWMDs are difficult, not intelligent or incapable of making decisions.[24] Even those in need of the medical treatment do not reach psychiatric services, since the Country has not developed the infrastructure for mental health care that keep pace with population expansion.[25] The disproportion between the burden of mental illness and disabilities on the one hand and the budget allocated on the other hand, compared to other health facilities is visible. The human rights conditions in psychiatric facilities are not consoling either.

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[20] Gostin, L. and Gable, L., 'Mental health as a human right: People and groups at risk', Maryland Law Review, Vol. 63(1), (2004), pp 44

[21] Philip, A., 'Disability and the International Covenant on Economic, Social and Cultural Rights (ICCPR)', in Theresia, D., "Disabled persons and human rights: The legal framework" in Human rights and disabled persons: essays and relevant human rights instruments (Theresia, D. and Yolan, K., eds., 1995); There are only few cases entertained on the rights of persons with mental disabilities across the regions of Africa and Americas.

[22] Justin, D., 'From privileges to rights: People labeled with psychiatric disabilities speak for themselves', National Council on Disability, Washington DC, (20004)

[23] Welansa, A., Interview with Tadias Magazine, August 20, 2012

[24] Alem, A., 'Human rights and psychiatric care in Africa, in particular in Ethiopia', *Acta Psychiatrica, Scandinavica* ISSN 0902-4441, Munksgaard , (2000)

[25] Ibid.

1.3 Literature Review

There is little research on the human rights of PWMDs in Ethiopia. In fact there is also a dearth of literature in the areas of human rights and disabilities in general.

Writing prior to the CRPD in 2000, Alem, A. in "human rights and psychiatric care in Africa, in particular in Ethiopia", explored the mental health services of the country. He discussed the neglect of the mental health service by the policy makers when he has revealed the extent to which mental health care in Ethiopia is consistently under-resourced.[26] He has shown that many people seek the care of informal community mental health services who offer a varying quality of service and level of efficacy.[27] He further pointed out that the failure to provide adequate treatment for mentally ill persons can be easily evidenced as in a country where there are more than 80 million people has only one psychiatric hospital. With this reality, the existence of effective medications, counseling and rehabilitation would be disheartening to have.

He has also explored the admission procedure of patients at the Amanuel Hospital and the available treatment. The admission to and discharge of patients from psychiatric settings is not free from scrutiny as there is no consistent and accepted policy of admission based on the will of the patients, their health conditions and the threat they posed on their family and the society. As the work is mainly a health research, it did not dwell much on the human rights of PWMDs. But he has recognized that there are no human rights guarantees in force and oversight mechanisms in the mental health facilities in the country.

In 2005, the WHO AIMS Report on Ethiopia divulged the lack of any policy framework and a human rights standard for PWMDs. It went on to unveil the budget and human resource with the existing facilities in the country for mental health. The professional training in mental health and the availability of mental health care in primary health system are equally considered by the report. It is once again worth reiterating that this report has scanty information on the human rights conditions of the persons interned in psychiatric facilities.

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[26] Jacob, K., *et al*., 'Mental health systems in countries: where are we now?' The Lancet, (2007), Vol. 370, pp 1061-1077; Kohn, R, et al, 'The treatment gap in mental health care', Bulletin of the World Health Organization, Vol. 82, (2004), pp 858-866; Saxena, S, et al., 'Resources for mental health: scarcity, inequity and inefficiency', The Lancet Vol. 370, (2007), pp 878-889.

[27] Alem, A., Supra at note24

Abebe, H. studied one of the areas of mental disabilities, intellectual disability, on "the right to education of children with intellectual disability and its implementation in Addis Ababa." By this research, she has addressed how the right of children with intellectual disabilities to education is limited owing to attitudinal problems in the community and the family, and the lack of commitment from the government to devise a policy and implementation strategy for the effective realization of this right. She has also analyzed the attitude of children with intellectual disabilities to inclusive and special education based on qualitative and quantitative methodology.

Finally, Kibebew, P. has carried out a qualitative research titled "the right to health of mentally ill women at Amanuel Hospital." By this research, the author attempted to address the quality of the health services for mentally ill women at the Hospital, ranging from consent to treatment to the alternative treatments, freedom from sexual violence and the hygienic conditions at the Hospital. He concluded that the conditions are not compatible with the human rights standards of the rights to get highest attainable standard of health, and the other human rights are threatened as there are recurrent sexual violence against women who are often admitted involuntarily.

The above researches have direct and indirect relevance for the rights of PWMDs. However, it is clear that they are not comprehensive on the human rights conditions of PWMDs in the larger context of the country, as two of them have a specific target group; children with intellectual disabilities and mentally ill women while the remaining ones are general situation analysis of the mental health conditions in the country.

1.4 Research Questions

This study has the following research questions:

- Is the right of PWMDs to access to mental health services respected in Ethiopia?
- Does admission to psychiatric institutions comply with due process in securing the consent and autonomy of PWMDs?
- After admission to psychiatric facilities, is there respect of the human rights of PWMDs and are there conditions that would help them to rehabilitate?
- Is the right to be discharged and community integration adequately safeguarded?

1.5 Objectives of the Research

This study has both a general and specific objectives in mind; Ethiopia is a party to the CRPD and other international and regional human rights instruments which have brought obligations for the protection and promotion of the rights of PWMDs. To conduct a research to what extent Ethiopia has complied with its obligations towards PWMDs and the general situation of PWMDs in the country are the general objectives of this study. The specific objectives of the study are:

- Exploring the international and regional human rights instruments on PWMDs
- Conducting situation analysis of access to mental health services for PWMDs in Ethiopia
- Revealing the procedure of admission to mental health facilities and, discharge and community integration in Ethiopia.
- Studying the human rights conditions of PWMDs in psychiatric settings in Ethiopia

1.6 Methodology

The level of access to mental health of PWMDs in Ethiopia is carried out by studying the burden of mental illness and disabilities and the respective budgetary and human resource of mental health from the necessary government bodies, including Ministry of Health, Ministry of Finance and Economic Development and Amanuel Hospital. Secondary data collected by WHO is availed to analyze the situation of mental health care in Ethiopia.

A survey of the existing human rights protection of PWMDs in psychiatric settings is conducted taking two mental health settings; Amanuel Hospital and Gefersa Mental Health Rehabilitation Centre. In addition to the necessary desk research, semi-structured interviews and personal observations constitute the methodology to probe information about the treatment of the PWMDs. This is conducted with a broad range of mental health stakeholders *inter alia*, patients, care-givers, officials of the respective institutions, psychiatrist and relevant organizations working on the cause. The legal capacity and the guardianship system of the Country is seen based on normative study and case analysis taking the Ethiopian laws and few court cases on the grounds and procedure of limiting the legal capacity of PWMDs.

The study in general tries to answer the research questions through the lens of Ethiopian laws and international human rights instruments and standards to which Ethiopia has binding obligations, with particular attention to the ICCPR, ICESCR, CRC, ACHPR and CRPD. The UN

Principles and Standard rules on Mental Illness and other resolutions and declarations are also considered to complement the binding instruments.

1.7 Ethical Considerations

Here, it is necessary to declare that a series of steps were taken to maintain ethical considerations of a research. First, the author has got an official letter from the Associate Dean of Graduate Studies of the Law School at Addis Ababa University requesting all concerned bodies to cooperate the author over this study. Based on this, the author has approached Amanuel Hospital, Gefersa Rehabilitation Center and other concerned bodies in the way to probe the mental health situations in the country and the human rights conditions at psychiatric institutions.

The Research Ethics Committee at Amanuel Hospital went through the proposal of the study and decided that the study has no any unethical elements and allowed the research to be undertaken with a hope that the research will contribute to the improvement of the hospital services. Gefersa Rehabilitation Center has no an independent body to control research activities. Therefore, the manager of the Center has decided individually to undertake the research. In order to interview inmates and relevant informants, the medical director of Amanuel Hospital and the manager of Gefersa Rehabilitation Center have selected competent informants, who have recovered from their illness and who can give reliable information for the study.

While most of the informants have consented verbally for their name to be identified in the research, one of them asks for anonymity. Therefore, the author has been curious about their consent and divulged the name of only those informants who have consented so.

1.8 Significance of the Research

This research is significant in many ways. So far there are very few researches done on the questions raised above in Ethiopia which can serve as a spring board for advocacy groups, legislators, researchers, patients and care givers to press efforts at improving the respect of the rights of PWMDs. The policy makers and other incumbent organs of the government have shown little sympathy towards mental health and the lives of PWMDs. Therefore this research will create an opportunity to remind the government that a large group of people are ostracized without due consideration in the way to get treatment and respect of their other human rights

through an ‘undeclared sanction’. Thus, this research will be significant to persuade and influence policy makers as an eye opener towards PWMDs. Based on this, policy making and amendment activities by the government can avail this research as an input. Finally, the research is not comprehensive in every aspect that other researches should be done on the human rights of PWMDs. This will thus encourage other researches in the area to capitalize this research and address the other areas not covered here.

1.9 Scope of the Research

The rights of PWMDs which are overlooked by policy makers and other incumbent bodies are a long list. To carry out a research on all those rights will suffer from time and resource limitations. The scope of this research is therefore delimited to the study of two basic areas; the right to access to mental health and the right to respect of their other human rights in the mental health facilities: the common civil and political rights which are susceptible to violation at psychiatric institutions including the right to liberty and security, the right to privacy, freedom from torture and all forms of ill treatment, right to legal capacity, right to legal counsel and right to rehabilitation and community integration.

The title refers to PWMDs because some of the most important rights under international law are enshrined in international instruments as disability rights. Though human rights are indivisible in a way that no hierarchy exists, the selected areas are found important that the respect of them can prevent further violation of the other rights. Many of the mental health problems are curable in which if they are treated timely, persons with mental health problems will not suffer the other human rights violations as they can mange their healthy life. Unfortunately, many PWMDs are relegated to poverty and become homeless as they fail to receive timely treatment and care they require. Therefore, access to mental health services is instrumental to prevent many other violations. If persons are mentally healthy, they can have the better access to attend school and get work which will help to lead an adequate standard of life. Moreover, the violation of legal capacity imports a violation of many other rights ranging from the right to liberty and political participation to forming family and access to justice. Therefore, the right to legal capacity is, too, instrumental in the way to respect and protect other rights. The right to education, employment, adequate standard of living, and other civil and political rights, which in the writer’s opinion their violations can be minimized if the above rights are respected, are not therefore covered by

this study. Moreover, as the literature review reveals, the rights to education and the rights to adequate standard of health are addressed at least indirectly, when the right to education of children with intellectual disabilities and the rights to health of mentally ill women are studied.

Finally, though mental disabilities encompass both psycho-social disability and intellectual disability, the latter one is not included for it is studied by another researcher as noted above. Therefore, this research delves only on the rights of persons with psycho-social disabilities. The study of the human rights conditions in psychiatric facilities is limited to Amanuel Hopsital and Gefersa Rehabilitation Center for these two institutions are the only mental health hospital and rehabilitation center respectively. The author thus believed that the study result in these institutions can best warrant getting a picture of the problem in the country.

1.10 Chapter Outline

The study is organized in to five chapters. Chapter one introduces the study, reviews the literatures, discusses the research questions and methodology, the significance of the study and ethical consideration. Chapter two discusses the definition of disability, models of disability, mental disability as one kind of disability and the myths about mental disability. This is followed by a major discussion of the human rights of PWMDs at the international, regional and national basis. Chapter three ascertains if the duty of Ethiopia as regards access to mental health services for PWMDs is fulfilled. It thence attempts to answer the meaning of mental health, the right to mental health for PWMDs and the global mental health gap. Then it evaluates the mental health service PWMDs in Ethiopia based on the indicators of mental illness; the policy and legislative framework on mental health, the mental health budget and the facilities, the human resources for mental health, the availability of psychotropic medicines in Ethiopia, cost of medication for mental health and mental health services in primary health facilities. This chapter finally analyzes the human rights implications based on the right to attainable mental health services for PWMDs. Chapter four explores the human rights conditions of PWMDs in psychiatric facilities in the process of admission, treatment and discharge at two large and representative institutions, the Amanuel Hospital and the Gefersa Rehabilitation Center. Chapter five contains concluding remarks and some plausible recommendations.

CHAPTER TWO

2. THE HUMAN RIGHTS REGIME ON THE PROTECTION OF PERSONS WITH MENTAL DISABILITIES

2.1 Introduction

The study of the human rights of PWMDs requires a clear identification of individuals that deserve the protections and the extent of the protections agreed at different human rights instruments. This thus needs defining disability and particularly mental disability and identification of the legal undertakings across several international and regional human rights instruments. Concerned with the rights of PWDs, after adopting the CRPD, a number of countries demonstrated their commitment to respecting the rights of PWDs by signing the CRPD and the Optional Protocol.[28] The Convention is an undertaking to bring about change nationally and internationally by facilitation and creation of a level playing field that equalizes opportunities and thereby help build better lives for all PWDs and their families.[29] It is often submitted that the CRPD does not introduce new rights, but only measures of implementation to hasten the inclusion of PWDs in the life and activities of their communities wherever in the world they live. But some rights are introduced that are peculiar to PWDs; specifically "accessibility"[30], "living independently"[31]and "personal mobility".[32] Moreover, children and women with disabilities are distinctively recognized to be protected against all forms of discrimination based on disabilities. These are among the newly recognized forms of legal protections in response to the discrimination and unequal opportunity reigned against PWDs.

[28] Until July 2012, the CRPD has 153 signatories with 119 ratifications, while the Optional Protocol has 90 signatories with 72 ratifications, UN Office of legal affairs, treaty section, "Status: Convention on the Rights of Persons with Disabilities," United Nations Treaty Collection," available at http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en , accessed on March 23, 2012; States Parties to Convention on Rights of Persons with Disabilities, General Assembly, HR/5106, fifth conference, 12 September (2012), As states parties open fifth conference, speakers stress need for united nations to advocate daily on behalf of people with disabilities, available at www.un.org/News/Press/docs//2012/hr5106.doc.htm, accessed on September 17, 2012.

[29] Giampiero, G. and Francesca, O. (eds.), Supra at note 7

[30] CRPD, Supra at note 13, article 9

[31] Ibid. Article 19

[32] Ibid. Article 20

The protections under the CRPD embrace both types of disability, physical and mental disabilities[33] while under the Optional Protocol, individuals living in States Parties to the Protocol who allege violations of their rights, and who have exhausted national remedies, can seek redress from the Committee on the rights of PWDs.[34] This is not however with out denying that the UN instruments hitherto have no any undertaking for the protection of PWDs.[35] Besides these, the regional human rights systems have their own undertakings on the protection of PWDs which equally applies to PWMDs. In addition to these binding human rights instruments, different standards and principles have the capacity to complement and better define the extent of the protections.[36] Despite these undertakings, there is however a dearth of jurisprudence involving the rights of PWMDs across the different human rights systems.[37] Be that as it may, the human rights that should be protected are recognized with measures of implementation.[38]

Under this chapter an attempt is made to study these human rights instruments on the rights of PWMDs ranging from the ICCPR and ICESCR to the CRPD and the regional human rights instruments complemented with the MI Principles. The Ethiopian legal regime on the protection of PWMDs shall also be discussed before a concluding remark is forwarded on the chapter.

2.2 Definition of Disability

Defining disability is always at the forefront of the study of the rights of PWDs as the phenomenon of disability must first be defined and categorized before it is possible to extend protections to the subjects of the rights. But this is found to be an arduous task for long and in

[33] Article 1 of the CRPD includes persons with physical, mental, intellectual or sensory impairments to be beneficiaries of the protections in the Convention. This will be seen further when the issue of definitions of disability is discussed by the next section.

[34]. Optional Protocol to the Convention on the Rights of Persons with Disabilities, Supra at note 14, article 2.

[35] The pre-CRPD international human rights documents including the UDHR, ICCPR, ICESCR, CRC, CERD, CEDAW and CED have all recognized the need for special protection for persons with disabilities.

[36] The Standard Rules on the Equalization of Opportunities for Persons with Disabilities and he UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care are the two basic standards which have tangible contribution for the protection of persons with mental disabilities.

[37] The Committee on the Rights of Persons with Disabilities in Communication No. 3/2011lodged against the State of Sweden has passed a notable view taking in to consideration the purpose of the Convention, discrimination on the basis of disability, reasonable accommodation, general principles enshrined in the Convention, general obligations under the Convention, equality and non-discrimination; accessibility, right to life; liberty and security of the person, living independently and being included in the community, personal mobility, health; Habilitation and rehabilitation; Adequate standard of living and social protection

[38] CRPD, Supra at note 33, article 4.

many jurisdictions. This is partly because PWDs may be regarded as such in one society or setting, but not in another.[39] The fact that society and opinions are dynamic has encumbered to arrive at consensus over the issue. These attitudes determine who are considered to be PWDs; what is even worse is the issue of defining disability may lead to inconsistencies in practices of protecting PWDs. Moreover, disability is closely linked to economic and social factors in which the capacity of a person may be restricted and placed in an incapacitating situation.

But there are some general understandings to the term as disability summarizes a great number of different functional limitations occurring in any population. Persons may be disabled by physical, intellectual or sensory impairment, medical conditions or mental illness. Such impairments, conditions or illnesses may be permanent or transitory in nature.[40] Therefore, persons who are experiencing these conditions may be categorized as PWDs. In this respect, Black's Law Dictionary defines disability as 'an objectively measurable condition of impairment, physical or mental.'[41] By this, persons who suffer from a measurable condition of physical and mental impairment are considered as PWDs. This imports limitations in the capacity of the person to participate in his community on an equal basis with others who have no disability. According to the ADA, an individual with a disability is 'a person who has a physical or mental impairment that substantially limits one or more major life activities, or has a record of such impairment, or is regarded as having such impairment.'[42] This definition has the capacity to accommodate several instances by which it recognizes the perception by the society towards an individual when it employs the clause '… or is regarded as having such impairment'.

The ICF defines disability as an umbrella term for impairments, activity limitations, and participation restrictions".[43] It denotes the negative aspects of the interaction between an

[39] Andrew, B., Supra at note 17; Len B., (ed.) 'Disability and Society: Emerging issues and insights', (1996), Longman; Ingstad, B. and Whyte, S. (eds.), Disability and culture, Berkeley, California, (1995), University of California Press; Coleridge P., Disability, liberation and development, Oxfam and ADD, (1993), London.

[40] Standard Rules on the Equalization of Opportunities for Persons with Disabilities, General Assembly resolution 48/96 of 20 December 1993 (Introduction, Para. 17), available at www.un.org/documents/ga/res/48/a48r096.htm, accessed on February 1, 2012

[41] Bryan, A., Black's law dictionary, 8th ed., (2004)

[42]The Americans with Disabilities Act (ADA), (1990) as amended, Section 3, www.usdoj.gov/crt/ada/t3hilght.htm accessed at February 6, 2012

[43] ICF-WHO, (2001), supra at note 3

individual with a health condition and other contextual factors both environmental and personal. The 2002 Housing and Population Census conducted by the Government of Uganda defines a PWDs as one who is limited in the kind or amount of activities that he or she can do, because of ongoing difficulties due to a long- term physical condition or health problem that has lasted 6 months or more. This is a broad understanding towards disabilities.

The CRPD, the most pertinent instrument on disability, does not define the word 'disability'; indeed, the Preamble acknowledges that 'disability' is an evolving concept.[44] Nor does it define the term "PWDs". This my be because any definition would necessarily include some people and not others, and that over time, the definition may change in a way that would exclude people who may not now be considered as members of the group of PWDs which complies with the dynamic and evolving nature of disability.[45] Moreover, by not including a specific definition of disability, the CRPD recognizes that a person may be considered as having a disability in one society, but not in another, depending on the role the person is assumed to take in his/her community and the barriers that limited him/her from participating in a given society.[46]

The CRPD rather chose to state that

> "the term includes persons who have long-term physical, mental, intellectual or sensory impairments that, in the face of various negative attitudes or physical obstacles, may prevent those persons from participating fully in society."[47]

This evidences that no rigid view of the notion is imposed, which rather assumes 'a dynamic approach that allows for adaptations over time and within different socioeconomic settings.'[48] Hence, this is not an exhaustive definition of the subjects of the protection under the Convention; nor does this definition exclude broader categories of PWDs found in national law, including persons with short-term disabilities or persons who had disabilities in the past. For instance, a person with psychotic history may not be protected under the definition of the CRPD, but may be excluded in the society and be a victim of attitudinal problems which implies that he/she still needs protection against social exclusion and a guarantee of equal participation. This requires

[44] CRPD, Supra at note Preamble Para (e)
[45] Kanter, S., 'The promise and challenge of the CRPD', Syracuse Journal of International Law, Vol. 34, (2007), pp 287-288
[46] Ibid.
[47] CRPD, Supra at note 38, **a**rticle 1
[48] Andrew, B., *et al*, Supra at note 39 , pp 6

states to acknowledge the existence of the disabilities and work on a reasonable accommodation of the persons by minimizing the effects of the disabilities.

2.3 Models of Disability

It is underscored that the meaning of disability varies according to the societal understanding and can be constructed in relation to several basic understandings of the phenomenon. Thus, instruments and methods of protecting PWDs are likely to be based on different underlying interpretations of what constitutes the issue of a disability.[49] There are around six models of disabilities. The first one is the charity model, which embraces the belief that PWDs are 'afflicted' with their disability which sought for protective care to be provided and society's responsibility is to meet the needs with very few expectations from the person.[50] This is followed by the medical model, by which it is generally believed that a disabled person has a part of the body that needs to be fixed and medical practitioners are the experts and disability is seen as an individual health issue.[51] Gradually, the economic model, social model, bio-psycho-social and human rights models have evolved with the evolution of society.

These models have been varying with the growth of society which impacts the evolution of the concept of disability. Each model approaches disability from a unique viewpoint. From this viewpoint, different limitations and facts are regarded as appropriate when defining disability. Moreover, these different models assume different ideological principles for how PWDs are endowed rights and become eligible for protective programs. Though the above different models are developed at different socio-cultural systems and times, the medical model, the social model and the bio-psycho-social model are the common ones. Therefore, the discussion that follows is limited to these three models of disabilities in their order.

2.3.1 The Medical Model

This emerged with the development of medical science in the 19th C. that approaches disability as a medical problem and PWDs are seen as sick and in need of treatment and rehabilitation. It

[49] Catherine, A. *et al* (eds.), Disabilities, Insights from across fields and around the world, Vol. 1, (2009), pp 31
[50] 'Disability and inclusive development', London School of hygiene and tropical medicine, Nov. 2010
[51] Ibid.

locates the 'problem' within the individual rather than in society;[52] because it regards disability as a personal problem, directly caused by illness or other forms of health issues, that are assumed to be improved through medical intervention in the form of treatment methods or rehabilitation measures. That implies an individual faces problems because of his own defects and the only way to live a normal life is treating the defect.[53] Disability by this model is therefore the deficits of the functional and physiological abilities of the impaired individual associated with diagnoses and pathological facts. Such a construction and understanding of disability emphasizes the problems associated with using confirmed medical conditions as a basis on which to describe the impairments an individual suffers from and to determine how their situation can be compensated for or improved.[54] This model promotes the view that PWDs are dependent and needing to be cured or cared for, and it justifies the way in which PWDs have been systematically excluded from society. In fact, this approach is useful if it is used to support the actual medical needs of PWDs and to improve their ability to function as independently as possible.

This interpretation of disability is criticized heavily for focusing on the individual and the 'problem' rather than the possibilities and predisposition of the person with the disability. It is also criticized for assuming a medical pre-evaluation or definitional power over the problems related to disability.[55] Shortcomings in the way that society has adapted for the PWDs and whether that individual has the opportunity to participate in various activities are not present. Furthermore, the model is criticized for understanding disability according to medically accepted factors and definitional procedures followed by medical science. Other types of impairments that are more or less difficult to clarify in medical terms are often excluded from this model. For example, it is difficult to define drug addicts, alcoholics and persons who deviate from the general population within the disability category; even if it is clear that these individuals are impeded by their surroundings. As Lindqvist has asserted, the medical model results in a

[52] Stone, A., The disabled state, (1984), pp 107-117; Thomas, C., Sociologies of disability and illness: Contested ideas in disability studies and medical sociology, (2007) Basingstoke, Palgrave Macmillan
[53] Moore, S., Social welfare alive, UK, Stanely Tornes Ltd, (2002), pp 403; Soder, M., 'Tensions, perspectives and themes in disability studies', Scandinavian Journal of Disability Research, Vol.11, No.2, (2009), pp 67-81
[54] Stone, A., Supra at note 52
[55] Thomas, C., 'How is disability understood? An examination of sociological approaches': Disability and society, Vol. 19, No. 6, (2004).

"medcalization" of social problems and living standards as a person who is disabled and has limited financial means will only be granted access to welfare benefits when he/she receives a diagnosis.[56]

This approach can also lead policy makers and service managers focusing their work on compensating persons with impairments for what is wrong with their bodies. This could be through targeting specific benefits at them or providing segregated services. The medical model also can affect the way PWDs think about themselves. The negative message can convey that all the problems of living with a disability stem from not having 'normal' bodies. PWDs could then think that their impairments automatically exclude them from participating in social activities.[57]

When this model has become seriously at odds with the daily lives and experiences of PWDs, it was inevitable that change had to come on the approach towards disabilities. It was clear to PWDs that, in the absence of any cure for their physical condition, the impairment must be regarded as given: a constant factor in the relationship between themselves and the society with which they attempt to interact.[58] It follows from this that any failure in the interaction must be overcome through a restructuring of the social and physical environment. This requires an approach which takes account of the many individuals with their particular impairments and dealt with the effect on such individuals of their social and physical environment. This model has, therefore, gradually could not stand all the criticism and suffered a rejection moving the focus onto society as the source of disability. Researches in the field of critical disability studies have clamored that it is society's failure to provide appropriate services and its failure to adequately ensure that the needs of PWDs are taken into account which creates disability.[59] Therefore, the social model came to succeed the medical model of disability with a hope to meet the gaps that the former has failed to address on the rights of PWDs.

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[56] Report of the United Nations High Commissioner for Human Rights on progress in the implementation of the recommendations contained in the study on the human rights of persons with disabilities [E/CN.4/2004/74], 15 December 2003, available at www.un.org/documents/ga/res/48/a48r096.htm, accessed on February 12, 2012

[57] Brisenden, S., "Independent living and the medical model of disability", International Journal of Disability and Society' Vol. 1, No. 2, (1986), pp 173-178

[58] Grant, C. 'The social model of disability', Scottish accessible information forum, (2009), available at www.saifscotland.org.uk, accessed on August 29, 2012. See also World Bank: Social analysis and disability**:** A Guidance Note, Washington, DC, Social Development Department, (2007)

[59] 'Living with disability in the UK', available at www.internationalstaff.ac.uk, accessed on August 29, 2012; Hales, G. (ed.), Beyond disability: Towards an enabling society, London: Sage in association with the Open University, (1996), pp114-23; Hurst, R. and Albert, B., 'The social model of disability: human rights and development cooperation' in Albert, B. (ed.), In or out of the mainstream? Lessons from research on disability and development cooperation, Leeds: The Disability Press, (2006), pp 24- 39

2.3.2 The Social Model

This model arose in response to the critique of the medical model and stands as an antithesis of the medical understanding of disability. Hence the name, social model, emphasizes the social explanation for why the phenomenon of disability comes into being. According to the social model, disability is not something that is given to persons by nature; it is constructed through human interaction. It also opposes the idea that disability is something that can be "repaired" or improved through rehabilitation measures or intervention by medical or other professional fields. It advocates that the solution for PWDs is with in the control of the society, attitudinal and physical accessibility can avoid the barriers against equal and effective participation.

WHO, commenting on the revised understanding of disability, stated that:

> "furthermore, the notion of disablement is not perceived in terms of an attribute of a person, but as a complex collection of conditions many of which are created by the social environment. Hence, the management of the problem requires social action and it is the collective responsibility of society to make the environmental modifications necessary for the full participation of PWDs into all areas of social life. The issue is, therefore, an attitudinal or ideological one which requires social change, while at the political level it is a matter of human rights".[60]

Harlan, H., writing about the North American context, stated that disability stems from

> "the failure of a structured social environment to adjust to the needs and aspirations of citizens with disabilities rather than from the inability of the disabled individual to adapt to the demands of society."[61]

Disability is therefore not an individual quality based on the social model, but arises as a consequence of man-made conditions and a society that is poorly adapted and organized. The fact that persons become disabled is a by-product of the social environment resulting from a lack of response to the need to make adaptations, including adjustments to the physical environment including building design, transportation system, etc. A child with an intellectual disability might have for instance difficulties in school because of teachers' attitudes toward him/her, inflexible

[60] WHO, 'International classification of impairment, activities and participation': A manual of dimensions of disablement - Beta-1 Draft, (WHO, (1997), Geneva.

[61] Hahn, H., (1986) as cited in Raymond L., 'The development and critique of the social model of disability', University of East Anglia, January, (2001); Ken D., 'The social model of disability – setting the terms of a new debate', The Derbyshire Coalition of Disabled People, (1996); Alvarez, E., "Pathways to accessibility: Disability and the physical environment in Latin America and the Caribbean", Working Paper, available at: http://www.iadb.org/sds/SOC/publication/gen_2547_3206_e.htm accessed on March 10, 2012

school facilities and possibly parents who are unable to adapt to children with different learning capacities. A person on a wheelchair might have difficulties taking public transport or gaining employment, not because of his/her condition, but because there are environmental obstacles, such as inaccessible buses or staircases in the workplace, that impede his/her access. Based on this approach, it is thus vital to change those attitudinal and environmental barriers.

In this respect, Paterson, K. has noted that

> *"*the social model of disability presupposes an untenable separation between body and culture, impairment and disability, while this has been of enormous value in establishing a radical politics of disability*."*[62]

Several countries that have introduced anti-discrimination laws to apply to disability have been inspired by the social model of disability.[63] This model has also influenced the use of the principle of 'universal design' wherein buildings, public gathering areas, educational and teaching processes, informational materials, and any resources are developed based on the notion that people participate in society in different ways. When something is universally designed, it is adapted in such a way that all can participate, regardless of an individual's capabilities or inhibitions.[64] The CRPD's approach to disability also emphasizes the significant impact that attitudinal and environmental barriers in society may have on the human rights of PWDs.[65]

This model is not however free from limitations; it is criticized for focusing too much on persons with physical disabilities and giving too little attention to experiences related to illness, pain and physical limitations as blindness and related disabilities which can be addressed by medical solutions.[66] It thus leaves, according to Swain, J. and French, S., the possibility that even in an ideal world of full civil rights and participative citizenship for disabled people, impairment could

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[62] Paterson, K., The social model of disability and the disappearing body: Towards a sociology of impairment disability and society, (1997), pp 325-340; Mike O., 'The social model in action: If I had a hammer', in Barnes, C. and Mercer, G. (eds.), Implementing the social model of disability: Theory and research, (2004), pp.21.

[63] Stone, A., 'The globalization of disability rights law', Syracuse journal of international and comparative law, vol. 30, (2003), p. 249; Debora D., 'Disability, human rights and justice', Sur international journal on human rights, Vol. 6, No. 11, December, 2009 , pp 61-71

[64] Marianne S., Understanding the UN Convention on the Rights of Persons with Disabilities, 3rd edition: (2010), pp 43

[65] CRPD, Supra at note 38, Preamble, Para (e)

[66] Shakespeare, T. and Watson, N., The social model of disability: Elsevier Science Ltd, Vol. 2, (2001), pp 9-28; Paterson K., Supra at note 62

be seen as a personal tragedy.[67] This is to mean that the model disassociates impairment from disability when it focuses only on the disabilities that are caused by the society, ignoring the impairments which are purely medical. Moreover, if disability is socially constructed, as this model proposes, the value of the real life experiences of PWDs will remain a puzzle. That is a question commonly posed to the social model of disability as the latter does not go so far as to negate the existence of disability or to deny the existence of a person's impairment, pain, suffering or need for treatment and rehabilitation as it places the responsibility squarely on society.[68] By refusing to discuss impairment, this model failed to acknowledge the subjective reality of PWDs lives that experience pain, illness, shortened lifespan or other factors due to an impairment. As a result, they may seek treatment to minimize these consequences and, in extreme circumstances, may no longer wish to live. Shakespeare, T. and Watson, N., submit that:

> "most activists concede that behind closed doors they talk about aches and pains and urinary tract infections, even while they deny any relevance of the body while they are out campaigning."[69]

Therefore, there is a need to ensure the availability of all the support and resources that an individual might need, whilst acknowledging that impairment can still be intolerable.[70]

This led to a paradigm shift from the mutually exclusive social and medical models to another model which could transcend the deficits of these two models and takes in to account impairment and disability together to help PWDs participate equally in the mainstream society and all their human rights be respected and protected on an equal basis with others. This new model is known as the bio-psycho-social model which is going to be discussed below.

2.3.3 The Bio-Psycho-Social Model

The above two models appeared as mutually exclusive; but it has been shown that disability should be viewed neither as purely medical nor as social: PWDs can often experience problems

[67] Ibid.
[68] Barnes, C., 'The social model of disability: Myths and misrepresentations, coalition': the Magazine of the Greater Manchester Coalition of Disabled People, Manchester: Greater Manchester Coalition of Disabled People, (1996)
[69] Shakespeare, T. and Watson, N., "The social model of disability: an outdated ideology?", University of Newcastle, Journal of Social Science and Disability' Vol. 2, (2002), pp 6
[70] Liz, C., Including all of our lives: Renewing the social model of disability, Encounters with strangers, Ed. Jenny Morris, Women's Press, (1996)

arising from their impairment and the socially constructed disability.[71] On their own, neither model has failed to be adequate, although both are partially valid. The WHO has described disability as:

> "a complex phenomena that is both a problem at the level of a person's body, and a complex and primarily social phenomena; disability is always an interaction between features of the person and features of the overall context in which the person lives, but some aspects of disability are almost entirely internal to the person, while another aspect is almost entirely external."[72]

Thus, both medical and social responses are appropriate to the problems associated with disability and it is not possible to wholly reject either kind of intervention.

A better model of disability is therefore the one that synthesizes what is true in the two models, without making the mistake each makes in reducing the whole, complex notion of disability to one of its aspects. This more useful model of disability might be called the bio-psycho-social model. This is an integration of the medical and social models. ICF provides, by this synthesis, a coherent view of different perspectives of health: biological, individual and social.

This model which evolves from the social model presents disability as a combination of medical and socially created phenomena which is viewed as a compromise between the two models as both models consider the problem only from one aspect and failed to appreciate the problem holistically.[73] Thus, disability cannot be explained by medical, biological or social factors exclusively but by the interaction between all of them. To blame the society alone for the problems suffered by the PWDs is too unfair and unrealistic. Rather than dichotomizing the solutions to disability as either medical or social, this model looks to bridge the gap through flexibility by recognizing a range of instruments that can be employed to resolve the dilemmas faced by PWDs. A disability can be cured by the medicine if it is possible and it similarly applies to socially addressed disabilities where the medical science can not afford a solution.

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[71] Thomas, C. Female forms: experiencing and understanding disability. Buckingham, Open University Press, (1999), as cited in the 2011 World Disability Report, pp 4

[72] 'Towards a common language for functioning, disability and health', WHO, (2002), Geneva; Barnes, C., 'The Social Model of Disability: Valuable or Irrelevant?' in Watson ,N. *et al* (2012): The Routledge handbook of disability studies, London: Routledge, pp 12-29.

[73]. World Disability Report 2011, supra at note 16, WHO, p. 11

In addition to the lacunas of the two models, Herbert, S. summarized the other catalyzing reasons for the adoption of this model as:

> "changing patterns in the distribution of disability in the population including evidence that socio-economic status puts people at risk for a higher proportion of congenital abnormalities, illnesses and injuries that can lead to disability, the emergence of new disabilities, disproportionate concentrations of disability among: people in poverty, people that lack access to quality preventions and interventions, people that are exposed to additional external or lifestyle risk factors, the prevalence of disability related to an aging world population." [74]

Thus, in addition to the constraints imposed by the society as the social models propounds and the impairments arising from the illness of the persons, other socio-economic realities may expose PWDs to greater degree of discrimination. The study of disabilities and the protections of the targets shall therefore take in to account all these variables coupled with the evolution of other forms of disabilities and the predisposition of individuals based on the level of economic development, risk factors and access to education and health facilities.[75]

2.4 Mental Disability as one Disability

2.4.1 Facts and Figures about Mental Disabilities

450 million people around the world have mental, neurological or behavioural problems; yet the majority of these people do not have access to appropriate mental health treatment and care.[76] 30% of countries do not have a specified budget for mental health. Of those that do, 20% spend less than 1% of their total health budget on mental health.[77] Some countries lack adequate services, while in others services are available only to certain segments of the population. 32% of

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[74]. 'Evolving definitions of disability', available at www.accessingsafety.org/.../understanding disability/ accessed on February 15, 2012. In this respect, the Committee on CESR has also shared the socio-economic perspective of disability when it commented on article 14 of the CESCR as: "disability is closely linked to economic and social factors - conditions of living in large parts of the world as so desperate that the provision of basic needs for all – food, water, shelter, health protection and education must form the cornerstone of national programmes. Even in countries which have a relatively high standard of living, persons with disabilities are very often denied the opportunity to enjoy the full range of economic, social and cultural rights recognized."

[75] It is widely recognized that PWDs make up a substantial proportion of the poorest in the developing world. See Elwan, A. Poverty and disability: A survey of the literature, a background paper for the World Development Report, World Bank, December 18, 1999.

[76] World Health Report 2001: Mental health: New understanding, new hope. Geneva, WHO, (2001), http://www.who.int/mental_health/en/ , accessed on February 11, 2012

[77] Mental Health Atlas, Geneva, WHO, (2005), available at http://globalatlas.who.int/globalatlas/default.asp, accessed on February 11, 2012

countries have no community care facilities defined as 'any type of care, supervision and rehabilitation of mental patients outside the hospital by health and social workers based in the community'.[78] There are huge regional variations in the number of psychiatrists from more than 10 per 100,000 to less than 1 per 300,000.[79] Worldwide, 68.6% of psychiatric beds are in mental hospitals as opposed to general hospitals or other community settings.[80]

Like persons with other disabilities, PWMDs face degradation, stigmatization and discrimination throughout the world; hence in particular, the development of human rights protections may be even more significant than for persons with other disabilities.[81] Disproportionately and more frequently, PWMDs are routinely confined against their will in institutions and deprived of their freedom, dignity and basic human rights. In some countries, people are locked away in traditional mental hospitals, where they are continuously shackled and routinely beaten because it is believed that mental illness is evil and that the afflicted persons are possessed by bad spirits. They may be tied to their beds, lying in soiled beds or clothing, and receiving no stimulation or rehabilitation for their condition.[82]

Those who are fortunate enough to live outside institutions often remain imprisoned by the social isolation they experience, often from their own families. They are not included in educational programs and they face attitudinal barriers to employment because as they could not receive the education and training needed to obtain employment and due to discrimination based on unsubstantiated fears. Discrimination against PWMDs does not always take the form of hatred or hostility, however. More often, 'discrimination against PWMDs takes the form of fear, pity, or patronization'[83] as Perlin, M. observes. Paul, H. has described PWMDs as 'one of the most marginalized and vulnerable groups in all countries.'[84]

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[78] Ibid.
[79] Ibid.
[80] Ibid.
[81] Perlin, M., 'Mental health and human rights: Evolution and contemporary challenges', New York Law School Legal Studies Research Paper Series, (2007/08), No. 28.
[82] Melvyn, F., *et al*, The WHO resource book on mental health, human rights and legislation, Geneva, (2005)

[83] See generally Perlin, M., 'The hidden prejudice: Mental disability on trial', (2000).
[84] Hunt P., 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health', E/CN.4/2005/51, 11 February 2005, www.un.org/documents/ga/res/48/a48r096.htm, accessed at March 6, 2012, pp 7.

However, in recent years, the human rights of PWMDs have attracted increasing attention. This is partly due to the fact that international treaty monitoring bodies have not made significant efforts to protect and enforce the rights of PWMDs, even though existing treaty rights cover the rights of PWMDs.[85] The advocacy works by the survivors of psychiatry and other stake holders have also pressed the need to reconsider the rights of PWMDs.[86] These concerted efforts have pushed the international community to draft the important binding instrument; the CRPD which heralds a new set of measures to implement the rights of PWDs in general and PWMDs in particular. There is now a growing jurisprudence in this field, as well as increasing interest from international organizations, civil society and academics. While attention has traditionally focused on the civil and political rights of PWMDs, their economic, social, and cultural rights, including the right to health, are also beginning to attract greater attention and concern. [87] But this is not a consolation. Despite increased knowledge about mental disabilities and new models of community-based services and support systems are developing, PWMDs still experience marginalization in different countries. Institutionalization persists in many countries. Elsewhere, community-based services do not always ensure integration, autonomy and dignity.[88]

2.4.2 Defining Mental Disabilities

When discussing mental disabilities, a complicating factor is the absence of agreement on the most appropriate terminology. Mental illness, mental disorder, mental incapacity, psychiatric disability, mental disability, psycho-social disability, intellectual disability and several other terms are all used with different connotations and shades of meaning. Some of the terms reflect very important and sensitive debates, such as the discussion about a 'medical model' or 'social model' of functioning.[89] The terminology 'mental illness', for instance clearly reflects a medical

[85] Alston, P., 'Disability and the International Covenant on Economic, Social and Cultural Rights, in human rights and disabled persons: Essays and relevant human rights instruments Vol. 94; Gerard, Q. et al., 'Human rights and disability': The current use and future potential of united nations human rights instruments, in the context of disability, (2002), pp 59-73; Rosenthal, E., and Rubenstein, S., 'International human rights advocacy under the Principles for the Protection of Persons with Mental Illness', International Journal of Law and Psychiatry , Vol. 16, (1993), pp 257-268

[86] The World Network of Users and Survivors of Psychiatry has done a tremendous work in this respect pressing for recognition and respect of the rights of persons with mental disabilities

[87] Hunt, P., and Mesquita, J., 'Mental disabilities and the human right to the highest attainable standard of health', Human rights quarterly, Vol. 28, (2006), pp 332

[88] World Disability Report, Supra at note 73

[89] WHO-ICF, (2001), available at http://www.who.int/m/topi cs/icf/en/index.html, accessed on March 29, 2012.

understanding and it is approached negatively by the social model advocates. Often times, the terms 'psychiatric disability' and 'mental disability' are used interchangeably.

The task of defining mental disability has been daunting for different reasons in addition to the general problems with defining disability. One, it is not a unitary condition but a group of disorders with some commonalties i.e. mental illness, intellectual disability, psychiatric disorder.[90] This imports intense debate about which conditions are or should be included in the definition of mental disabilities.[91] This can have significant implications when, for example, a society is deciding on the types and severity of mental disorders that are eligible for involuntary treatment and services.[92] The other problem with defining mental disability is someone may experience a mental illness for a brief time or for over many years. The type, intensity and duration of symptoms vary from person to person. They come and go and do not always follow a regular pattern, making it difficult to predict when symptoms and functioning will flare-up[93] and ultimately affecting if the person suffers from mental disability. For some people, mental illness is not permanent, and the level of disability experienced often fluctuates, while for some others, the illness is so debilitating, they have to struggle their whole life.[94] Consequently, some people with mental illness need no support, others may need only occasional support and still others may require ongoing support to maintain their productivity.[95]

Mental illness and mental disability should be distinguished here. Mental illness is a broad term used to describe a wide range of diagnosable psychiatric illnesses that impair a person's ability to think, feel and behave in a manner that allows optimum functioning in day to day life. More precisely, mental illness refers to the actual disorder.[96] On the other hand, mental disability refers

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[90] Kendell, R. and Jablensky, A., 'Distinguishing between the validity and utility of psychiatric diagnoses', American Journal of Psychiatry, Vol. 160 No. 1, (2003), pp 4-12; Kumar, A., and Nevid, JS., 'Acculturation, enculturation, and perceptions of mental disorders in Asian Indian immigrants', *Cultur divers ethnic minor psychol*, Vol.16(2), (2010), pp 274-83; Maser, JD, Akiskal HS, 'Spectrum concepts in major mental disorders', American Journal of Psychiatry, Vol.25, No. 4, (2002), pp 11-13

[91] Perlin, M ., supra at note

92 Jeff, F. *et al*, 'How definition of mental health problems can influence help seeking in rural and remote communities', Australian journal of rural health, Vol. 8, Issue 3, (2000), pp 148–153; Steven, R. and Peter, J., **'**Uncovering the social world of mental illness'**,** University of California, Annual Review of Psychology, Vol. 51, (2000), pp 571-598.

[93] Ibid.

[94] Johannes, R., et al, 'Relationships between psychiatric conditions and behavior problems among adults with mental retardation', American Journal on Mental Retardation, Vol. 109, No. 1, (2004), pp 21-33.

[95] Ibid.

[96] Ibid.

to the difficulty the individual experiences as a result of mental illness. While many psychological and mental conditions can create enough interference in a person's life to be considered a mental disability, not every person who has had a mental illness will experience a disability. Moreover, mental disability is not synonymous with mental disorder, but includes persons with mental disorder. Persons who have recovered from a mental disorder may continue to have disabilities and many persons with ongoing mental disorder will also have disability due to the disorder. This is because the society may still treat a person with psychotic history as disabled as one who is suffering from the disorder yet.

In this study, the umbrella term 'mental disabilities' is used, which includes disabilities arising from major mental illness and psychiatric disorders, e.g., schizophrenia and bipolar disorder; more minor mental ill health and disorders, often called psychosocial problems, e.g., mild anxiety disorders; Down's syndrome and other chromosomal abnormalities, brain damage before, during or after birth and malnutrition during early childhood. The term therefore refers to a range of impairments, activity limitations and participation restrictions, whether permanent or transitory. In general, mental disabilities encompass notably two sets of conditions; psychosocial disabilities and intellectual disabilities. The choice of the term is not however random, it has the capacity of referring directly to persons' immediate perceptions of their lives, their environment and their needs and limitations,[97] and that professionals from outside the health sector more easily understand this concept. Be that as it may, the UN has defined a PWMDs as one who in the course of his/her disability is unable to care for his/her own person or affairs, and requires care, treatment or control for his/her own protection or that of others or of the community.[98]

2.5 The Myths about Mental Disabilities

Much like other types of disabilities, deep societal prejudices remain against PWMDs, as a mental disability is generally considered to be a condition that causes a person to be unable to perform various tasks that he/she might otherwise perform without it. The inability may arise from the medical problem of the individual or the environmental and social barriers depending

[97] Bertolote, J. and Sartorius, N., WHO initiative of support to people disabled by mental illness, Vol. 11, Supplement 2, (1996), pp 56-59

[98] Erica, I., Rapporteur, 'Principles, guidelines and guarantees for the protection of persons detained on grounds of mental ill health or suffering from mental disorder', U..N. doc. E/CN.4/Sub.2/1983/17, Para43, available at www.un.org/documents/ga/res/48/a48r096.htm, accessed at March 12, 2012

on the model adopted. Besides these, what makes PWMDs severely victimized than others is, there are many destructive myths that continue to impede efforts to eliminate discrimination and stigma and foster political support for mental health services.[99] These myths have fuelled misperceptions about PWMDs and perpetuated enduring negative stereotypes. As a result, they have become pervasive and influential on the public discourse about mental disability rights.[100]

The first myth is the 'myth of incompetency' which relies on the assumption that PWMDs can not competently make decisions or grant consent. Many national laws presume automatic or perpetual incompetency for PWMDs or fail to assess separately a person's competency with regard to specific services, decisions or functions.[101] A person's right to exercise other human rights may be undermined if he or she is inappropriately denied the ability to make decisions. In actuality, mental disabilities vary substantially and a continuum of competency exists. While some PWMDs lack competency, others have full competency or merely limited incapacity.

A second destructive myth is the common misconception that PWMDs generally pose a threat to others which is termed in short as the 'myth of dangerousness'. Based on this understanding, families and the community are mostly scared of PWMDs and they try to detain them to restrict the presumed threat. Research on this issue however demonstrates that PWMDs have no greater propensity to commit violent acts than persons who do not have a mental disability.[102] The key variable in predicting dangerousness is co-morbidity with alcohol and drug dependency. Moreover, most violent acts are committed by people who do not have a mental disability.[103] Nevertheless, the media often give disproportionate attention to the rare cases when PWMDs commit a violent crime.[104] In reaction to a highly-publicized violent crime, the UK Parliament

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99 Gable, L. and Gostin, O., 'Global mental health: changing norms, constant rights', Georgetown Journal of International Affairs, Vol. 1, (2008), pp 83–92; Thomas, S., 'Ideology and insanity: Essays on psychiatric dehumanization of man', Syracuse University Press, (1991).

100 Wapnick, K., 'Mysticism and schizophrenia', Californian Journal of Transpersonal Psychology, Vol. 1, (1969), pp 49-67; Melton *et al*., Psychological evaluations for the courts: A Handbook for Mental Health Professionals and Lawyers, (1997), pp 277-93; Shah, S., 'Dangerousness and civil commitment of the mentally ill: Some Public Policy Considerations', American Journal of Psychiatry, Vol.132, (1975), pp 501-5

101 Gable, L. and Gostin, O., 'Mental health as a human right', Wayne State University Law School Research Paper, No. 09-15

102 Rethinking risk assessment: The MacArthur Study of Mental Disorder and Violence. New York: Oxford University Press, Executive Summary, (1999), available at www.macarthur.virginia.edu/risk.html, accessed on March 5, 2012

103 Seena, F. and Martin, G., 'The population impact of severe mental illness on violent crime', American Journal Of Psychiatry, Vol. 163, (2006), pp1397–1403

104 Smith, M., 'Role of the popular media in mental illness', The Lancet, Vol. 349, (1997)

for instance enacted the Mental Health Act of 2007,[105] which embraces the aforementioned stereotypes about dangerousness and enhances government powers of preventive confinement at the expense of treatment and patients' rights.[106] Such approaches threaten to deplete the right to mental health by enacting punitive measures instead of treatment.

The third myth invokes the misconception that the deinstitutionalization movement resolved the most important human rights issues facing PWMDs. After effective psychotropic medications were discovered and made available, thousands of persons with severe mental disabilities became able to receive treatment in the community, and were released from institutional settings. These medications held great promise to benefit patients with more effective treatments and greater freedom. Additionally, governments strongly supported deinstitutionalization for its economic benefits. Costly psychiatric institutions could be shuttered and resources directed elsewhere.[107] However, deinstitutionalization is more complex and more costly to implement than its proponents had claimed and states ever anticipated. The array of supports that people with serious mental illness need to live independent and successful lives in the community were not appreciated and therefore not provided. Chronically ill persons should not be deinstitutionalized in the absence of community system that can help them integrate to the larger community. Therefore, taking deinstitutionalization as a panacea is slippery that place persons with chronic mental disabilities at a higher risk.

These myths import many other implications on PWMDs including sanism and pretextuality, as Perlin, M. submits. Perlin defines 'sanism' as:

> "an irrational prejudice of the same quality and character of other irrational prejudices that cause and are reflected in prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry."[108]

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[105] The UK Mental Health Act, (2007), available at http:// www.opsi.gov.uk/acts/acts2007/pdf/ukpga_2007 , accessed on March 15, 2012

[106] Gostin, O., 'From a civil libertarian to a sanitarian' Journal of Law and Society, Vol. 34 (2007), p. 594–616; Phil, B. and Buchanan, P., 'Myth of mental health nursing and the challenge of recovery', International Journal Of Mental Health Nursing, Vol. 20, (2011), pp 337–344

[107] Frank, G. and Glied A., Better but not well: Mental health policy in the United States since 1950,Baltimore: The Johns Hopkins University Press, (2006)

[108] Perlin, M.,"Things have changed:" Looking at non-institutional mental disability law through the sanism filter, New York Law School Journal of Human Rights, Vol. 19, (2003), pp 165; Perlin, M. challenges mental disability laws at civil, criminal and legislative levels by asking for a heightened objectivity rooted to the enlightened parameters of legal principle and promise. Sanist attitudes are manifested by such as culturally accepted notions of

As a result of this stigma associated with having a mental disability, 'sanism' in implementing laws and policies that affect PWMDs, and society's overwhelming fear of those who are perceived as dangerous, it is difficult for a person with an obvious mental disability to be tried and executed fairly.[109] Champine, P. shares Perlin's concern for the discriminatory impact of 'sanism' on legal procedure and decision-making when she draws attention against the predominantly unconscious preconceptions in regard to the mentally ill and elderly people unwittingly taint judicial procedure and outcome.[110]

Pretextuality on the other hand is coined by Perlin as 'a biased expert testimony and the acceptance by the courts the testimonial dishonesty and engage in similarly dishonest decision-making.'[111] This happens specifically where expert witnesses show a high tendency to purposely distort their testimony to achieve desired social end. These ends are exclusion of PWMDs from the society and sending them to an institution where their human rights would far worse be violated. These misperceptions by a society and the expert witnesses are the direct effects of the myths discussed above that, PWMDs suffer from the erroneous presumption of incompetence and dangerousness that, they should be segregated from the society and be kept at an institution.

2.6 The Human Rights of Persons with Mental Disabilities

Until the declaration of the International Year of Disabled Persons and World Programme of Action Concerning Disabled Persons,[112] there was hardly any significant activity on an international level on the rights of PWDs in general and PWMDs in particular. As part of the latter efforts, the UN Human Rights Commission appointed two Special Rapporteurs to investigate and report on the human rights of PWMDs, and in 1991, the General Assembly

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what it means to be "crazy" and/or "incompetent," which can infiltrate and corrupt the goals of mental disability laws as well as other legal spheres. Sanism is so pervasive that it is witnessed in the tendency of human beings to act upon and create self-fulfilling predictions about others. In so doing, biased preconceptions about the other, individuals or groups, dictate what people see and how they react.

[109] John, W., 'The death penalty and persons with mental disabilities: A lethal dose of stigma, sanism, fear of violence, and faulty predictions of dangerousness', Mental and Physical Disability Law Reporter, Vol. 29, No. 5, September/, October 2005, pp 667-669

[110] Champine, P., 'The sanist will', New York Law School Law Review, Vol. 46, No.547, (2003)

[111] Perlin, M., Supra at note 108

[112] International Year of Disabled Persons, U.N. Doc. A/RES/36/77 (1081), December 1981

adopted the MI Principles.[113] These Principles established the most comprehensive international human rights standards for PWMDs and their adoption was a critical step in recognizing mental disability rights within the human rights arena.

There was however a widespread misconception that the human rights instruments existing before the CRPD are not directly applicable to PWMDs and those relating specifically to mental health and disability are non-binding resolutions, rather than obligatory conventions. As a result, mainstream human rights protection systems and advocacy organizations had difficulty acknowledging mental disability rights as part of their mandates. Based on this, the protection of PWMDs was considered subject only to the domestic discretion of governments. This is not true, as governments are under obligation under international human rights law, to ensure that their policies and practices conform to binding international human rights law and this includes the protection of PWMDs. In fact, some treaty monitoring bodies at the international and regional levels have been monitoring compliance by States that have ratified international human rights treaties on the protection of PWMDs. As part of this, the treaty bodies of the regional human rights system have also established individual complaints mechanisms, which provide the opportunity for individual victims of human rights violations to have their cases heard and to seek reparations from their governments. This following is an overview of some of the key provisions of international and regional human rights instruments and standards that relate to the rights of PWMDs coupled with the CRPD.

2.6.1The International Protection of Persons with Mental Disabilities

2.6.1.1 International Bill of Rights

The UDHR, ICCPR and ICESCR together make up what is known as the "International Bill of Rights". The UDHR provides that all people are free and equal in rights and dignity.[114] Thus

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[113] Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care, G.A. res. 46/119, 46 U.N. GAOR Supp. (No. 49) at 189, U.N. Doc. A/46/49 (1991), available at **www.un.org/documents/ga/res/48/a48r096.htm,** accessed on March 22, 2012

[114] UDHR, adopted and proclaimed by the UN General Assembly in resolution 217 A (III) of 10 December 1948 at Paris, Article 1

PWMDs are also entitled to the enjoyment and protection of their fundamental human rights. In 1996, the CESR adopted General Comment 5, detailing the application of the ICESCR with regard to persons with mental and physical disabilities. The Human Rights Committee has yet to issue a general comment specifically on the rights of PWMDs while it has issued General Comment 18 which defines protection against discrimination against PWDs. [115]

A fundamental human rights obligation in all these three instruments is the protection against discrimination.[116] Furthermore, the CESCR under General Comment 5 specifies that the right to health includes the right to access rehabilitation services and a right to access and benefit from services that enhance autonomy which could protect the right to dignity. Other important rights specifically protected in the International Bill of Rights include the right to community integration, the right to reasonable accommodation,[117] the right to liberty and security of person[118] and the need for affirmative action for PWDs, which includes PWMDs.

The ICESCR establishes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.[119] The CESCR has also adopted General Comment 14 with an aim to assist countries in implementation of article 12 of ICESCR. The Committee specifies that the right to health contains both freedoms and entitlements, which include the right to control one's health and body, including sexual and reproductive freedom and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. Entitlements also include the right to a system of health protection that provides people with equality of opportunity to enjoy the highest attainable level of health.

2.6.1.2 Other International Conventions Related to Mental Disability

Apart from the International Bill of Rights; the other UN human rights instruments have some thing worth considering on the rights of PWMDs. These include the CRC, CERD, CAT, CEDAW and CED.

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[115] ICCPR, adopted by the UN General Assembly in resolution 2200 A (XXI) of 16 December 1966 at New York, article 26

[116] UDHR, Supra at note 114, article 2; See also ICESCR, adopted by the UN General Assembly in resolution 2200 A (XXI) of 16 December 1966 at New York, article 2(2), ICCPR, article 2(1).

[117] Committee on ICESCR, General Comment No. 5, Para 15

[118] ICCPR, Supra at note 116, article 9

[119] ICESCR, Supra at note 116, article 12

The CRC contains human rights provisions specifically relevant to children and adolescents. These include protection from all forms of physical and mental abuse, non-discrimination, the right to life, survival and development, the best interests of the child and respect for the views of the child. A number of its provisions are specifically relevant to mental health. For instance it recognizes children with mental or physical disabilities to enjoy a full and decent life in conditions that ensure dignity, promote self-reliance and facilitate the child's active participation in the community.[120] It also recognizes the right to periodic review of treatment provided to children who are placed in institutions for the care or treatment of physical or mental health.[121] The recognition of the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development[122] is highly dependent on the respect of the right to access to physical and mental health. Finally, the recognition of the right of children to be protected from performing any work that is likely to be hazardous or to interfere with their education or to be harmful to their health or physical, mental spiritual, moral or social development has the capacity to protect children from mental disability.[123] The right to health of PWDs is also recognized in the CERD,[124] and the CEDAW[125].

The CAT is another important instrument to PWMDs. It requires States Parties to prevent acts of torture, cruel, inhuman or degrading treatment or punishment.[126] In many mental health institutions, there are a vast number of examples that could constitute inhuman and degrading treatment. These include: lack of a safe and hygienic environment; lack of adequate food and clothing; lack of adequate heat or warm clothing; lack of adequate health-care facilities to prevent the spread of contagious diseases; shortage of staff leading to practices whereby patients are required to perform maintenance labour without pay or in exchange for minor privileges; and systems of restraint that leave a person covered in his or her own urine or faeces or unable to

[120] CRC, adopted by the UN General Assembly in resolution 44/25 of 20 November 1989 at New York, article 23
[121] Ibid. Article 25
[122] Ibid. Article 27
[123] Ibid. Article 32
[124] CERD, adopted by the UN General Assembly in resolution 2106 A (xx) of 21 December 1965 at New York, article 5(e)(iv)
[125] CEDAW, adopted by the UN General Assembly in resolution 34/180 of December 1979 at New York, Articles 11.1(f) and 12
[126] CAT, adopted by the UN General Assembly in resolution 39/46 of 10 December 1984 at New York Article 16,

stand up or move around freely for long periods of time.[127] The guarantees under CAT are thus equally applicable to that group of persons who are languishing behind closed doors.

The lack of financial or professional resources is not an excuse for protection against torture, inhuman, cruel and degrading treatment as there is no any justification for it.[128] Governments are required to provide adequate funding for basic needs in psychiatric facilities to protect the user against suffering that can be caused by a lack of food, inadequate clothing, improper staffing at an institution, lack of facilities for basic hygiene or inadequate provision of an environment that is respectful of individual dignity. Thus, the respect of the CAT is necessary at preventing torture, inhuman, cruel and degrading treatment against PWMDs at psychiatric facilities.

The CED requires States Parties to punish crimes of enforced disappearance with aggravated degree when the victims of the crime are vulnerable groups including pregnant women, minors, PWDs or other particularly vulnerable persons, without prejudice to other criminal procedures.[129] This also gives a sort of warranty for the protection of PWDs as a sever punishment may be imposed against the perpetrators of the crime of enforced disappearance.

2.6.1.3 The CRPD and the 'New Dawn' on Mental Disability Rights

Before the adoption of the CRPD, the hitherto human rights instruments were in force and there were even dilemmas if a separate convention on disability is necessary. The irony is, although all the human rights expressed in those conventions certainly apply to PWMDs, no express protection is extended to PWMDs to help fully enjoy their human rights except some provisions discussed above. With the exception of the CRC,[130] none of the core human rights conventions even mentions PWMDs specifically.

Theresa, D., a noted disability scholar and activist has observed:

> "drafters of the International Bill of Human Rights did not include disabled persons as a distinct group vulnerable to human rights violations. None of the equality clauses of any

[127] Report of the Special Rapporteur on the question of torture and other cruel, inhuman or degrading treatment or punishment, in accordance with Assembly resolution 57/200 of 18 December 2002, available at www.un.org/documents/ga/res/48/a48r096.htm, accessed on March 21, 2012
[128] The Human Rights Committee, General Comment No. 20 on article 7, Para 3
[129] CED, Adopted by General Assembly resolution 61/177 of 20 December 2006 , article 7(2),(b)
[130] The Human Rights Committee, General comment No 20, Supra at note 128, Para 23

of the three instruments of this Bill, the UDHR, ICCPR, and the ICESCR mention disability as a protected category."[131]

At the same time, governments have not done a good job of reporting to treaty monitoring bodies about how they are applying the various human rights conventions to PWMDs. Neither the monitoring bodies have asked for this information. Although the CESR released a document[132] to advise States Parties on how to ensure that PWDs enjoy the rights in the ICESCR, few other monitoring bodies have addressed the situation in their work. Moreover, the instruments that do address disability issues like the UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities and the MI Principles are not legally binding.

For the reasons mentioned above, over the years a number of different groups and governments have supported the idea of creating a new convention for PWDs. As a result, the CRPD together with its Optional Protocol was adopted. As the first comprehensive international legal instrument specifically for PWDs, the provisions of the CRPD reflect global consensus in which countries should fulfill their obligations towards PWDs. It treats the life of PWDs as equally valuable to that of any other human being which recognized them as subjects of rights.[133]

As noted by former Secretary General of the UN, Annan, K., "we have already learnt from experience, in countries that have implemented legislation related to disability, that change comes more rapidly when laws are in place."[134] There was therefore optimism that "the CRPD will both prompt as well as guide the passage and reform of domestic legislation ensuring substantive equality and non-discrimination for PWDs''.[135]

In a nutshell, the innovations in the Convention that marked the beginning of a new era in the efforts of realizing the full and equal enjoyment of human rights to PWDs in general and PWMDs in particular are mainly the following;

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[131]Theresa, D., 'International disability law - A new legal subject on the rise': The interregional experts' meeting in Hong Kong, December 13-17, 1999, Berkeley Journal of International Law, Vol. 18, (2000), pp180, 187.
[132] So far the Committee on ICESCR has issued only one general comment, General Comment, No. 5 on disability related issues.
[133] CRPD, Supra at note 65
[134] Secretary-General, SG/SM/10797 HR/4911 L/T/4400, available at www.un.org/News/Press/docs/2006/sgsm10797.doc.htm accessed on March 21, 2012
[135] Katherine, G. *et al*, 'Convention of the Rights of Persons with Disabilities: Its implementation and relevance for the World Bank', Special Protection Discussion Paper, No. 0712, June, 2007, pp 9

- It is the first binding document on the rights of PWDs and recognizing their inherent dignity in comprehensive and detailed arrangements.
- It is the reflection of the shift of perceptions from how disability was seen from the traditional medical model to that of human rights based and social models.
- It has made explicit directions and obligations to States Parties to enforce the previously ratified international instruments in the way of making them sensitive to these people.
- It recognized the full spectrum of civil, cultural, political, economic and social rights to help equally and inclusively applicable to the benefits of PWDs.[136]

Among the wide range of basic rights to PWDs, it recognizes the inherent human dignity of all human beings. Along with equality and non-discrimination as the general principles forming the Convention, it provides for dignity, individual autonomy, full and active participation and inclusion, respect for difference and accessibility.[137] Article 5 of the Convention explicitly addresses the right to equality and non-discrimination.

The Convention also asserts the right to life, freedom from torture or cruel, inhuman or degrading treatment or punishment, freedom from exploitation, violence and abuse, protecting the integrity of persons and respect for privacy. The Convention thus accords unequivocal rights to life, inherent dignity, equality and non-discrimination to the life of PWDs, the same rights enjoyed by other human beings. The right to life and right to health provided under the Convention are catalysts to achieve the human rights paradigm. It states: "States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by PWDs on an equal basis with others."[138]

The right to life was included in the Convention mainly in view of the stereotypes and flawed assumptions prevailing in society against a life with disability. Children born with disabilities

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[136] Report of the UN high Commissioner for Human Rights on progresses in the implementation of the recommendations contained in the study on the Human Rights of Persons with Disability, A/HRC/14/75.para.19, www.un.org/documents/ga/res/48/a48r096.htm, accessed at March 14, 2012

[137] CRPD, Supra at note 133, article 3; See in general Amita, D., 'Constructing a new human rights lexicon: Convention on the Rights of Persons With Disabilities', Sur International Journal on Human Rights, Vol. 5, No. 8, São Paulo, June, 2008, pp 43-59

[138] Ibid. CRPD, article 10

were seen as symptom of bad omen to the family and the community which exposed them to death based on a 'wrongful birth' assumption. With respect to the right to health, the Convention provides: "States Parties recognize that PWDs have the right to enjoyment of the highest attainable standard of health without the discrimination on the basis of disability."[139] It further provides for right of access to gender-sensitive, equal and non-discriminating health services. The content of the right to health for PWMDs under the CRPD and its condition in Ethiopia will be discussed in detail at the next chapter.

A. Innovative Provisions of the CRPD on Civil and Political Rights

Almost half of the substantive provisions of the Convention are based in civil and political rights.[140] Though these rights are existing rights under UDHR and ICCPR, there are new or amplified applications or extensions of these rights in the CRPD. For example, it extends the right to life and survival to situations of emergencies. States are required to ensure the protection and safety of PWDs in situations of risk, including armed conflict, humanitarian emergencies and natural disasters.[141] The recognition of legal capacity of PWDs on an equal basis with others is extremely important for PWMDs. This is an attempt to bridge the long reigned trend of substituting PWMDs of their decisions without considering their functional limitations. The plenary guardianship system which takes away the capacity of the persons unequivocally is avoided by the CRPD when it extends equal legal recognition irrespective of any disability and adopted supported decision making in the place of substituted one.[142] The duty of states to extend all necessary support in the way forward to exercise their rights is a noble addition in the CRPD.

Furthermore, article 16 extends the traditional right to freedom from torture or cruel, inhuman or degrading treatment to freedom from all forms of exploitation, violence and abuse. This is also a guarantee worth considering for PWMDs who are institutionalized; where there may be abuses amounting to these prohibited practices which are confused with medication and treatment. The Convention also extends the right of liberty and security of the person in a different way as article 17 is particularly directed towards non-interference with both the physical body and the mind, which has a direct implication on PWMDs whose liberty and security is prone to

[139] Ibid. CRPD, article 25
[140] That runs from article 10 to 23 and article 29 of the CRPD
[141] Ibid. Article 11
[142] Ibid. Article 12

restriction based on the myth of dangerousness. A detail of the CRPD on the protection of PWMDs on their liberty and security, freedom from torture, cruel, inhuman and degrading treatment, the right to legal capacity, the right to rehabilitation, the right to community integration and the other related rights will be discussed at some length taking the psychiatric facilities in Ethiopia in focus.

B. **Innovative provisions of the CRPD on SER**

In addition to the civil and political rights, the CRPD also provides the detail for the application of economic, social and cultural rights which have relevance to PWMDs. It extends the right to education for PWDs in an inclusive education system at all level and directed at lifelong learning,[143] the right to health regarding habilitation and rehabilitation,[144] the right to work and adequate standard of living[145] according to the needs of PWDs. These provisions do not provide any newly created rights, they are only meant to direct the means for application.

Here, the CRPD reaffirmed the existing socio-economic and cultural rights which have been recognized in international human rights instruments dealt above and provide some innovations regarding the application of those existing rights in the context of PWDs. In this respect, it is stated that "the Convention is a way of stating in one instrument a number of things that are scattered in half a dozen other human rights treaties."[146] The Convention therefore stands in affirmation of the "right to have rights"; an official, unambiguous and long overdue solemn recognition of the absolute equality of PWDs with all other persons.[147]

2.6.2 International Legal Standards and Principles on Mental Disabilities

Furthermore, in view of the protection of PWMD, various international organizations have established minimum standards for the protection of their basic rights and fundamental freedoms. These standards are enshrined in international law and are usually declarations and reports promulgated by the UN General Assembly and the Commission on Human Rights and Specialized Agencies of the UN such as WHO. The MI Principles and the Standard Rules on the

[143] Ibid. Article 24
[144] Ibid. Article 26
[145] Ibid. Article 27 and 28
[146] Mégret, F., 'The Disabilities Convention: Human rights of persons with disabilities or disability rights*?'*, Human Rights Quarterly, Vol. 30, (2008), pp 500
[147] Ibid.

Equalization of Opportunities for Persons with Disabilities are the important ones which are directly applicable to PWMDs. These instruments lack the binding force to oblige states to comply as they are simply declarations, though they are accepted as standards of interpretation.

2.6.2.1 The MI Principles[148]

In 1991, the MI Principles is passed by the General Assembly which established minimum human rights standards of practice in the mental health field. The Principles are regarded as the most complete standards for protection of the rights of PWMDs at the international level. International oversight and enforcement bodies have used these Principles as an authoritative interpretation of the requirements of international conventions such as the ICESCR. They hence reinforce the rights by providing guidance as to how those rights ought to apply to PWMDs.

Moreover, the Principles serve as a guide to States in the design and reform of mental health systems and are of utmost utility in evaluating the practices of existing systems. It establishes that each State must adopt the legislative, judicial, administrative, educational and other measures that may be necessary to implement them.[149] Australia, Hungary, Mexico and Portugal, among others, have incorporated the MI Principles in whole or in part into their own domestic laws. The Principles also establish standards for treatment and living conditions within mental health facilities,[150] and they create protections against arbitrary detention in such facilities.[151] These apply broadly to PWMDs, whether or not they are in psychiatric facilities, to all persons admitted to a mental health facility whether or not they are diagnosed as having a mental disability. They also recognize that PWMDs shall have the right to live and work, as far as possible, in the community.[152]

These Principles have, however, been subject to some criticism. In 2003, the UN Secretary-General in a report to the General Assembly noted that the MI Principles "offer in some cases a lesser degree of protection than that offered by existing human rights treaties, for example with regard to the requirement for prior informed consent to treatment."[153] In this regard, some

[148] MI Principles, supra at note 113
[149] Ibid. Principle 23
[150] Ibid. Principle 9
[151] Ibid. Principle 15
[152] Ibid. Principle 7
[153] Secretary-General SG/SM/10797 HR/4911 L/T/4400, Supra at note 134, Para 49

organizations of PWMDs, including the World Network of Users and Survivors of Psychiatry, have called into question the protection afforded by the Principles[154] and their consistency with existing human rights standards in the context of involuntary admission and treatment.

2.6.2.2 Standard Rules on the Equalization of Opportunities for PWDs

The 1993 Vienna Declaration reiterated the fact that international human rights law protects PWDs, and that governments should establish domestic legislation to realize those rights. In what has come to be known as the Vienna Declaration, the World Conference declared that all human rights and fundamental freedoms are universal, and thus unreservedly include PWDs.[155]

The Standard Rules were adopted at the end of the 'Decade of Disabled Persons' (1982-1993) by General Assembly Resolution 48/96. As a policy guidance instrument, the Rules reiterate the goals of prevention, rehabilitation and equalization of opportunities established by the World Programme of Action. There are 22 rules which provide for national action in three main areas: preconditions for equal participation, targets for equal participation, and implementation measures. The Rules are a revolutionary new international instrument because they establish citizen participation by PWDs as an internationally recognized human right.[156] To realize this right, governments are expected to provide opportunities for PWDs and organizations made up of PWDs to be involved in drafting new legislation on matters that affect them. The Rules finally call on every country to engage in a national planning process to bring legislation, policies and programmes into conformity with international human rights standards.[157]

2.6.3 The Regional Human Rights Systems towards Mental Disability

The regional human rights instruments also recognize the right to persons PWDs and the PWMDs in various forms. The European Convention for the Protection of Human Rights and

[154]The principles adopted the medical model towards mental disability and in particular, principles 11 and 16 are called in to question for the former creates room for nonconsensual treatment and the latter to involuntary admission to mental health institutions.

[155] The Vienna Declaration and Program of Action, A/CONF.157/23, on the World Conference on Human Rights, 14 - 25 June, 1993, Para 3 available at www.unhchr.ch/huridocda/huridoca.nsf/(symbol)/a.conf.157.23.en, accessed on March 23, 2012

[156] Standard Rules on the Equalization of Opportunities for Persons with Disabilities, Adopted by the United Nations General Assembly, forty-eighth session, resolution 48/96, annex, of 20 December 1993, Rule 18

[157] Ibid. Rule 20

Fundamental Freedoms, the ACHPR and the Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities are the basic regional human rights instruments which are the subject of discussion with a direct implication on the protection of PWMDs. These systems will be discussed in this section in their order.

2.6.3.1 The African Human Rights Regime on the Protection of PWMDs

The ACHPR contains a range of articles on civil, political, economic, social and cultural rights. Clauses pertinent to PWMDs include, the right to life and the integrity of the person,[158] the right to respect of dignity, prohibition of slavery, slave trade, torture and cruel, inhuman or degrading treatment or punishment[159] and the right of the aged and disabled to special measures of protection. It specifically states that the "aged and disabled shall also have the right to special measures of protection in keeping with their physical or moral needs".[160] The Charter also guarantees the right for all to enjoy the best attainable state of physical and mental health.[161]

In this respect, the African Commission has decided on one case involving mental disability; *Moore and Purohit vs. The Gambia.*[162] In determining the merits of the case, the Commission found that when States ratify the ACHPR, they undertake a responsibility to bring their "domestic laws and practice in conformity with the African Charter."[163] Further, the Commission found that articles 2 and 3 of the Charter, guaranteeing equal protection and anti-discrimination, are non-derogable rights.[164] Thus, Gambia violated these rights through the implementation of the Lunatic Detention Act (LDA), which detained more people from poor backgrounds and provided only those charged with capital offenses with legal assistance.[165]

The Government of The Gambia was found in violation of the Charter as the scheme of the LDA lacks in terms of therapeutic objectives as well as provision of matching resources and

[158] African (Banjul) Charter On Human And Peoples' Rights, Adopted 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58, (1982), article 4
[159] Ibid. Article 5
[160] Ibid. Article 18(4)
[161] Ibid. Article 16
[162] ACHPR, *Purohit and Moore Vs The Gambia* (2003) AHRLR 96 (2003), Communication 241/2001
[163] Ibid. Para 42
[164] Ibid. Para 54
[165] Ibid. Para 53-54

programmes of treatment of LDA, a situation that the State did not deny but which nevertheless falls short of satisfying the requirements laid down in articles 16 and 18(4) of the Charter.[166]

The LDA failed to conform to the Charter by its classification persons as "lunatics" and "idiots." The African Commission found that these terms dehumanized PWMDs and took away their inherent right to human dignity in violation of article 5.[167] In addition, the Commission found that the LDA violated article 6 of the Charter as it authorized detention on the basis of opinions by general medical practitioners, lacked fixed detention periods and precluded review or appeal.[168] The Commission has also turned to the MI Principles in considering the right to health of PWMDs, as it found that the right to health crucial and as a result of their condition and by virtue of their disabilities, PWMDs should be accorded special treatment enabling them to sustain the optimum level of independence in accordance with both the Charter and MI Principles.[169] Even though only *Purohit and Moore* involved a decision explicitly concerning the right of PWMDs, many decisions concerning other human rights, including the rights to life and liberty and the prohibition of torture and inhuman and degrading treatment, offer indirect protections for particular freedoms and entitlements encompassed by the right to health and can inform interpretation of the right to health of PWMDs.

The ACRWC on the other hand provides for special protection of children with disabilities when it refers to handicapped children, both mentally and physically disabled and provides for special measures of protection, together with the principle of self-reliance, participation and access.[170] Further, that such children must be ensured active participation in the community and their physical or moral needs and their dignity must be ensured.[171]

The African Women's Protocol is the other human rights treaty aimed at protecting the rights of women. Although the Protocol was concluded to deal with issues affecting a particular

[166] Ibid. Para 83
[167] Ibid. Para 59
[168] Ibid. Para 68
[169] Ibid. Para 81
[170] African Charter on the Rights and Welfare of the Child, OAU Doc. Cab/Leg/24.9/49 (1990), entered into force Nov. 29, 1999, ACRWC, article 13(2). Among the new measures of implementation introduced under the Charter the States Parties shall use their available resources with a view to achieving progressively the full convenience of the mentally and physically disabled person to movement and access to public highway buildings and other places to which the disabled may legitimately want to have access to.
[171] Ibid. Article 14

vulnerable group, it recognizes that some members of this group suffer double jeopardy, and there are women with disabilities, of course including from mental disabilities. First they suffer discrimination based on sex, and second as PWDs. State Parties undertake to ensure the protection of women with disabilities and to take specific measures to facilitate their access to employment, professional and vocational training. They also undertake to ensure the participation of disabled women in decision-making.[172] Because of the extreme vulnerability of women with disabilities, the Protocol further enjoins state parties to ensure their freedom from violence, discrimination based on disability and the right to be treated with dignity.[173]

2.6.3.2 The European Human Rights Regime on the Protection of PWMDs

The European regional human rights system has more detailed and specific safeguards for the rights of PWMDs backed by the decision of the European Court of Human Rights. The European Convention for the Protection of Human Rights and Fundamental Freedoms as the first instrument provides binding protection for the human rights of PWMDs residing in the States that have ratified the Convention.[174]

Mental health legislation in European States is required to provide for safeguards against involuntary hospitalization, based on three principles laid down by the European Court of Human Rights: mental disability should be established by objective medical expertise; recognition of the fact that the disability is of a nature and degree warranting compulsory confinement; and for continued confinement, it is necessary to prove persistence of the mental disability.[175] By this, the European Court of Human Rights provides fairly detailed interpretations of the Convention concerning issues related to mental health.

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[172] Protocol to The African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted in adopted in 200, article 23(a)
[173] Ibid. Article 23(b)
[174] The European Convention for the Protection of Human Rights and Fundamental Freedoms, Rome, 4.XI.1950
[175] ECtHR, *Shtukaturov v. Russia*, application no. 44009, judgment of 27 March 2008; See Council of Europe Commissioner for Human Rights, "Persons with mental disabilities should be assisted but not deprived of their individual human rights", Viewpoints, 21 September 2009, available at: http://www.coe.int/t/commissioner/Viewpoints/090921_en.asp; accessed on September 2, 2012; "A neglected human rights crisis: persons with intellectual disabilities are still stigmatised and excluded", Viewpoints, 14 September 2009, available at: http://www.coe.int/t/commissioner/Viewpoints/090914_en.asp; accessed on September 2, 2012; "Respect and rights-based action instead of charity for people with disabilities", Viewpoints, 20 October 2010, available at: http://www.coe.int/t/commissioner/Viewpoints/081020_en.asp, accessed on September 2, 2012.

The European Convention on Human Rights and Biomedicine adopted by member states of the Council of Europe and other States of the European Community, was the first binding instrument to embody the principle of informed consent, provide for equal access to medical care and for the right to be informed, as well as establishing high standards of protection with regard to medical care and research.[176] This Convention is supported and influenced by Recommendation 1235 on Psychiatry and Human Rights, which was adopted by the Parliamentary Assembly of the Council of Europe in 1994. This lays down criteria for involuntary admission, the procedure for involuntary admission, standards for care and treatment of PWMDs, and prohibitions to prevent abuses in psychiatric care and practice.[177]

In September 2004, the Committee of Ministers of the Council of Europe approved another recommendation,[178] which calls upon member states to enhance the protection the human rights PWMDs, in particular, those subject to involuntary placement or involuntary treatment. The 8th Annual Report of the Committee on Torture of the Council of Europe stipulated standards to prevent mistreatment of PWMDs.[179] The revised European Social Charter too, provides binding protection for the fundamental rights of PWMDs who are nationals of the States that are parties to the Convention.[180]

Last but not least, in December 2010, the EU ratified the CRPD. By doing so, the EU has become the first intergovernmental organization to sign on to any human rights treaty and take on its binding obligations. The CRPD's ratification by the EU has received a warm welcome by many disability groups. Shantha, B., disability rights researcher with Human Rights Watch describes the ratification by EU of the Convention as "a clear message that disability rights are a priority in the region and worldwide".[181]The European Disability Forum, a European platform on disability hailed it as an historic landmark and "a major policy shift in putting disability on top of

[176] Council of Europe: Convention on Human Rights and Biomedicine, Done at Oviedo, Spain, April 4, 1997
[177] Recommendation 1235 (1994) On Psychiatry and Human Rights, Section 1-4
[178] Recommendation Rec. (2004)10 Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (2004)
[179] 8th General Report on the CPT's activities covering the period 1 January to 31 December 1997
[180] In particular, article 15 of the Charter provides for the rights of these persons to independence, social integration and participation in the life of the community.
[181] Human Rights Watch, 'EU: A commitment to disability rights, EU ratifies international treaty; First Intergovernmental Group to Join, Press release, December 30, 2010

the human rights agenda."[182] Ratifying the CRPD obliges the various institutions of the EU to protect the rights of PWDs. While it obliges its institutions, individual member states of the EU however must ratify the Convention domestically to be legally bound with the Convention.

2.6.3.3 The Inter-American Human Rights Regime on the Protection of PWMDs

The Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities is the pertinent instrument in the Inter- American region which is agreed to prevent and eliminate all forms of discrimination against persons with mental or physical disabilities, and to promote their full integration into society. It is the first international convention that specifically addresses the rights of PWMDs. In 2001, the Inter-American Human Rights Commission issued a Recommendation on the promotion and protection of human rights of PWMDs, recommending that countries ratify this Convention. The Recommendation also urges States to promote and implement, through legislation and national mental health plans, the organization of community mental health services, in order to achieve the full integration of PWMDs into society.

The Commission's recent examination of a case in *Victor Rosario Congo v. Ecuador*[183] provided an examination of its position on the protection of PWMDs. The case goes as follows; *Víctor Rosario Congo*, a detainee on murder case with mental disability had been struck in the head, denied medical treatment, and left in his cell for forty days and finally died in the penitentiary institution. The Commission found violations of the rights to physical integrity, life and judicial protection under the American Convention on Human Rights and finally passed its decisions that "the State has violated the right to judicial protection enshrined in article 25(1) in conjunction with article 1 of the Convention, as no judicial proceedings have been opened to investigate and establish the responsibilities for the injuries to and death of *Víctor Rosario Congo*."[184] The Commission asserted that "a violation of the right to physical integrity is even more serious in

[182] Mary, K., 'EU ratification of disability treaty sends strong signal to member states', Human Rights in Ireland, January 11, 2011
Jarlath, C., 'The UN disability convention and its impact on European equality law', The Equal Rights Review, Vol. 6, (2011)

[183] . Inter American Court of Human Rights, *Victor Rosario Congo vs. Ecuador*, 63/99, Para. 67.
[184]. Ibid. Para 97

the case of a person held in preventive detention, suffering a mental disease, and therefore in the custody of the State in a particularly vulnerable position."[185]

On another submission in 2003, the Commission granted precautionary measures,[186] to protect the lives and physical, mental and moral integrity of 460 individuals detained in Neuro-Psychiatric Hospital in Paraguay.[187] This decision was ground breaking as it was the first time that the Commission called for immediate, life-saving measures to combat ongoing abuses in a psychiatric institution. The rights alleged by the petitioners that need precautionary measure are the protections on freedom from discrimination,[188] right to life,[189] right to humane treatment,[190] right to personal liberty,[191] rights of the child[192] and right to equal protection[193] of the American Convention. As a result, based on the decision of the Commission, the Paraguayan president pledged resources to end abuses in the institution and changed the hospital's administration.

2.7 The Obligations of Ethiopia towards Mental Disabilities

2.7.1The Obligations of Ethiopia before the UN

Ethiopia has been a member of the UN since 1945. It is a party to seven core UN human rights treaties to date. It has joined the CERD in 1976, but did not make the declaration under article 14 that would allow individuals to submit complaints to the Committee on the CERD. It has ratified the CEDAW in 1981, but not the 1999 Optional Protocol. In 1991, Ethiopia joined the CRC, but it has not yet taken any action with respect to the Optional Protocols on the sale of children, child prostitution and child pornography and on the involvement of children in armed conflict. In 1993, Ethiopia joined both the ICCPR and the ICESCR. It has not joined the 1966 Optional Protocols to the ICCPR on an individual complaint mechanism and on the abolition of the death

[185]. Ibid.

[186] Precautionary measures are an instrument within the inter-American human rights system that allows the Commission to quickly address compelling human rights violations. Article 25(1) of the Commission's Procedural Rules states that the Commission may issue precautionary measures: "In serious and urgent cases, and whenever necessary according to the information available . . . to prevent irreparable harm to persons."

[187] The petition for a decision on precautionary measure was filed by Mental Disability Rights International(MDRI) and the Center for Justice and International Law (CEJIL)

[188] American Convention on Human Rights, ACHR, Nov. 22, 1969, article 1(1)

[189] Ibid. Article 4

[190] Ibid. Article 5

[191] Ibid. Article 7

[192] Ibid. Article 19

[193] Ibid. Article 24

penalty of 1989. It has also become a party to the CAT in 1994, but did not make the declaration under article 22 that would allow individual complaints, nor did it join the 2002 Optional Protocol establishing a system of regular visits. Finally, Ethiopia has ratified the CRPD in 2010 but not the Optional Protocol of 2006 on considerations of communications from or on behalf of individuals or groups of individuals.

This can be considered a good ratification record. It should be noted furthermore that Ethiopia has not made any reservations under the substantive provisions of any of these conventions. Even though the country has a good record of ratification, it has however no good record in case of reporting. There are many overdue reports at different committees. Until now, under the CERD, Ethiopia delivered reports in 1978, 1979, 1981, 1984, 1985 and 1988, but since then, it has not reported. Under the CEDAW, Ethiopia submitted three combined reports in 1993 and two combined reports in 2002. Currently two reports are due. Under the CRC, it has submitted reports in 1995, 1998 and 2005. Ethiopia has recently reported under the ICCPR after seventeen years, but still two reports are due. Ethiopia has not yet reported on the ICESCR, the CAT and the CRPD. On the report on the CRPD, the Convention is relatively recent and only handful of states have reported so far.[194]Ethiopia did not report as the ratification itself is relatively recent.

Thus, as a signatory to all the above instruments, Ethiopia has undertaken to comply with the obligations enunciated therein which are applicable to PWMDs, too. Especially, the ratification of the CRPD imposes direct obligations to act towards the full and effective participation of PWMDs guaranteeing equality both substantively and procedurally.

The obligations are traditionally threefold; the obligation to respect, to protect and to fulfill. In turn, the obligation to fulfill contains obligations to facilitate, provide and promote. The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with the guarantees. Finally, the obligation to fulfill requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

[194] Twenty nine states have reported on the CRPD until September 2012

2.7.2 The Obligations of Ethiopia at the African level

At the African level, Ethiopia has ratified the Banjul Charter in 1998, the African Charter on the Rights and Welfare of Children in 2002 and the African Women Protocol among other related human rights instruments. As discussed above, Africa as one regional system has some guarantees for the protection of PWMDs. This imports a duty on members of the regime to take all necessary measures for its effective implementation and achieving the intended purposes. From this regime too, the three typologies of obligations, the duty to respect, to protect and fulfill emerge which should be complied simultaneously.

2.8 Ethiopian Laws on Mental Disability

Though Ethiopia is a party to many international and regional human rights instruments including the CRPD which have extended protections for PWMDs, there is no yet any comprehensive law neither a policy on the protection and treatment of PWMDs. However, the FRDE Constitution, the Civil Code, the Criminal Code and the Labour Law have incorporated scant provisions aimed at PWMDs in different forms. Especially, the Civil Code and the Criminal Code provide rules on excusing an 'insane person' from criminal and civil liabilities with different level depending on the extent of incapacity suffered by the person. The Labour Proclamation established rules on equal access to work and education for PWDs. These laws are going to be discussed in their order in the following sub-sections.

2.8.1 The FDRE Constitution

The Constitution of the FDRE was adopted in 1995, and it therefore pre-dates the CRPD by several years. It is tipped as 'one of the new generations of African constitutions, which clearly engages with the role that international human rights law should play at domestic level.'[195] The Constitution provides that international agreements ratified by Ethiopia are an integral part of the law of the land.[196] Furthermore, it notes that the third Chapter which is a human rights chapter

[195] Tobias, R., and Helen, C., 'The UN Convention on the Rights of Persons with Disabilities in Africa: Progress after 5 years', International Journal of Human rights, Vol. 14, available on www.surjournal.org/eng/conteudos/getArtigo14.php?artigo=14 accessed on March 25, 2012

[196] The FDFRE Constitution, Proclamation No. 1/95, article 9(4)

must be interpreted in a manner conforming to the principles of the UDHR, international covenants on human rights and international instruments adopted by Ethiopia.[197]

Looking at the provisions of Chapter 3, a number of rights are of particular significance to PWDs in general. When it guarantees everyone the right to dignity and the right to freely develop his personality in a manner consistent with the rights of others,[198] the equality clause which is accompanied by a prohibition of discrimination lists a number of prohibited grounds, such as race, nationality, sex, language and religion… or other status.[199] Disability is not in fact explicitly listed. In fact, the last clause 'other status' can be interpreted to include disabilities.

On the part dealing with economic, social and cultural rights, it provides that all Ethiopians have the right to engage in any economic activity and gain their living by work that they freely choose.[200] This is accompanied with the right to choose their vocation, work and profession.[201] Concomitantly, there is an obligation to progressively allocate increasing funds for the purposes of promoting access to health, education and other social services.[202] The State must further, within the limits permitted by the economic capability of the country, care for and rehabilitate the physically and mentally handicapped, the aged, and children who are left without parents or guardian.[203] In addition, the State must devise policies designed to create employment of the poor and unemployed, issue programmes designed to open up work opportunities in the public sector and undertake projects.[204]

2.8.2 Criminal Law

The FDRE Criminal Code makes provisions for cases in which, when a PWMDs commits a crime, directing the judge to investigate the personal background of the accused and his behavior prior to commission of the offense.[205] When the law deals about criminal responsibility and defenses for responsibility, it considers insanity as a defense. This is based on the assumption

[197] Ibid. Article 13(2)
[198] Ibid.
[199] Ibid. Article 25
[200] Ibid. Article 41(1)
[201] Ibid. Article 41(2)
[202] Ibid. Article 41(4)
[203] Ibid. Article 41(5)
[204] Ibid. Article 41(6)
[205] The FDRE Criminal Code, Proclamation No. 214/ 2004, article 51

that one who is insane cannot have the necessary *mens rea* to commit a crime as the latter is one of the essential requirements to establish criminal responsibility in which the absence of it may absolve one from responsibility for an act which is not premeditated and not aware of the consequence of his/her act. Accordingly, the court is authorized to order an inquiry to be made as to the character, antecedents and circumstances of the accused person.

The law lists three essential conditions to establish the defense of insanity which include: the defendant is incapable of understanding the nature or consequences of his act or of regulating his conduct according to such understanding, that such incapacity is due to age, illness, abnormal delay in his development or deterioration of his mental faculties and that such incapacity exists at the time of his act that produced the consequences in question.[206] In such cases the person is not responsible for his acts. When it is found that the offense was committed by a person suffering from mental illness, the competent judge must order his confinement in a psychiatric hospital for treatment or protection. The health facility which received a court order for the treatment of the person should follow up and report the treatment so that the court will proceed with the other measures.[207] This can be considered as a protection for PWMDs from criminal responsibility on acts which they do not have the necessary faculties. Moreover, the obligation of the judge to order psychiatric care for such kind of defendants serves a rehabilitation purpose in which they should be medically cared and followed up.

2.8.3 Civil Laws

The Civil Code on legal capacity also makes reference to insanity as a ground to limit legal capacity when the mental health of a person is questioned by the society he is living with or where a court passed a judgment of judicial interdiction. The law defines insane person as 'one who cannot understand the importance of his actions as a result of being insufficiently developed, mental disease or senility.'[208]

The law classifies insane persons into two groups, namely those who are not interdicted and those whose interdiction is pronounced by court.[209] The law here is meant to protect this group of

[206] Ibid. Article 48(1)
[207] Ibid. Article 135
[208] The Ethiopian Civil Code, Proclamation No. 165 of 1960, article 339(1)
[209] Ibid. Articles 339 to 379

people form obligations which they have entered with out the required mental health. The best means of securing adequate and sustained legal protection for insane persons is however through judicial interdiction. The latter is a withdrawal of the capacity to perform juridical acts in order to protect the interest of the interdicted person and his presumptive heirs by a court order. This will give more protection for the person since the order is going to have better force. Therefore, judicial acts concluded by judicially interdicted persons in excess of their powers shall be invalidated upon application by the judicially interdicted person, his representatives or heirs.[210] The protections are justified for the person does not know the nature and quality of his or her act, in other words, may not appreciate what he was doing so that the act requirement is not fulfilled

2.8.4 The Labour Law

In 2008, a Proclamation named as "The Right to Employment of Persons with Disability" was adopted which clearly states its objective to tackle the deeply-rooted negative perceptions of disability which had affected the rights of PWDs to employment. By reserving vacancies for PWDs, previous legislation had created an image that PWDs were regarded as incapable of performing jobs based on merit, thus failing to guarantee their right to reasonable accommodation and to provide for proper protection.[211]

The Proclamation defines PWDs in line with the CRPD as "an individual whose equal employment opportunity is reduced as a result of his physical, mental or sensory impairments in relation with social, economic and cultural discrimination"[212] and further provides explanations for discrimination, reasonable accommodation and undue burden. It prohibits discrimination against PWDs in employment practices and imposes concomitant responsibilities on employers, including taking measures to provide appropriate working and training conditions and materials for PWDs, taking all reasonable accommodation and measures of affirmative action to women with disability, taking into account the multiple burden that arise from their sex and disability and assigning assistants to enable PWDs to perform their work or follow their training. Significantly, a duty is imposed on employers to protect women with disabilities from sexual violence that occurs in work places.

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[210] Ibid. Article 373(1) cum article 314
[211] Proclamation No. 568/2008, Right to Employment of Persons with Disability Proclamation , Preamble , Para 1&2
[212] Ibid. Article 2(1)

2.9 Conclusion

Though an international system of human rights with universal application has been developed under the auspices of the UN since 1948, the international community was late to adopt a tool to advance the rights and freedoms of PWMDs for longer time. International human rights law is obviously important for countries without democratic and constitutional systems as it may provide better safeguards against the violations of the rights of PWMDs. This has left the persons to egregious forms of violations on their freedom and human dignity.

Relatively latter, the rights of PWMDs have received the momentum owing to the advocacy of many disability organizations and other sections of the society who suffer the direct and indirect brunt of the neglect and inhumane treatment of PWMDs. As a result, the international community moved on to adopt various forms of human rights instruments at the UN level and regional human rights systems have also applied additional human rights protections to their respective geographic regions. Both the international and regional systems have addressed the human rights of PWMDs through treaties, declarations, and thematic resolutions. Moreover, regional institutions have incrementally formulated a body of law that protects the human rights of PWMDs. Especially the CRPD is considered a 'new dawn' to the protection of PWDs, which equally applies to PWMDs in introducing a new paradigm for treatment of PWDs with new sets of measures. The MI Principles too, while not formally binding, serve as influential aids in the interpretation of the treaty obligations. Further, the legal precedent and public pressure created by this body of international law has encouraged domestic governments to apply human rights principles to their policies affecting PWMDs at the national and sub-national level. These international systems, agreements, institutions and decisions have collectively help the development of recognizable human rights standards at the international and regional levels with a potential to put an end to ongoing human rights violations targeting PWMDs.

Ethiopia, as a signatory to the core UN Conventions and the African human rights instruments which have binding obligations on the rights of PWMDs, it has owed a duty to respect, protect and fulfill the rights enunciated there in. While there are some domestic laws before ratification by Ethiopia of the international human rights instruments, there have been also newly adopted and amended laws which have a direct implication on the respect of the rights of PWMDs.

CHAPTER THREE

3. THE RIGHT TO ACCESS MENTAL HEALTH SERVICES FOR PERSONS WITH MENTAL DISABILITIES IN ETHIOPIA

3.1 Introduction

PWMDs are exposed to a wide range of human rights violations; inter alia, the lack of access to mental health is one of the rights that are neglected significantly. Recent research has revealed the extent to which mental health care in low and middle income countries is consistently under resourced.[213] Compared to the physical health, the human and financial resources dedicated to mental health is significantly inadequate. The lack of access to mental health services means that persons are denied the basic right to the treatment and care that they are entitled to.

In recent years, several public health studies indicated that general mental distress and specific mental disorders in Ethiopia are as common as elsewhere.[214] However, mental health care in form of modern psychiatric services are far from adequate and is often one of the lowest health priorities in Ethiopia. Alem, A. in this respect submitted that,

> "in common with many low income countries, Ethiopia has not developed the infrastructure and public services, including mental health care, to keep pace with population expansion. The available services are located in the capital city and very few patients have access to them. Patients usually come to medical services having tried the available local means."[215]

All these problems have far reaching consequences on the respect and promotion of the rights of PWMDs in Ethiopia. In this chapter, the mental health services of Ethiopia will be assessed and evaluated based on a human rights approach.

Accordingly, discussions will come first on cross-cutting issues about the meaning of mental health, the rights of PWMDs to access mental health services and the global mental health gap followed with the situation analysis of the Ethiopian mental health care system ranging from the policy and legislative framework to other detailed infrastructure issues. Finally, a discussion will

[213] Kohn, R., *et al*. 'The treatment gap in mental health care', Bulletin of the WHO, Vol. 82, (2004), pp 858-866; See also 'Mental health gap action program for mental, neurological and substance use disorders in non-specialized health settings', WHO, (2001) available at www.who.int/mental_health/mhgap/en/ , accessed on May 12, 2012

[214] Mental Health Atlas, WHO, (2011); See also Alem A., Supra at note 24, pp 93-96.

[215] Ibid. Alem, A.; See also WHO-AIMS Ethiopia, 2004. Despite this imbalance is studied a decade ago or earlier, there are no significant changes to date to rebut the assertions, as it will be discussed by the ongoing sections.

be made how the existing systems and services are short of the international human rights obligations that Ethiopia has undertaken to.

3.2 What is Mental Health?

To make a discussion on the human rights approach to mental health meaningful, it is important to have some shared understanding of what is meant by mental health. A challenge is however posed in defining mental health, as differences in values across countries, cultures, classes and genders in articulating what they mean by mental health appear.[216] The WHO in sharing this problem submitted that:"… it is nearly impossible to define mental health comprehensively….. It is, however, generally agreed that mental health is broader than a lack of mental disorders."[217] In spite of this challenge, since its inception, WHO has included mental well-being in the general definition of health as it defines health as: "… a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[218]

Three ideas central to the concept of mental health are drawn from this definition: mental health is an integral part of health, mental health is more than the absence of mental illness, and mental health is intimately connected with physical health, in which there is no health with out mental health.[219] Based on this understanding, neither mental nor physical health can exist alone as mental, physical and social functioning are interdependent.

While it has been tried to infer the definition of mental health from the general definition of health, later on WHO came up with a definition that mental health is:

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[216] The World Health Report, Mental health: New understanding, new hope, Geneva, WHO, (2001) available at (http://www.who.int/whr2001/2001/main/en), accessed on February 2, 2012; See also Kleinman, A, and Cohen, A., World mental health: problems and priorities in low income countries. New York: Oxford University Press, (1995); Vikram, P. et al., "Stressed, depressed or bewitched? A perspective on mental health, culture and religion," in 'Development for Health', Oxford, UK: Oxfam (UK and Ireland), (1997).

[217] Ibid. The World Health Report, WHO, (2001)

[218] WHO Constitution, adopted on 22 July 1946 by the representatives of 61 States, preamble Para 2; The WHO proposition that there can be "no health with out mental health" has been endorsed by the Pan American Health Organization, the EU Council of Ministers, the World Federation of Mental Health and the UK Royal College of Psychiatrists.

[219] Helen, H., *et al (*eds*.),* 'Promoting mental health', A report of the WHO, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne, WHO (2005), available at www.who.int/mental_health/evidence/en/promoting_mhh , accessed on May 19, 2012

> "… a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[220]

In this sense, mental health is the foundation for well-being and effective functioning for an individual and for a community. Despite this, mental health is still portrayed by many as a luxury. The misunderstandings on which this view is based are now clearer than they were in the past with setting human rights standards on the duty to consider mental health, and WHO and other bodies such as the World Bank identify the improvement of mental health as a concern for low and middle income countries as well as for wealthier nations and people.[221]

3.3 The Right of PWMDs to Access Mental Health Care

Before proceeding to the normative content of the right to health and mental health, it is hardly possible to escape the justiciability debate of SER, as access to mental health care is one aspect of SER. Therefore, this needs to be settled here before progressing to the discussion on elements of the rights and its current situation in Ethiopia.

3.3.1Justiciability of the Right to Mental Health

Since the adoption of the ICESCR in 1966, advocates of the SER have been complaining that it has no an appropriate oversight body and implementation mechanism like its counter parts, civil and political rights, despite a theoretical affirmation to the effect that they have equal status. [222] The adjudication of these set of rights has been customarily challenged on three grounds.

First, it is argued that SER are different in nature from civil and political rights and are therefore non justiciable as the former are said to impose positive duties rather than negative ones; to require allocation of resources and progressive fulfillment rather than immediate compliance;

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[220]. WHO, Strengthening Mental Health Promotion, Geneva, (Fact sheet no. 220), (2010), available at www.who.int/mediacentre/factsheets/fs220/en/, accessed on May 13, 2012

[221] Ibid. WHO; Lynne, F., 'Mental health, resilience and inequalities', WHO Regional Office of Europe, available at: http://www.euro.who.int/pubrequest , accessed on May 21,2012; See also Pratap, S. *et al*(eds.), 'Research capacity for mental health in low and middle-income countries', Global Forum for Health Research and WHO, (2007)

[222] The Vienna Declaration, World Conference on Human Rights (1993), article 3; See Gloppen, S., 'Legal enforcement of social rights: Enabling conditions and impact assessment', Erasmus Law Review, Vol. 2, Issue 04 (2009); Gearty, C. and Mantouvalou, V., 'The case for social rights, debating social rights', Oxford: Hart Publishing (2010); Leckie, S., 'Another step towards indivisibility: Identifying the key features of violations of economic, social and cultural rights, Human Rights Quarterly, Vol. 20, (1998), pp 81-124.

and to be vague and open-ended rather than precise and legally defined.[223] However, this side of argument is loosing importance especially after the end of the cold war and the development of case laws at national and international jurisdictions. Oladimeji, A. asks that 'how could people exercise civil and political rights of free speech, due process, protection from arbitrary punishment and so on while on verge of dying out of hunger and curable diseases'.[224] Even the more negative obligation to respect a right such as the right to housing has been held to entail important positive obligations such as providing adequate procedural safeguards and ensuring alternative housing in the case of evictions. These obligations have therefore a nature which requires immediate actions in addition to measures of non discrimination.[225]

The Masstrict Guidelines on violation of socio-economic rights also conveys the above assertion as:

> "the fact that the full realization of most economic, social and cultural rights can only be achieved progressively… does not alter the nature of the legal obligation of States which requires that certain steps be taken immediately and others as soon as possible. The State cannot use the "progressive realization" provisions in Article 2 of the Covenant as a pretext for non-compliance."[226]

The Constitution of the Republic of South Africa[227] has largely refuted the assertions that these set of rights are not justiciable as it creates a robust and extensive system for the realization of

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[223] Shany, Y., 'The international justiciability of economic, social and cultural rights', The Hebrew University of Jerusalem, Faculty of Law, Research Paper No. 9-06, August 2006; Tina, M., 'Justiciability of economic, social, and cultural rights in the Inter-American system of protection of human rights: Beyond traditional paradigms and notions', Human Rights Quarterly, Volume 29, Number 2, May 2007, pp 431-459; McDougall, J., and Tars, E., 'The justiciability of economic, social, and cultural right in the U.S, domestic implementation of the right to equal education', A plan for action, U.S. Racial Discrimination Program, October 2004; Palmer, E., 'Judicial review, socio economic rights and the Human Rights Act(UK)', Human Rights Law in Perspective, Oxford and Portland, Oregon, Vol.10, (2007).

[224] Oladimeji, A., **'**Economic, social and cultural rights: rights or privileges?' Groningen University, available at http://ssrn.com/, accessed on July 12, 2011

[225] CESCR, Supra at note 117, General comment No. 3, Para 5

[226] The Maastricht Guidelines on Violation of Socio-economic Rights, Maastricht, January 22-26, 1997, Principles 14 and 15

[227] Rights in the South African Constitution have been formulated in three different ways, each of which requires different responses from the courts; See generally Brand, D., 'Introduction to socio-economic rights in the South African Constitution', in Brand, D. and Heyns, C. (eds.), 'Socio-economic rights in South Africa', Pretoria: Pretoria University Law Press, (2005), pp 1-56. In respect of the second category of rights, which includes the majority of specific socio-economic rights (access to adequate housing, healthcare, food and water, and social security), the state is required to take reasonable legislative and other measures within its available resources to achieve the progressive realization of the right. By contrast, the third category, which has been negatively formulated, prohibits the state from interfering with the enjoyment of other rights. For example, in the case of the right to housing in Article 26, the state is directly prohibited from evicting people from their homes 'without an order of the court made after considering all the relevant circumstances.' In addition, Article 27 contains a negatively framed right 'prohibiting the refusal of emergency medical treatment.'

SER in which it explicitly requires the State to take action to realize these rights, commanding it to respect, protect, promote and fulfill them and to take reasonable legislative and other measures, within its available resources, to achieve their progressive realization.[228] Most interestingly, the Constitution explicitly renders these rights, as all the other rights that it entrenches, justiciable as it gives to courts the power to interpret these rights and to resolve disputes on their basis.[229]

A second common claim against justiciability of SER is that it is a violation of the separation of powers for unelected courts to interfere with social and economic policy adopted by elected branches of government. This emerges due to the fact that the courts are scrutinizing the budget appropriations and prioritization of sectors while assessing respect and violations of SER. These areas are accepted as the mandate of the legislature and the executive branch of the government of a state.[230] Malcolm, L. argues disavowing the above assertion as follows:

> "the question of whether it is undemocratic for courts to interfere with social and economic policy must be assessed in light of the recognized function of human rights in enhancing, rather than undermining, democratic governance. If judicial oversight of minority rights by ensuring that relatively powerless and vulnerable groups do not have their rights violated is seen as enhancing democracy why not the same dynamic should not be recognized in relation to those deprived of adequate food, clothing or housing, or of access to heath care or education."[231]

This in no way implies that courts will or should take over policy making from governments. Rather, in adjudicating SER just as civil and political rights, courts can influence or shape policy formulated by the executive branch of the government and impact on the realization of SER.[232]

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[228] The Constitution of the Republic of South Africa, See Sections 7(2) and 25(5), 26(2), 27(2) and 29(2) respectively

[229] In the case between the *Government of the Republic of South Africa Vs. Grootboom* (Communication No. 182/1984), Justice Yaccob considering the suffering of the victims due to lack of housing facility asserted that:"the case brings home the harsh reality that the constitutional promise of dignity and equality for all remains a distant dream."

[230] Many constitutional provisions reserved the purse (budget) to remain in the hands of parliaments and the enforcement machineries on the executive.

[231]Human Rights Commission Report of the Independent Expert to examine the question of a draft Optional Protocol to the ICESCR, (E/CN.4/2002/57, Para. 20.

[232] The South African Constitutional Court in the *Minister of Health and Ors Vs Treatment Action Campaign and Ors*, (Para 99) held that "the primary duty of courts is to the Constitution and the law, which they must apply impartially and without fear, favor or prejudice.' The Constitution requires the State 'to respect, protect, promote, and fulfill the rights in the Bills of Rights.' Where the State policy is challenged as inconsistent with the Constitution, courts have to consider whether in formulating and implementing such policy the State has given effect to its constitutional obligations."

On this question of justiciability, the CESR also notes that:

> "it is sometimes suggested that matters involving the allocation of resources should be left to the political authorities rather than the courts. While the respective competences of the various branches of government must be respected, it is appropriate to acknowledge that courts are generally already involved in a considerable range of matters, which have important resource implications".[233]

Therefore, excluding the SER from the judicial activism is considered by the Committee as "incompatible with the principle that the two sets of human rights are indivisible and interdependent."[234] Enabling courts to adjudicate SER simply means that courts can hear and adjudicate claims involving alleged rights violations. This does not in no way imply that courts assume the function of designing social programs.

A third claim is that SER involve complex issues and competing claims on resources which courts are not competent to decide as they are considered lack the requisite expertise and information to resolve the competing policy considerations and consequences that would flow from their decisions.[235] However, experience thus far demonstrates that courts are quite capable of performing these tasks where they are convinced that it is their responsibility to do so.[236] Where governments are limited by competing demands on resources, this evidence can be effectively conveyed to courts and they can give it full consideration. It must also be recognized that in some instances, courts are better equipped than legislatures to assess complex evidence particularly in relation to the effects of policies on disadvantaged groups who may have been ignored by legislators.

It has also become clear that SER claimants do not turn to courts for some kind of superior expertise in social and economic policy. Rather, they rely on the traditional competence of courts to provide a fair hearing and to review facts and evaluate government decisions or policies against the requirements of the law.[237] Even if an issue is multi-faceted and complex, the courts have a responsibility to uphold and protect fundamental rights. Thus, the arguments that adjudication of SER is too complex for members of the judiciary are exaggerated. Judges are, on

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[233] CESCR, Supra at note 225, General Comment No. 9, Para 10(5)
[234] Ibid. Para 10(5)
[235] See for example Horowitz D., 'The Courts and social policy', Washington D.C., Brookings Institution, (1977). See also Fuller L., "The forms and limits of adjudication" Harvard Law Review, Vol. 92, (1978-1979), pp 353.
[236] Porter, B. and Nolan, A., 'An updated appraisal on the justiciability of socio-economic rights', (2006), available at www.SocialRights.ca, accessed on August21, 2012
[237] Ibid.

a daily basis, called to analyze complex legal matters in a variety of different fields.[238] Thus the argument against the justiciability of SER based on lack of expertise of courts is nor far reaching.

Corroborating the above arguments, the Optional Protocol on ICESCR was adopted by 2008 with consensus after marathon of negotiation for almost two decades. This protocol is praised as a historic victory to balance the long reigned inequality between the civil and political and SER. Generally, the theoretical arguments advanced against justiciability of SER are tested as self-serving, which failed to go far beyond the political and ideological attitudes towards the rights.

Having said this on justiciability of SER, in general, the right to physical and mental health dates back to 1946 when the WHO adopted its Constitution, recognizing 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'.[239] This guarantee, to the extent that it exists in international instruments, necessarily and clearly includes both physical and mental health. Many of the international texts specifically mention "mental health" in their right to health guarantees.[240] Those that do not explicitly mention mental health contemplate an ideal of health that encompasses mental as well as physical well-being.[241] It is thus difficult to consider mental and physical health separately in the context of human rights as certain level of both mental and physical health are necessary to ensure the ability to enjoy and benefit from other human rights.

3.3.2 The Normative Content of Mental Health for PWMDs

[238] Wiles, E., 'Aspirational principles or enforceable rights: The future for socio-economic rights in national law' American University International Law Review, Vol. 22, (2006-7), pp 35-42; See also: Jheelan, N., 'The enforceability of socio-economic rights', European Human Rights Law Review, Issue 2, (2007), pp 146- 152.

[239] WHO, Constitution, in Basic Documents, 36th ed., Geneva, (1986); Katherine, G. et al, 'Convention on the Rights of Persons with Disabilities: Its implementation and relevance for the World Bank', The World Bank, June, 2007

[240] The UDHR, the ICESCR, and the ACHPR are among the instruments which recognize health to include both physical and mental health.

[241] The CRC under article 24 submitted that States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health and oblige states to strive to ensure that no child is deprived of his or her right of access to such health care services. The CRPD under article 25 also provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons); Gostin, O., 'Beyond moral claims: A human rights approach in mental health', Cambridge Quarterly, Vol. 10, (2001), pp 264-270

In 1948, the UDHR established the legal framework for enforcing the right to health.[242] By this, the lack of access to treatment, food, or safe and decent housing is a violation of human right to an adequate standard of living. Though UDHR was not binding at the time, it has become a model for subsequent binding international and regional human rights treaties that codify the right to health, often explicitly referring to mental health.[243] For instance, the ICESCR recognizes 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'[244] According to Hunt, P., the ICESCR provides 'the cornerstone protection of the right to health in international law.'[245]

In 2000, the CESR issued its General Comment No. 14: 'the right to the highest attainable standard of health', which interprets article 12 of the ICESCR to specifically include 'appropriate mental health treatment and care'.[246] The Committee established the traditional approach to examining the right to health based on the availability, accessibility, acceptability and quality of health-care facilities, goods, services and programmes,[247] an approach later endorsed by Hunt.[248] This non-exhaustive catalogue of interrelated and essential elements is meant to guide States to take action to protect the right to physical and mental health. According to these standards, health care in general must be available to all, especially the most vulnerable or marginalized sections of the population, without discrimination; and they must be appropriate in terms of being respectful of medical ethics and culture, while also being scientifically and medically appropriate and of good quality.[249] This criterion is meant to illustrate the content of the right to

[242] UDHR, Supra at note 240, article 25

[243] See article 16 of the ACHPR which calls for the protection of the dignity of mental health patients. Some of these protections were called to the forefront before the African Commission in the landmark case, *Purohit and Moore v. Gambia* No. 241/2001, (2003). The Commission held that all States Parties to the Banjul Charter should guard and protect the rights of the mentally disabled to dignity and the enjoyment of life. Article 11 of the European Social Charter, article 24 of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women (1979), and article 5(e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (1966) have all undertakings on the right to health of persons with mental illness. All these undertakings were agreed based on the framework set by the UDHR; See also Perlin, M. *et al* (eds.), 'International human rights and comparative mental disability law', Israel Law Review, Vol. 39, No. 3, (2006), pp 69-97

[244] ICESCR, Supra at note 240, article 12(l)

[245] Paul, H., 'Report of the Special Rapporteur to the Commission of Human Rights', Addendum: Mission to the World Trade Organization, E/CN.4/2004/49/Add.1

[246] CESCR, Supra at note 234, General Comment No. 14, (2000) 'On the right to the highest attainable standard of health', UN Doc. E/C.12/2000/4, Para. 17.

[247] Ibid. Para 12

[248] Ibid. Para 41

[249] Ibid.

health. Indeed, General Comment No. 14 clarifies that 'the highest attainable standard of physical and mental health is not confined to the right to health care', it rather 'embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.'[250]

The Committee also underscores the importance of making health care services accessible.[251] This means that facilities, goods and services must be physically accessible i.e., within safe physical reach for all sections of the population, including rural populations and vulnerable or marginalized groups, economically accessible: affordable to all based on the principle of equity and accessible to everyone without discrimination.[252] Information on health matters must also be accessible in which people have the right to seek, receive and impart information and ideas concerning health issues. Finally, the Committee stresses that health facilities must be acceptable and of good quality. In other words, health facilities should be respectful of medical ethics and the right to confidentiality, be culturally and medically appropriate and have human resource that is adequately skilled.[253] Although not binding, this comprehensive General Comment is nonetheless authoritative on the right to physical and mental health.

PWMDs and their advocates could therefore utilize the standards set by the Committee to insist that governments deliver on their obligations related to the right to health in general and the right to mental health in particular. The government's "duty to respect" the right to health mandates that it refrain from limiting equal access to mental health services, including treatment facilities and preventive mental health services.[254] The "duty to protect" requires that the government take action to prevent private parties from interfering with the right to mental health.[255] Thus,

[250] Ibid. Para 4
[251] Ibid. Para 12
[252] The CESCR in its Concluding Observations on the report of from Trinidad and Tobago inquired whether health facilities were equally available and accessible in rural and urban areas, whether any problems had been encountered in ensuring full health services to all segments of the population, in which the State Parties said that health facilities were not equally accessible in rural and urban areas.
[253] Ibid. CESCR; The MI Principles also establish a series of standards to safeguard the human rights of mentally ill persons, guarantee adequate treatment, care and rehabilitation, and ensure humanitarian and non-discriminatory conditions. The UN Declaration on the Rights of Mentally Retarded Persons too sets out the rights of such persons to health care, therapy and education.
[254] Ibid. Para 34
[255] Ibid. Para 35

individuals could hold the government accountable pursuant to the right to health for failing to impose or enforce sufficient standards and regulations on community mental health care facilities or special residences for PWMDs.[256] Finally, the "duty to fulfill" supports affirmative government efforts to ensure, for example, that they adequately provide mental health services in the community setting, make efforts to educate the public about mental disability, and undertake preventive and population mental health initiatives.[257] The UN General Assembly also affirmed the various international treaties, the Constitution of the WHO, as well as other standards on the right to physical and mental health in December 2003, by adopting its own resolution, reaffirming that: 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health is a human right, and that such right derives from the inherent dignity of the human person'.[258]

Besides the above and other several documents, the 'centre piece' of international human rights law in the field of mental health is often said to be the MI Principles as discussed under chapter Ptwo. These principles have a symbolic importance in providing visibility to the needs of the mentally ill, in stressing the right of access to adequate mental health care and in establishing the principle equivalence between psychiatry and the rest of medicine. The Principles can be tremendously helpful as an advocacy tool because they provide a detailed guide to the application of treaty-based rights to PWMDs.[259]

As Rosenthal and Rubinstein applaud these Principles, they have expressed their views from different perspectives: the first thing is the adoption of the Principles is an evidence to the fact that the UN has recognized that the manner in which governments provide mental health treatment raises international human rights concerns; secondly, the Principles elaborate upon provisions in the ICCPR offering specific rights to detained patients which States are obliged to enforce immediately; and lastly the adoption of the Principles by the UN establishes international

[256] Ibid.
[257] Ibid. Para 36
[258] UN General Assembly, 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health', UN Doc. A/RES/58/173, available at www.un.org/depts/dhl/resguide/r58.htm, accessed on may 21, 2012
[259] These principles also include standards on admission to treatment, treatment and care standards, discharge and community integration of mentally ill persons, among others.

standards and marks a point where their implementation can begin.[260] The Principles though they are not free from criticisms,[261] they represent a major international step forward both in terms of civil and political rights and of SER. With all the above recognition that they are the first to provide detailed protections for the right to mental health, it is a fact that they lack a binding force. This gap is now nonetheless in the process of being filled as many states are taking them as guidelines in adopting their mental health laws, which extends a force of authoritative guidelines for tribunals which entertain violation of human rights of various kinds.[262] This will contribute for detailed protection clauses for PWMDs in and out of psychiatric facilities.

3.4 The Global Mental Health Gap

Although international law indisputably protects the right to mental health, States have neglected the right to mental health, following the general trend of relegating SER secondary to civil and political rights coupled with a lack of coordination between various national and international players. As a result, there is inconsistent and reluctant international cooperation and minimal financial and technical support for these much needed mental health interventions.[263] In addition, States feel no external pressure to address the mental health needs of victims of violations of the right to mental health, and thus fail to protect them.[264] Therefore, mental health care facilities in many countries have poor standards of treatment and care and inadequate living conditions repeatedly complained by the WHO and other Special Rappaurters.

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[260] Rosenthal, E, and Rubinstein, L. 'International human rights advocacy under the Principles for the protection of persons with mental illness', International Journal of Law and Psychiatry, Vol. 16, (1993), pp 257-259.

[261] The Principles are especially criticized in the context of nonconsensual psychiatric interventions, as that always presupposes loss of liberty. In this respect, Tina, M. categorically opposes to the Principles as a violation of the right to liberty and security in which the violation of which may amount to torture or other forms of ill treatment.

[262] Australia, Hungary, Mexico and Portugal, among others, have incorporated the MI Principles in whole or in part into their own domestic laws. The South African Mental health Act too, incorporates Principle 12 on the Notice of Rights in article 17 of the Act providing that mental health patients must be informed of their rights up on admission to a psychiatric facility; In *Victor Rosario Congo v. Ecuador*, the IACtHR found a violation of the right to humane treatment relying on the MI principles: "inhuman and degrading treatment or punishment should be interpreted so as to extend the widest possible protection against abuses, whether physical or mental.

[263] Saraceno, B. et al, "Barriers to improvement of mental-health services in low-income and middle-income countries" The Lancet, Vol. 369, (2007); See also 'Expert opinion on barriers and facilitating factors for the implementation of existing mental health knowledge in mental health services', Department of Mental Health and Substance Abuse, WHO, (2007)

[264] Lisa, J. and Roxana, C., 'Expanding the definition of the right to mental health: attending to victims of political violence and armed conflict in their communities of origin', Essex Human Rights Review, Vol. 2, No. 1, pp 38-56

The 2001 World Health Report called for adequate access to effective and humane treatment for people with mental health conditions.[265] In low and middle-income countries there is less than one outpatient contact or visit and 0.7 per day spent in inpatient care.[266] The move from institutional to community care is slow and uneven. A recent study of mental health systems in 42 low and middle-income countries showed that resources for mental health are overwhelmingly concentrated in urban settings.[267] A considerable number of people with mental health conditions are being hospitalized in mental hospitals in large cities. Many people with mental health problems do not receive mental health care despite the fact that effective interventions exist, including medication.[268] In ensuring access to mental health services, one of the most important factors to consider is the extent to which services are community-based.[269] But in most countries, care is still predominantly provided in institutions.[270] A large multi-country survey supported by WHO showed that between 35% and 50% of people with serious mental disorders in developed countries, and between 76% and 85% in developing countries, received no treatment in the year before 2011.[271]

The 2011 Mental Health Atlas too, shows that there is a substantial gap between the disease burden caused by mental illnesses and the resources available to prevent and treat them. It is estimated that four out of five people with serious mental illness living in low and middle income

[265] WHO Report, Supra at note 216

[266] Mental health systems in selected low and middle income countries: a WHO-AIMS cross-national analysis, WHO, (2009); The WHO Mental Health Atlas reports that more than 24% of countries do not have a system for collecting and reporting even basic mental health information. Other countries have information systems, but these systems are typically neither comprehensive nor appropriate for mental health planning and reforms.

[267] Ibid.

[268] Ibid.

[269] 'Economic aspects of mental health', Evidence and Research Department of Mental Health and Substance Abuse, WHO, Geneva, (2006), See also Thornicroft, G., and Tansella, M., 'What are the arguments for community-based mental health care?' Copenhagen, WHO Regional Office for Europe (Health Evidence Network report; (2003)), available at http://www.euro.who.int/document/E82976, accessed at May 19, 2012; Alem, A. et al, 'Community-based mental health care in Africa: mental health workers' views', World Psychiatry. February, Vol. 7, No.1, (2008), pp 54–57.

[270] Survey studies conducted by MDAC disclosed that many patients are in deplorable conditions in countries including Hungary, Romania, Turkey, and Russia and in many Latin American Countries. In Ethiopia, as it will be discussed a little later, institutional care is in place, though not available to the volume of the need.

[271] Demyttenaere, K. et al., 'WHO world mental health survey consortium: Prevalence, severity, and unmet need for treatment of mental disorders in the WHO', World Mental Health Surveys, Journal of the American Medical Association, (2004), pp 291, as cited in the 2011 World Disability Report

countries do not receive mental health services that they need.[272] The WHO further indicated that:

> "only 32% of countries have a majority of facilities that provide follow-up care. This figure varies across income classifications; 7% of low income, 29% of lower-middle income, 39% of upper-middle income, and 45% of high income countries provide follow-up care at a majority of facilities. Similarly, only 44% of countries have a majority of facilities which provide psychosocial interventions, a figure which also varies by income classification; 14% of low income, 34% of lower-middle income, 61% of upper-middle income, and 59% of high income countries provide psychosocial care at a majority of facilities."[273]

Analysis of data from the WHO'S Atlas Project on mental health shows widespread, systematic and long-term neglect of resources for mental health care in low-income and middle-income countries.[274] Pervasive homelessness among individuals with mental illness or the lack of appropriate treatment and social support for such individuals may be construed as a form of neglect and human rights abuse.[275] Furthermore, while advances have been made in general health promotion and prevention, the same cannot be said for mental health. The burden of mental health is likely to have been underestimated because of inadequate appreciation of the connectedness between mental illness and other health conditions, too.[276]

The following are some of the reasons advanced why mental health care has not had its due priority in general; the burden of mental illness is relatively invisible to current forms of measurement, the concept that psychiatric conditions are not real illnesses, amenable to the kind of definition, identification, evaluation, treatment, and research as other medical conditions and the belief that there are few or no effective treatments for mental illness.[277] Furthermore, religious beliefs and traditions which surround mental illness have contributed for the neglect of modern mental health care as they are full of superstitions that mental illnesses are not curable with scientific medicine, as the cause is attributable to possession by evil spirit or divine

[272] Mental Health Atlas, Supra at note 266
[273] Ibid.
[274] Saxena, S. *et al.,* "Resources for mental health: scarcity, inequity, and inefficiency", The Lancet, Vol. 370, Issue 9590, (2007), pp 878-889
[275] Goldman, H., 'Implementing the lessons of mental health service demonstrations: human rights issues', *Acta Psychiatr Scand* :, Munksgaard, (2000), Vol. 101, pp 51-54
[276] Alem, A., "My professional journey and mental health research in Ethiopia", Inaugural Professorial Lecture, July 17, 2012, Addis Ababa
[277] Desjarlais, R, *et al*, World Mental Health, Problems and Priorities in low-income countries, New York: Oxford University Press, (1996).

intervention.[278] For all the above reasons, the mental health service is globally disproportionate to the burden caused by mental health problems which in effect is a neglect of PWMDs.

3.5 Mental Health Services in Ethiopia: A Situation Analysis

While the facts remain about mental illness and their contribution to the global burden of diseases and disabilities, the attention given to mental health in terms of putting into place proper policies, legislation, and allocation of adequate resources for equitable service is shown above that it is grossly inadequate. This is even more visible in low-income countries like Ethiopia.

In Ethiopia, super natural causes are often considered as the main reasons of mental illness and traditional and spiritual methods of treatment have been utilized as the main way of treatment and PWMDs have been victims of stigma. As a result most Ethiopians believe that mental illness is not some thing that can be dealt by modern medical science.[279] These perceptions might have also affected the policy makers as there is a substantial neglect of the availability of the services for mental health as it will be discussed below.

In the coming sub-sections, a discussion will be held on the indicators of mental health services which can give evidence as to the extent of access to mental health and the compliance with the human rights obligations towards PWMDs. Accordingly, the burden of mental health problems, the policy and legislative framework, the budget for mental health, the mental health facilities, the human resources for mental health, the training on mental health care professionals, the cost of mental health care and the availability of mental health care in primary health care facilities in Ethiopia will be discussed in their order.

3.5.1The Burden of Mental Health Problems in Ethiopia

People may ask a question "why is mental health important in Ethiopia when people are dying from malaria, HIV/AIDS and poverty?" or they may say "mental health is a luxury for the

[278] Jugal, K., *et al*, 'Myths, beliefs and perceptions about mental disorders and health-seeking behavior in Delhi, India', Indian Journal of Psychiatry, Vol. 53, No. 4, Oct-Dec 2011, pp 324–329; Sathiya, A., 'Mental health promotion in Ethiopia: Emerging issues', University of the Western Cape, Faculty of Natural Sciences, Cape Town, South Africa, (2010); 'Attitudes to mental illness in England survey report', The health and social care information center, (2011), available at www.bedrepsykiatri.dk/media/321911/**mental illness** report.pdf, accessed on September 12, 2012; Makanjuola, R., 'Yoruba traditional healers in psychiatry, Healers' concepts of the nature and etiology of mental disorders', African Journal of Medicine and Medical Sciences, Vol. 16, (1987), pp 53–59.

[279] Alem, A., Supra at note 276, Professorial inaugural lecture, pp 6

West." These attitudes come from ignorance and the stigma that surrounds mental illness.[280] The data below however shows why we should ponder about mental health problems and the gap in services in Ethiopia.

Collection of up-to-date and accurate disaggregated data on the epidemiological burden of mental illness and the disabilities is an essential part of implementation of the rights of PWMDs to access mental health services. Moreover, accurate information on the occurrence and distribution of the mental illnesses is an essential foundation for the prevention and promotion of mental health and the rights of PWMDs.[281] It is unfortunate that there is no such data in Ethiopia on the prevalence of mental illness and disabilities which has thus profound implications for rational health planning for mental health.

However there is no a national comprehensive data on the prevalence rate of mental illness, there are few researches conducted at different sites and different times in the country which are availed by domestic policy makers and reports of international organizations.[282] Most of these earlier studies were done using clinical samples from attendees of out-patient clinics and some of them are community based studies.[283] Based on these data, the prevalence of mental health problems and their disabling impact on individuals' is severe at about the same level that is found in other countries. A study conducted by Kebede, D. *et al* in 1999 examined a sample from an urban community of 10,203 and reported a diagnosis of psychosis in 5% of the sample.[284] The same researchers in 2003 out of 49 respondents reported 0.5% prevalence rate of schizophrenia.[285] In studying the prevalence of bipolar disorder, Negash, A. *et al* in 2005 reported a 0.5% prevalence rate out of 7 respondents.[286] Additionally, Awas, M. *et al* in 1999

[280] Ibid.
[281] Ibid.
[282] The Mental Health Strategy is designed for instance solely based on these researches and the 2005 Mental Health Atlas and the 2005WHO-AIMS Ethiopian report have all analyzed the epidemiological burden and the prevalence rate of mental illness in Ethiopia based on these data.
[283] The Buajira study is by far the largest community based study in the world for schizophrenia and bipolar disorder which involved more than 68,000 subjects.
[284] Kebede, D. and Alem, A, 'Major mental disorders in Addis Ababa, Ethiopia', *Acta Psychiatrica Scandinavica, Supplementum*, vol. 397, (1999), pp 24-9
[285] Ibid.
[286] Negash, A., *et al*., 'Prevalence and clinical characteristics of bipolar disorder in Butajira, Ethiopia', Journal of Affective Disorders', Vol. 87, No. (2-3), (2005), pp 193-201.

reported a 5.7% and 5% prevalence of anxiety disorders and depression respectively.[287] Even though there is no accurate data on suicide rates, it is estimated around 4,000 every year. Added to this large number is 3-5% of the adult population suffers from substance abuse resulting from excessive use of alcohol and khat.[288] Children also suffer from mental illness and disabilities, in which one in ten children suffers from mental disorder.[289] In summary, with out including child disorders, the burden of mental illness accounts around 15%-17% in the country.

The author considers this data as conservative for various reasons; one, the data is a relatively old and the mental health burden of the country must be on the rise as the socio-economic conditions of the country are worsening coupled with the increased dependency on alcohol, khat and other drugs. Two, the above figures do not take into account the HIV/AIDS related mental health problems. It is widely accepted that there is an increased risk of mental illness among people who are HIV positive.[290] This includes both "organic" mental disorders such as AIDS dementia, and the psychological effect of living with HIV, such as depression, anxiety and temptation to suicide. Third, the above data is only on the priority mental illness which are treated often times and it does not incorporate other illnesses which are most of the times categorized as 'others cases' by clinical classification. Fourth, as Alem, A. pointed out, in Ethiopia where health information is mainly dependent on clinical records, it is seldom times that mental illness is reported.[291] Finally, the true burden is likely to have been underestimated because of lack of appreciation of the connection between mental illness and other health conditions.[292] In an interview with the weekly newspaper, Addis Admas, Dawit, A., Chief Executive Officer of Amnuel Hospital submitted that it is difficult to know exactly the burden of

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[287] Awas, M. *et al*, 'Major mental disorders in Butajira, Southern Ethiopia', *Acta Psychiatrica Scandinavica, Supplemen*t, Vol. 99, (1999). pp 56-64.

[288] Alem, A., *et al*, 'The prevalence and socio-demographic correlates of khat chewing in Butajira, Ethiopia', *Acta Psychiatrica Scandinavica, Supplementum*, Vol. 397, (1999), pp 84-91; Fekadu, A. *et al,* 'Alcohol and drug abuse in Ethiopia: past, present and future', African Journal of Drug and Alcohol Studies, Vol. 6, No.1, (2007), pp 39-53., See also Mental Health Atlas, Ethiopia, (2005)

[289] Mulatu, M., 'Prevalence and risk factors of psychopathology in Ethiopian children', Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 34, (1995), pp100-109

[290] Peter, J., 'Mental health in the era of HIV: Investigating mental distress, its determinants, conceptual models and the impact of HIV in Zambia', (2010**)** available at www.ajol.info/index.php/mjz/article/viewFile/76371/66827 accessed on May 12**,** 2012**,** See generally 'Double stigma, double challenge': Mental health and HIV/AIDS in Central and Eastern Europe and the Newly Independent States an advocacy and information document, Global Initiative on Psychiatry, (2006); Brandt, R., 'The mental health of people living with HIV/AIDS in Africa: a systematic review'. African Journal of AIDS Research, Vol. 8, No. 2, (2009), pp 123–33

[291] Alem, A., Supra at note 281, Professorial inaugural lecture

[292] Ibid.

mental illnesses in Ethiopia, but he guessed that mental illness shares 15-20% of the total burden of diseases in Ethiopia.[293] Therefore, the mental health problem of the country is more alarming beyond the above data.

It is submitted above that mental illness and mental disability are not synonymous as all mental illness cases may not generate a disability if they are treated timely and effectively. Thus, the above number is not equivalent to the prevalence of mental disability in Ethiopia though there is a tendency that the disability arising from the prevalent mental illness may be alarmingly high owing to the insignificant access to mental health services as it will be discussed a little below. Be that as it may, the Ministry of Labor and Social Affairs has produced by its 2007 census that mental health problem in Ethiopia in general as 58,726.[294] This data is far from the reality compared to the above prevalence rate. Moreover, the figure does not distinguish between the mental illness and the disability caused by the illness, except putting blanket classification as mental health problems. And for what is worse, it does not consider mental disabilities as a disability while it listed down disabilities entirely on physical considerations. Mental health problems are categorized independently with no consideration of the disabilities arising therefrom as mental disability is not subsumed under disability. This adds to the problem as these are the individuals that are most vulnerable to human rights violations because they are the most stigmatized and their disabilities invisible.

3.5.2 Policy and Legislative Framework on Mental Health

It is an indisputable fact that every society needs mental health legislations in the way forward to protect, promote and improve the lives and mental well-being of citizens.[295] Human rights oriented mental health policies and laws can be an effective way of preventing violations and discrimination against and promoting the autonomy and liberty of PWMDs and should be put in place.[296] This offers an important mechanism to ensure adequate and appropriate care and

[293] Addis Admas Weekly News paper, Interview with Dr Dawit, A., CEO, Amanuel Hospital, Vol. 12, No. 664, October 6, 2012

[294] The Central Statistics Agency of Ethiopia, CSA, 'The 2007 housing and population census of Ethiopia results for country level', Statistical Report, Addis Ababa, Ethiopia, (2007)

[295] Melvyn, F., Supra at note 82

[296] Promoting the Rights of People with Mental Disabilities, Mental Health, Human rights and Legislation Information Sheet, Sheet1, Geneva, WHO, (2007) available at: http://www.who.int/mental_health/policy/services/en/index.html, accessed on April 29, 2012.

treatment, protection of human rights of PWMDs and promotion of the mental health of populations. Progressive legislation can be an effective tool to promote access to mental health care as well as to promote and protect the rights of PWMDs.[297] Providing mental health services to all who need them, in an equitable way, in the most effective manner possible, and in a fashion that promotes human rights and health outcomes all need a clear policy and action plan on that.[298] Moreover, mental health legislation can promote access through funding mental health services at parity to physical health services, or by specifying that services need to be provided through primary health care facilities and in general hospitals in least-restrictive treatment settings, allowing them the possibility to continue working and participating in their communities.[299] Moreover, elimination of prejudice and stigma attached to mental illness would require promotion of effective and comprehensive mental health services, which would obviously require a legislative framework on mental health services and the coordination and following up of the professionals in the field.

Most importantly, the presence of mental health legislation and policy will ensure responsibility and accountability at various levels of the mental health system and economic use of resources to ensure that there is no misuse and wastage of resources.[300] When comprehensive and well conceived, a mental health legislation could address critical issues such as establishment of high quality mental health facilities and services, access to quality mental health care, protection of human rights, patients' right to treatment, development of procedural protections, integration of PWMDs into the community and promotion of mental health throughout society.[301]

Moreover, the legal capacity of PWMDs is often restricted based on general assumptions that they lose their capacity to make decisions about their personal and pecuniary interests. Unless there is a legislation which regulates the legal capacity of PWMDs and the power of their guardians and a system for supervision of the power and function of the guardians, it will obviously endanger their other human rights. This also requires a mental health legislation which is designed based on human rights considerations.

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[297] Melvyn, F., Supra at note 295
[298] Improving health systems and services for mental health, Mental health policy and service guidance package, WHO, (2009)
[299] Ibid.
[300] Ibid.
[301] Ibid.

In a nutshell, legislation can ensure that appropriate care and treatment are provided by health services and other social welfare services, when and where necessary. It can also help make mental health services more accessible, acceptable and of adequate quality, thus giving PWMDs better opportunities to exercise their right to receive appropriate treatment, thereby reducing perpetuation of human rights violations and improving the quality of life for one of the most vulnerable and marginalized subgroups in a society.

Unfortunately, there is neither a mental health law nor any policy in Ethiopia. While there is a general health policy adopted during the time of the transitional government in 1993, a reference to mental health is made only once like a foot note.[302] While the country has adopted Health Sector Strategic Development Plans (HSDP)[303] for four consecutive terms on a four year basis, there is no any significant indication on the threat posed by mental health problems and the disabilities arising out of it. The Growth and Transformation Plan (GTP), which was adopted in 2010 projected for the grand transformation of the country for five years, on the part dealing about the health sector, it is dominated by HIV/AIDS, malaria, TB and maternal health endorsing the HSDPs. This shying away from the problem may obviously cause more problems on the effective protection and promotion of the human rights of PWMDs as it will be discussed latter.

3.5.3 Funding Mental Health Services in Ethiopia

How a country organizes its health services will be dictated by political and economic views, but there is a need for provision of funds so that all public health services do not fall below a given level. The WHO's suggestion for a minimum level of national funding for health[304] provides a good basis for policy formulation. For mental health, the issue is how this amount

[302] Though the process for drafting a separate and comprehensive mental health policy was started in 2007, for unknown reasons it has not become a reality. Rather there is now a Mental Health Strategy for four years from 2011-2015 which is launched in October 2012. This Strategy is however simply a government program on the expansion of mental health and does not incorporate details on the rights of persons with mental disabilities to access mental health services and their other human rights. It is however interesting to learn from this Strategy that 'it calls for a decentralized and fully integrated approach in which mental health treatment is available at local health posts, centers, and general hospitals, and, as a last resort, referral to a tertiary psychiatric centre. All health care workers will be expected to be able to deliver mental health care, in accordance with their skill level.' The general health policy which was adopted in 1993 by the transitional government indicated that "appropriate support shall be given to the curative and rehabilitative components of health including mental health." But no other reference is made in the policy about mental health care of the country.

[303] HSDP I (1997/98-2001/2002), HSDP II (2002/ 03 - 2004/ 05), HSDP III(2005/6-2009/10), HSDP IV(2010/11 – 2014/15) are the four strategic plans for health adopted by the Ministry of Health, FDRE

[304] WHO Recommendation for Mental Health Services, Geneva, World Health Organization, (1996).

should be shared among the components of the health service as a whole. Traditionally, mental health has been neglected in this context. The fact that mental illnesses are among the top ten causes of disability in the world, and that their contribution to the overall burden of disease is going to rise makes a strong case for giving them due attention. Adequate funding must also be supported by information on the best standards of care and by local data on how mental disabilities affect quality of life. Policy-makers need to stress the cost–benefit ratio of treating PWMDs and making them active participants in national economic activities.[305]

The vulnerability of PWMDs is attributable both to the causes and effects of mental illness and they are easily marginalized by the social services, including health care services. Mental health policies ought to take particular note of this vulnerability and marginalization and set guidelines to counteract it. Shortages of money, staff and facilities make unequal access to care, but equity is about the way the available resources are distributed, however inadequate they may be.[306] The most economically disadvantaged have the least access to services and are likely to experience social isolation and low self-esteem. Establishing a mental health desk in the Ministries of Health with the responsibilities of planning, implementing and monitoring the mental health services may help to ensure equity for the mentally ill.[307]

In Ethiopia, there is no disaggregated budget for mental health, but 29.5 million ETB is allocated for Amanuel hospital in 2005 Ethiopian budget year, which is less than 1% of the total health budget that is 3.6 billion ETB. This budget in fact shows 2 million ETB increase from the 2003 budget year, which is a very insignificant increase in two budget years. And this is the only fund allocated by the federal government for mental health services, as the Amanuel Hospital is the sole psychiatric hospital and an authority to follow up capacity building activities in the mental health services of the country. As Ethiopia is a federalist country, there is decentralized system for health services management, too. However, neither of the regional governments has any budget specifically reserved for mental health services. Most of the in-patient and out-patient facilities found in the regions are hitherto run by the federal government as most of them are

[305] Gureje, O. *et al.* , 'Mental health policy development in Africa', Bulletin of the WHO, Vol. 78 (4), (2000)
[306] Ibid.
[307] Ibid. See also generally 'Investing in mental health', WHO, Department of Mental Health and Substance Dependence, Geneva, available at www.who.int/mental_health , accessed on May 18, 2012

affiliated to universities which are in fact funded by the budget of the federal government.[308] If we see even among sub-Saharan countries, national budgets for mental health as a percentage of national health spending during 2007-08 is 3.7% in Ghana and 6.6% in Uganda.[309] Compared to these low-income countries, the inadequate budget allocated to mental health in Ethiopia is clearly visible.

3.5.4 The Mental Health Facilities

WHO under the Mental Health Policy and Service Guidance Package has outlined key elements of needed policies and programs to provide services to PWMDs living in the community. These include: mental health services provided by primary care professionals, psychiatric services in general hospitals, formal out-patient community mental health services and specialist mental health services.[310]

Mental health care in Ethiopia is given under one psychiatric hospital, psychiatric units under few general hospitals and private clinics, both in in-patient and out-patient forms. There are seven facilities which give in-patient service in the country including the Amanuel Psychiatric Hospital with 360 beds, Kidus Michael Higher Clinic with 7 beds,[311] Kidus Paulos Hospital with 5 beds,[312] the Jimma University Teaching Hospital with 26 beds, the Hayder Hospital under Mekele University with 9 beds, the Hiwot Fana Hospital under the Haramaya University with 6 beds, the Felege Hiwot Hospital, a regional referral Hospital in Bahir Dar with 6 beds,[313] the Army Hospital with 30 beds totally reserved for army members, 35 beds at Kality Prison, a forensic inpatient unit that is maintained exclusively for the assessment and treatment of PWMDs and substance abuse who are involved with the criminal justice system and 5 beds at the

[308] It is now projected that the regions should have a specific budget for mental health and psychotropic drugs to be accessible based on the strategy document.
[309] Raja, S., *et al*, 'Mapping mental health finances in Ghana, Uganda, Sri Lanka, India and Lao PDR', International Journal of Mental Health Systems, Vol. **4**, No.11, (2010), pp 1.
[310] Organization of Services for Mental Health, Mental Health Policy and Service Guidance Package, WHO, (2003), Geneva, available at www.who.int/mental_health/resources/en/Organization.pdf, accessed on August 12, 2012.
[311] This is a private higher clinic run by one moonlighting psychiatrist who diagnoses at average 40 patients everyday. In addition to this, there are few other hospitals and clinics which have psychiatric diagnosis two or three days a week by part time doctors, who are working on a moonlighting basis.
[312] Though this hospital is a general hospital, it has recently opened a unit for rehabilitation of drug addicts, including, khat, alcohol and other addictions.
[313] In this hospital, there are no psychiatrist doctors; all the services are given by psychiatric nurses. Unfortunately, there is no any psychiatrist at the Amhara region, which is the second populace region in the country.

Federal Police Hospital. In the Kotebe district area in Addis Ababa, a new in-patient facility is currently being built with anticipated completion date of 2012. Therefore, there are currently a total of 489 beds in the country giving psychiatric service for mental health.

Apart from the above in-patient facilities, there are currently 57 out-patient facilities available in the country run by psychiatrist doctors and nurses, mainly by nurses that focuses on the management of mental illnesses, and the clinical and social problems related to them, on an out-patient basis. All the above facilities which cater in-patient service have an out-patient service, too. The Zewditu Hospital, Yekatit 12 Hospital[314] and Black Lion Hospital under the Addis Ababa University psychiatry department are some of the facilities which have out-patient service run by psychiatrist doctors while all the others are run by two psychiatric nurses each. All of these facilities are public facilities which are run by the government under the federal and the state health bureaus. Psychiatrists and senior psychiatric nurses visit the units in the regions annually from Addis Ababa. The visiting senior assists and discusses with the practicing nurse regarding problems cases, and discusses with the health managers and the administrators of the area about administrative problems.[315]

Additional to the above facilities, there is one rehabilitation center, the Gefersa Mental Health Rehabilitation Center, established in 1982 for other purpose which was changed to be a mental health rehabilitation facility. This is located at the outskirts of Addis Ababa at about 20 kilo meter distance. The Centre is providing care and support to 157 patients at present. This facility has now become expanded which enables it to admit additional 196 inmates.[316] This Center was recently refurbished with a vision to become a center of excellence for mental health and taken by a faith based organization, Borthers Charity.

There are also few organizations, both NGOs and faith based organizations that cater to the homeless and mentally ill persons especially in Addis Ababa. The Maekedonia Center for the

[314] This hospital diagnoses children with psychiatric problems on an out-patient basis supported by one psychiatrist and one psychologist.

[315] Mental Health Strategy Document, Federal Democratic Republic of Ethiopia, Ministry of Health (2011-2015), pp37; Interview with Dr Melkamu A., former medical director and currently the emergency case team leader at Amanuel Hospital, on May16, 2012

[316] The additional building block, which is constructed at a cost of over 2 million Euros on 5,000 sq. meter area of land, was co-sponsored by Salini Constructors, an Italian construction company.

care of the aged and mentally ill persons in Addis Ababa at Kotebe area is one which is extending care and support for about 100 persons. Apart form the above fixed mental health facilities and care centers, the Addis Ababa University psychiatric clinic has started to give a mobile psychiatric service at the Monastery of Debrelibanos, about 125 kilometeres from Addis Ababa and Entoto Kidanemihiret Church in Addis Ababa, where many patients are getting a spiritual treatment through holy water.[317]

3.5.5 The Human Resources for Mental Health

Mental health care requires a multidisciplinary team of professionals and para-professionals including psychiatrists, psychiatric nurses, psychologists, social workers and other professionals trained in basic psychiatric or mental health care such as AIDS counselors.[318] One of the concerns in Ethiopia that hold back access to mental health care for PWMDs is the inadequate number of professionals who are trained to provide psychiatric care. In a situation where there are no sufficient professionals, the access to mental health will be inhibited to a big extent. In Ethiopia, currently, there are 43 psychiatrist doctors, 3 social workers, 14 psychologists and about 461 psychiatric nurses both in public and private mental health care service.[319] But the number of nurses is varying from time to time as they tend to change their specialty to other fields of health in their bachelor and specialty studies.[320]

In a country like Ethiopia, where there is no sufficient number of professionals for psychiatric care, it may be necessary to train the general doctors and nurses mental health care trainings, at least as a temporary measure. Currently, in the Ethiopian medical education curriculum, 2% of the training for general doctors and 3% of training for nurses is devoted to mental health while

[317] In an interview with the bi-weekly newspaper Amharic Reporter (16 May, 2012), Dr Yonas, B., a practicing psychiatrist and an Assistant Professor at Addis Ababa University submitted that the service should be delivered at the place where the needy reside. One of these places is holy water places of the Ethiopian Orthodox Church to which 85% of mentally ill persons pray for recovery.

[318] Improving Health Systems and Services for Mental Health, WHO, (2009)

[319] While this number of the psychiatrist doctors is an updated data, the number of nurses, psychologists and social workers is a data collected in 2010. The nurses who have been trained by Amanuel Hospital since 18 years for one year are not remaining at the mental health service as there is a tendency to switch to other fields of health when they pursue their study to bachelor degrees. It is thus difficult to know how much nurses are working in the psychiatric field. Moreover, Amanuel Hospital has suspended the training since last year, 2011. In this respect, see also the draft mental health strategy document (2011-2015), (2010).

[320] Interview with Dr Melkamu, A. Supra at note 315

there is no training in mental health for health extension workers.[321] Health extension workers are a new type of frontline non-physician/non-nurse primary health care workers who have actually boosted the health care coverage for maternal care, birth control and other epidemic diseases. They are all female high school graduates trained for one year on various basic health care issues. These health workers who are closer to the community and who could have helped in preventing and managing mental health problems are not trained on mental health.[322] Moreover, there is no any refresher training in mental health for primary health care doctors, primary care nurses and other primary health care workers.

As regards the training of mental health professional, the Amanuel Hospital has been training psychiatric nurses since 1986 which has now stopped it for the time being. These nurses are dispersed across the country in the units which give in-patient and out-patient services. In 1993, the Addis Ababa University established a specialization program on psychiatry in cooperation with the University of Toronto, and so far has produced many psychiatrists. There are now 20 residents at the Addis Ababa University specializing in psychiatry. A PhD in mental health epidemiology is planned in the near future at the same University, which will help to expand the capacity to conduct policy-relevant studies, including clinical trials and health service research, and thus support development of an evidence base for effective treatments in Ethiopia.

In 2009, in collaboration with Amanuel Psychiatric Hospital, Gondar University has also established a masters program in psychiatric nursing. Currently, there are 20 trainees who have enrolled in this program. Gondar University has also started in 2010 a clinical psychology program while Jimma University started a master's program in mental health in psychiatric nursing in 2010. This evidences that there is an expansion of training for mental health professionals which may help to fill the gap observed in the human resources in the field.

3.5.6 Availability of Psychotropic Medicines in Ethiopia

Psychotropic drugs are important medical products within the mental health system when used with psycho-social interventions. They can be used for treating the symptoms of mental

[321] Ethiopia-WHO AIMS Report, (2005), Supra at note 282.
[322] In the Strategy Document for Mental Health, one of the plans is to train these primary health care workers in primary mental health care. The health extension workers are mostly working on the maternal and prevention of infant mortality and birth control in addition to awareness creation to the community in prevention of communicable diseases.

disorders, and can help reduce disability and prevent relapse. Affordability, rational selection and sustainability and proper management of these drugs will ensure that these drugs are available in this field.[323] But the mental health system of countries affects access to psychotropic drugs as it is determined by the legislation, the available fund and other measures taken by a country, including issues of patent.[324] As it is submitted above, there is a general neglect of mental health by States in funds and policies, which would directly impact on the availability of these medicines. In this regard, the WHO study discovered that 50% to 80% of physician-based primary health care institutions have at least one psychotropic medicine of each therapeutic category available while none of the non-physician based primary health care clinics have such medicines.[325]

In Ethiopia, apart from the general gap with mental health facilities and the human resources, the availability of these drugs varies at out-patient facilities, in-patient facilities and mental health hospitals. The basic drugs including anti-psychotics, anti-depressants, mood stabilizers and anti-epileptics are available in the hospitals and clinics which have in-patient units and at Amanuel Hospital, while their availability is limited to 50-60% in out patient facilities.[326] These drugs are mostly available in most drug stores and pharmacies in the capital city and in some towns.[327]

3.5.7 Cost of Medication of Mental Health

The other indicator of access to mental health is the cost of medication for mental illness, i.e. economic accessibility. Most PWMDs are marginalized sections of the society who may not afford expensive medication. Payment for mental health care services; including diagnosis, laboratory, medicine and in-patient care have to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially

[323]Benedetto, S. (eds.), Increasing access and use of psychotropic medicines, WHO, (2005); See generally Kleinman, A, and Cohen A. World mental health: problems and priorities in low income countries. New York: Oxford University Press, (1995)
[324] 'Improving access to psychotropic medicines in low- and middle-income countries', Harvard School of Public Health, Press Release, June 18, 2012, available at www.hsph.harvard.edu/, accessed on June 18, 2012.
[325] WHO AIMS, Ethiopia, Supra at note 321, pp 16
[326] Ibid.
[327] Ibid.

disadvantaged groups. Especially, poorer households should not be disproportionately burdened with health expenses as compared to richer households.[328]

As part of the study of access to mental health care for PWMDs, the author has conducted a survey in one public facility, Amanuel Hospital and another private psychiatric clinic, Kidus Michael Higher Clinic, in the way to assess affordability of psychiatric care in the country. At Amanuel Hospital, free psychiatric care is given for indigent patients who can prove a pauper from their respective *Kebelle* administration. In other cases, a simple visit to a doctor is for 5 ETB, and if the patient has to be admitted to the in-patient unit, he will be charged 400 ETB inclusive of drugs, laboratory and meal for maximum of two months in which the patient will be indebted for more if he stayed more than two months. Diagnosis for electroencephalography which is an epilepsy test costs 200 ETB.[329] Laboratory for physical examination is similar to all other public health facilities ranging between 10-80 ETB. Antipsychotic drugs are available at between 5-10 ETB per a capsule, while anti-depressants are sold between 5-33 ETB per capsule. Anti-epileptics and mood stabilizers, too, are available between 5-25 ETB per capsule.[330]

On the other hand, at Kidus Michael Higher Clinic, a visit to a psychiatrist costs 150 ETB while the in-patient service costs 450 ETB per day excluding the cost of laboratory, meals and of drugs. In this facility, the diagnosis for epilepsy test (EEG) costs 450 ETB. The cost of psychotropic drugs in Addis Ababa does not show significant differences between public and private pharmacies.

3.5.8 Mental Health Services in Primary Health Care Facilities

Primary Health Care (PHC) is the most important avenue through which mental health services will be accessed for the majority of people, owing to geographic and information accessibility. The management and treatment of mental illness in primary health care is therefore a fundamental step which enables the largest number of people to get easier and earlier access to services, at an affordable cost, and in a way that minimizes stigma and discrimination.[331] PHC

[328] CESCR, General Comment No. 14, Supra at note 251
[329] Interview with Nujuma, B., Case team leader, Admission and liaison department, Amanuel Hospital, interview held on July 23, 2012
[330] Interview with Tilahun, W., Head of pharmacy, Amanuel Hospital, interview held on July 23, 2012
[331] Integrating mental health into primary care: A global perspective, WHO, Geneva, (2008), pp 21, See also The World Health Report 2008: primary health care – now more than ever, WHO, Geneva, (2008)

can be provided in physician-based and non-physician-based forms. In many countries, since the number of medical doctors is insufficient, PHC centers are staffed only by nurses or other health professionals. WHO-AIMS contains a number of indicators assessing the extent to which mental health care is integrated into PHC systems. These items include whether laws allow psychotropic drugs to be prescribed by PHC staff, if assessment and treatment guidelines are available in PHC centers, the availability of medicines in PHC and the number of referrals made to a higher level of care from PHC facilities.[332] For mental health to be successfully integrated into PHC, the staffs need therefore to be allowed by law and armed with the necessary training to treat cases of mental illness, prescribe psychotropic medicines and to refer to higher facilities for acute cases.

In Ethiopia, where there is no separate mental health legislation, it is not possible to get a complete understanding of the organization of mental health care in PHC settings, and whether the persons in charge could prescribe psychotropic drugs and refer to higher psychiatric facilities is not well understood. But the WHO report divulged that both physician based and non-physician based PHC clinics do not have assessment and treatment protocols as manuals and guidelines for mental health conditions.[333] Despite there is no a comprehensive data, some PHC facilities made referrals to the Amanuel Hospital. PHC doctors are allowed to prescribe psychotropic drugs in any circumstances.[334] PHC nurses are also allowed to do the same but with some restrictions; however the lack of any protocols still encumbers the extent of restrictions imposed on nurses. Other PHC workers may not prescribe these medications except to dispense them. Recently, in collaboration between Amanuel Hospital and John Hopkins University, a training curriculum has been developed to increase the competence of primary physicians to prescribe psychotropic medications.[335]As said above, health extension workers are not trained with mental health care and they could not prescribe psychotropic drugs, too. It is unfortunate that the people who are close to the community are not trained to involve in psychiatric care.

By the next section, the human rights implications of the existing inadequate mental health services in Ethiopia will be discussed taking the effect of each of the indicators on the fulfillment of the right to health of PWMDs. Accordingly, the extent to which the right to mental health for

[332] WHO-AIMS standard, WHO, Geneva, (2005); this is a new WHO tool for collecting essential information on the mental health system of a country or region.
[333] WHO-AIMS, Ethiopia, Supra at note 327, pp 16
[334] Ibid.
[335] The Mental Health Strategy Document, Supra at note 322

PWMDs is affected by the grossly inadequate budget and the absence of any mental health legislation coupled with the lack of sufficient human resource and health facilities will be analyzed in their order based on human rights considerations.

3.6 The Mental Health Services in Ethiopia: A Human Rights Issue for PWMDs

As the above situation analysis has divulged, there are many concerns on the mental health system of the country and the available services. This has far reaching implications on the human rights of PWMDs to access adequate standard of mental health care.

To begin with, there is no any mental health legislation in Ethiopia except the strategy document; if at all the latter has a legislative value. This vacuum certainly creates problems with the human rights of PWMDs. Because, set of norms and standards for the mental health care of PWMDs will at least help in ensuring protection and promotion of patients' right against involuntary admission or treatment, provision for requiring consent for admission or treatment and specific protections for use of ECT and other medications which may cause a violation of human rights PWMDs. The lack of any normative standard thus opens a loophole for violation of human rights in the procedure ranging from admission to discharge at psychiatric facilities. The development of a comprehensive community-based mental health service that is decentralized, equitable, accessible, affordable and acceptable to the people and integrated into the general health service and the traditional psychiatric care could have been better promoted by a well defined and comprehensive mental health policy. This has a direct impact on the respect, protection and fulfillment of the human rights of PWMDs. This is one of the loopholes that put the human rights of PWMDs at stake in Ethiopia. The lack of any policy also causes problems on prioritization and maximization of scarce public resources and support systems in the provision of the best possible care for PWMDs.

The absence of any legally prescribed mechanisms on the standards of psychiatric care gives a 'blank cheque' to the mental health facilities and caregivers to act arbitrarily based on mere intuition in the process of extending psychiatric care. In the absence of any law on mental health and psychiatric care, there are no guarantees for humane treatment based on the standards of human rights. In addition, the absence of any legislative and policy framework has added a problem in the way to fight the negative perception of mental disabilities by raising the

awareness of the public to reduce the incidence of mental illness, including those associated with inappropriate use of addictive substances, and provides adequate care for the mentally ill. This is a typical case of lack of access to information which is one indicator of accessibility of health, as pointed out by the Committee on ICESCR.[336] Last but not least, the absence of a law on mental health and mental disabilities may create a problem over the definition of who has a disability at the domestic level so that the guarantees can be extended to the appropriate targets based on the special protection and programmes developed for them. All these have a direct implication on the human rights of PWMDs in that they can not access and be cared based on the human rights standards as there is no any separate legislative guarantee to oblige the state agencies.

When we see the budget apportionment for mental health care, it clearly shows a substantial gap between the burden caused by mental illnesses and the budget allotted to treat them. This proves the importance attributed to mental health care services compared to physical health is a worrisome imbalance. The gross inadequacy of the budget allocated for mental health obviously limits the expansion of facilities working for mental health and the development of the human resources. Compared to the population size and the mental health burden in the country, it is disheartening to have one psychiatric hospital, one rehabilitation center, less than 500 beds, 43 psychiatrists and less than 15 psychologists and social workers and with no community integration system in the mental health care service. This has an enormous effect on the rights of PWMDs to access mental health care and rehabilitation services

At the ceremony held at Gefersa Rehabilitation Center to commemorate the World Mental Health Day in 2010, Wro Azeb Mesfin, founder and chairperson of the National Initiative for Mentally-ill Persons in Ethiopia (NIMIE) admitted this inequity as she submitted that

> "in addition to the lack of awareness and the stigma that surrounds mental health makes, it is difficult to seek or receive help for mentally ill with just one referral hospital ready to give service to millions of mentally ill people in which the existence of effective treatments such as medications, counseling and rehabilitation would be heartening to have."[337] She went on to add that "it is necessary to provide help to mental patients, but it is also of the utmost importance to provide help to their families as they will also be hurt by the situation."[338]

[336] CESR, General Comment 14, Supra at note 328
[337] Capital Nerws Paper, Volume13, No. 662, September 2, 2010
[338] Ibid.

This gap between the burden of mental illness and disability on the one hand and the inadequate budget and lack of sufficient facilities and human resources is obviously a human rights issue. The State has an obligation to provide services for the health needs of its people; and it is clear that services for those with mental illness and disability are woefully inadequate against its commitments.[339] This is a denial of the disabilities arising from the mental illnesses and the neglect of PWMDs to access health services on an equal basis with other persons. This can even be considered as discrimination among PWDs based on the type of disabilities they suffer.[340] While much emphasis is paid to physical health, it is in effect giving priority to persons with physical disabilities and discriminating against PWMDs. This discrimination has thus a far reaching consequence on the respect of human rights of PWMDs to the best available mental health care, which should have been part of the health and social care system guaranteed under the CRPD[341] and the MI principles.[342] Ethiopia has declared its commitment towards the rights of PWDs including those with mental disabilities when it ratified the CRPD. This is thus a failure to fulfill one's obligation towards health services for PWMDs.

As it is asserted above, mental health issues are low on the public health priority agenda. Though the government may attempt to defend this complain for the resource limitation and poverty that the country is living in, it is the position of the author that the barrier to progress in developing mental health services can be overcome if there is the political will on mental health similar to physical health. Bornemann, T. corroborates this lack of political will as he commented generally that the political will necessary for building up mental health capacity and leadership has been lacking and continues to be a significant challenge.[343] The Special Rapporteur points out that even countries with very limited resources can take steps to protect the right to health of PWMDs such as: include the recognition, care, and treatment of mental disabilities in training curricula for all health personnel, promote public campaigns against stigma and discrimination of PWMDs, formulate modern policies and programmes on mental disabilities and support the formation of civil society groups that are representative of mental health care users and their

[339] ICESCR, Supra at note 244, article 12; CRPD, Supra at note 242, article 25
[340] CESCR, Supra at note 336, General Comment No. 5
[341] CRPD, Supra at note 339
[342] The first principle enunciated under the MI Principles is the guarantee to the best available mental health acre, which should be part of the health and social acre system, (Principle 1).
[343] Bornemann, T., 'Barriers to improving mental health care in low and middle income countries, London school of psychiatry and tropical medicine', available at www.acmedsci.ac.uk/download.php?file=/images/.../MentalHe.pdf, accessed on May 28, 2012.

families.[344] Political will to address the wellbeing of PWMDs is therefore instrumental to adequately increase funds and to face the resistance of various groups including managers of government departments or professional associations who are apathetic to mental health reforms. Boyle, P. and Callahan, D. have written an authoritative account of setting priorities in mental health services and analyzed the ethical dilemmas in allocating scarce resources. They advocate informed public participation in the formulation of mental health policy. Their central conclusion is that a higher place should be given 'to caring for those who can not care for themselves'.[345]

Although the government has an important role to play in assuring maximum levels of mental health care services and in championing the interests of PWMDs more generally, NGOs and civil society organizations are not assuming stronger roles in providing and delivering health care services for mental health; donors have rarely supported PWMDs in their policies or assessed policies for their impact on PWMDs.[346] The funds that are available from the intergovernmental organizations and NGOs are mainly taken away for communicable diseases and for child and maternal care. As a result, societies and other associations working on mental health activities are seriously encumbered by lack of funds.[347]But this does not exonerate the government when the rights of PWMDs is seriously compromised while a very insignificant budget is reserved to the mental health services of the country in which PWMDs can not have access to mental health services adequately. This is another trait of a violation of the rights of PWMDs in Ethiopia.

When the geographic distribution of mental health services is observed among the regions and the capital city, there is an imbalance between the service and the need. While many people live in the regions, the distribution of the services in the regions compared to the capital city is

[344] Report of 11th February 2005 to the United Nations General Assembly, E/CN.4/2005/51, available at http://daccessdds.un.org/doc/UNDOC/GEN/G05/108/93/PDF/G0510893.pdf?OpenElement . accessed on May 23, 2012

[345] Boyle, P. and Callahan, D. 'Minds and hearts: priorities in mental health services', Hastings Center Reports, Vol. 5, (1993), pp 3-23

[346] Interview with Alehegne, A., Head of Ethiopian Mental health Society, interview conducted on April 10, 2012; See also Paul, H, 'Mental disabilities and the human right to the highest attainable standard of health', Human Rights Quarterly, Vol. 28, (2006), pp 332

[347] Thara, R. and Vikram, P., 'Role of non-governmental organizations in mental health in India', Indian Journal of Psychiatry, (2010), pp389-395; The Head of Ethiopian Mental health Society shares this as he complains of lack of fund from NGOS as they are remain seized of other matters which took the conscious of the government and which are part of the Millennium Development Goals, like child and maternal health coupled with HIV/AIDS, TB and other communicable diseases.

insignificant. Out of the 43 psychiatrists working in the country, only10 of them work in the regions and out of the 489 beds which give an in-patient service, only 47 are found in the regions. Regions including the Gambella, the Benishangul, the Somali, the SNNPR, the Dire Dawa City Administration and the Afar have no any in-patient mental health facilities at all. Thus, the service is concentrated in the capital city where less than three percent of the population resides[348] and in few cities across some regions including Jimma, Mekelle, Adama, Jigjiga and Harar. This evidently shows the inequitable geographic distribution of mental health services in the country which has limited access to mental health care for PWMDs.

As regards economic accessibility of the mental health services, even though the public mental health facilities are not considered unaffordable, the private one is not affordable. As it is shown above taking samples, it is easy for persons with low income to pay 150 ETB to see a psychiatrist, 400 ETB daily to get an in-patient treatment and 450 ETB to get an EEG test at this private clinic which is the only clinic giving an in-patient service so far.

3.7 Conclusion

Globally, the burden of mental illness and disabilities is huge. It has been estimated that 14-15 per cent of the global burden of disease is caused by mental, neurological, and substance-use disorders and almost three-quarters of this burden occurs in low- and middle-income countries. Against this, the importance given to mental health services is significantly low compared to the bountiful of funds flowing to the general health care by governments, NGOs and international organizations. This has seriously endangered the rights of PWMDs as the latter could not access adequate standard of mental health care. The lack of adequate mental health services is contributing to the disability while treatable forms of mental illnesses are elevating to disable persons permanently.

The Ethiopian mental health system suffers from many problems with far reaching implications on human rights of PWMDs. The assessment made above shows there is an enormous disparity between mental health and general health services, disproportionate to the burden and disability arising from mental illness. The lack of sufficient fund for mental health has inhibited the

[348] (CSA), Ethiopia, (2007), Supra at note 294. By this statistics, it is only 2.7% of the total population of Ethiopia that resides in Addis Ababa.

availability of facilities that give in-patient and out-patient services and the necessary human resources trained in mental health care. The concentration of the existing facilities in the capital city and in some major cities ahs limited the accessibility of mental health services for those in need. Moreover, mental health care is not supported by any binding legislative framework that can set guidelines and directions on the delivery of mental health services, respecting the human rights of the patients. While most of the facilities are run by the government with modest cost, the private mental health care is expensive for a low income person. All these things coupled with the lack of awareness about mental illness has exposed to discrimination of and stigma towards PWMDs. As a result, it is not surprising that the majority of PWMDs remain untreated, despite the fact that an effective treatment exists. Alem A. believes not more than 1% of PWMDs currently get modern psychiatric care in Ethiopia.[349]

Policy-makers and health planners have therefore failed to provide accessible mental health services to the many people in need. It is also seen that mental health services are not integrated with the general health system to the extent possible. Perhaps most importantly, this failure will cause the substantial burden of untreated mental disabilities, thereby importing human rights violations for one of the most vulnerable and marginalized subgroups in the society.

[349] Alem, A, Supra at note 292

CHAPTER FOUR

4. BEHIND CLOSED DOORS: THE HUMAN RIGHTS CONDITIONS IN PSYCHIATRIC FACILITIES IN ETHIOPIA

4.1 Introduction

In the previous chapter, the mental health services of Ethiopia has been proven evidently inadequate to the need and shown that the government has failed to meet its obligations in ensuring a highest standard of health for PWMDs as its access is limited economically, geographically and owing to lack of information. While the paradigm for the care of PWMDs has been shifting from institutional care to community care, it is disheartening in Ethiopia that the institutions are not even enough to give the necessary care. With this reality, it would be a leap in the dark to advocate for deinstitutionalization in the absence of community settings that fit for treatment of mental illness. Therefore, it is an extravagant and untimely claim to look for community treatment and advocate for closure of the psychiatric facilities at this point of time.

Be that as it may, having institutions to admit PWMDs and giving the necessary treatment is not a sacrosanct system; there must be protection, respect and fulfillment of the human rights of the clients all the way through admission, treatment and discharge. The provision of services in a segregated setting that cuts people off from society, often for life, the arbitrary internment of people to institutions without due process, denial of a person's legal capacity under plenary guardianship, the denial of appropriate medical care or basic hygiene in psychiatric facilities, the practice of subjecting persons to unjustified medications without consent and adequate standards and the lack of human rights oversight and enforcement mechanisms to protect them against the broad range of abuses in institutions are among the concerns that put the right of PWMDs at stake in psychiatric facilities. This has been attracting the conscious of a number of human rights bodies and advocacy groups as the clamor behind closed doors is increasing.[350]

[350] Open Society Institute, Mental health and human rights: A resource guide, 4th ed., (2009), available at **www.equalpartners.info,** accessed on July 1, 2012**,** pp 32; Theo B., Special Rapporteur of the Commission on Human Rights on the question of torture and other cruel, inhuman or degrading treatment or punishment, 3 July 2003, pp 12-16; Tina, M., 'The CRPD and the right to be free from nonconsensual psychiatric interventions', Syracuse Journal of International law, Vol. 34, pp 405-428; Mental Disability Advocacy Center (MDAC), 'Human rights in psychiatric hospitals and social care institutions in Croatia', October 2011

Though there are no specific undertakings adopted to the protection of PWMDs in psychiatric facilities, the MI Principles approved by the UN can be used as a complement to the interpretation of other international human rights agreements as they apply to PWMDs.[351] In doing so, it is tried to see whether these standards are being met in the way how people live in these institutions and the human rights conditions in their admission, treatment and discharge.

This chapter is therefore an attempt to unveil the human rights conditions of persons PWMDs in psychiatric settings in Ethiopia. Accordingly, the common civil and political rights which are susceptible to violation at psychiatric institutions including the right to liberty and security, the right to privacy, freedom from torture and all forms of ill treatment, right to legal capacity, right to legal counsel and right to rehabilitation and community integration at Amanuel hospital and the Geferssa Rehabilitation Center are studied. The choice of these rights is not however arbitrary. The nature of the admission and treatment system is usually treated equivalently with detention, in limiting the right to liberty.[352] The right to liberty and security is thus at the forefront in the study of the human rights of PWMDs in psychiatric facilities. Moreover, the rights to privacy and freedom from torture are committed in most cases against these persons. The rights to legal capacity, rehabilitation and community integration have also a special importance for PWMDs for the respect and protection of all other rights.

The virtual absence of any special mental health legislation as a standard on admission of PWMDs and treatment benchmark has obviously made this study difficult. Therefore, the study is conducted based on semi-structured interviews with several stakeholders including the medical directors and other psychiatrists at the respective institutions, patients and their care givers coupled with first-hand accounts by the author and secondary data. The study has intentionally

[351] The MI principles have been availed by human rights monitoring bodies. In the case of Victor Rosario Congo, for example, the Inter-American Commission on Human Rights made this finding: "The MI Principles are regarded as the most complete standards for protection of the rights of persons with mental disability at the international level. These principles serve as a guide to states in the design and/or reform of mental health systems and are of utmost utility in evaluating the practices of existing systems"; In the case between *Moore and Purohit Vs The Gambia* too, the African Commission in coming to its conclusion, it draws inspiration from Principle 1(2) of the MI Principles. It specifically submitted that Principle 1(2) requires that 'All persons with mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person'.

[352] Lance, G. *et al*, 'Mental health and due process in the Americas: Protecting the human rights of persons involuntarily admitted to and detained in psychiatric institutions': Wayne State University Law School Legal Studies Research Paper Series No. 08-302005, available at http://ssrn.com/ 1247069, accessed on July 12, 2012; See also Héyer, G. 'On the justification for civil commitment', *Acta Psychiatr Scand*, (2000), Vol., 101, pp 65-71

refrained from highly relying on the information that is probed from the patients as it has appeared difficult to get reliable information from persons who suffer from mental illness.

4.2 The Right to Liberty and Security

One of the fundamental guarantees recognized under international, regional and national human rights instruments is the right to liberty and security.[353] This is a guarantee that no one shall be denied of his liberty and security without a due process. All restrictions on the liberty and security of a person shall be justified and based on fair hearing of the detainee. In psychiatric facilities the liberty and security of a patient may be infringed in two cases; involuntary admission and seclusion and restraint. The history that the disability discourse comes from clearly evidenced that mental disability was a legitimate ground to deprive the liberty and security of those persons.[354] In reaction to this legacy, the CRPD emerged totally against the deprivation of liberty and security based on disability and, disability and legal capacity are totally de-linked.[355] Even though involuntary admission and restraint and seclusion are not supposed to be wholly excluded, they should be carefully monitored taking into account the due process rights of the patient. By the following subsections, these circumstances and their implementation at the selected institutions will be discussed in their order.

4.2.1 Involuntary Admission

Admission to a psychiatric facility is equated to detention for all practical purposes as it tantamount to restriction with liberty of a person. Unless one is discharged based on the decision of a psychiatrist, an inmate of a psychiatric facility is not allowed to leave at any time. In this regard, the Human Rights Committee recalls that the protection of liberty and security under

[353] Article 9(1) of the ICCPR and article 14(1) of CRPD have similar undertakings on the right of persons to liberty and security the latter specifically on PWDS. Article 6 of the ACHPR further states that no one may be arbitrarily arrested or detained. Prohibition against arbitrariness requires among other things that deprivation of liberty shall be under the authority and supervision of persons procedurally and substantively competent to certify it. This is substantiated by the decision of the African Commission in the case *Moore and purhoit Vs the Gambia*, when it decides "Every individual shall have the right to liberty and to the security of his person. No one may be deprived of his freedom except for reasons and conditions previously laid down by law. In particular, no one may be arbitrarily arrested or detained". The FDRE Constitution also guarantees the right to liberty and security of persons under article 17 which is the direct replica of the guarantees of the ICCPR and UDHR.

[354] Eric, R. & Clarence J**.** Human rights in national mental health legislation, Department of Mental Health and Substance Dependence, WHO, (2004); Lawrence O., 'International human rights law and mental disability', March-April 2004, Hastings Center Report.

[355] CRPD, Supra at note 354, article12; Tina M. Supra at note 350

article 9 of the ICCPR is applicable to all deprivations of liberty, whether in criminal cases or in other cases such as, for example, mental illness.[356] This imports an obligation up on States Parties to ensure that measures depriving an individual of his or her liberty, including for mental health reasons, comply with article 9 of the ICCPR. This engenders another important guarantee i.e. the right to control by a court of the legality of the detention to be applicable to all persons deprived of their liberty by arrest or detention.[357] The Committee has submitted its concluding observation on the report of Estonia in this respect as:

> 'the State Party should ensure that measures depriving an individual of his or her liberty, including for mental health reasons, comply with article 9 of the Covenant. The Committee recalls the obligation of the State party to enable a person detained for mental health reasons to initiate proceedings to review the lawfulness of his/her detention.[358]

This is a reminder to make sure that due process is respected before a person is committed to a psychiatric facility involuntarily.[359]

In the absence of any normative standard on admission standards in Ethiopia, Amanuel Hospital admits patients with out any regard to their consent. The Gefersa Rehabilitation Center has been serving simply as a "dumping ground" for long time since its establishment during the Derg regime for all kinds of disabled persons. It is absurd that PWMDs and physical disabilities have been living together for long time with out any distinction on their treatment and residence facilities. Recently, after the "Brother Charities" took over the Center, it has developed a standard for admission which lists down the conditions to be complied with up on admission complemented with a contract form to be signed by the patient and his/her respective family member with the center.[360] Despite this, the Center is more concerned if there is a family

[356] Human Rights Committee, General Comment No 8, 'Right to liberty and security of persons', (article 9), (16th session), (1982), Para 1

[357] Ibid. Para 4

[358] Human Rights Committee, Concluding observations on the report of Estonia on article 9 of the ICCPR, 77th session, (2003), Para. 10

[359] Due process rights traditionally termed as 'fair trial rights', are guaranteed under ICCPR, article 14;The African Commission in the case between *Moore and Purhoit vs. The Gambia*, decided that the State should create an expert body to review the cases of all persons detained under the Lunatics Detention Act(LDA) and make appropriate recommendations for their treatment or release.

[360] This standard is a recent development after the Rehabilitation Center is given to a faith based organization, 'Brothers' Charity', only less than a year before. Before that, the Center has been used simply as a 'dumping zone' for mentally ill persons. It is ironic that persons with physical disabilities are also living in the Center with mentally ill persons. But, this new standard is not yet tested in practice as the Center does not admit new patients.

member to consent on behalf of the patient. What is really required in both facilities is the consent of the family member or any escort and based on the severity of the disorder. This is true especially for persons with psychosis as most of them come to treatment against their will.[361] Families, friends, neighbors, work-mates and the police bring persons with psychosis to the hospital.[362] Especially, the will of this category of patient is usually not taken into consideration because in most cases patients are not considered to have insight into their problems.[363]

This arbitrary and involuntary admission to a psychiatric facility involves a serious deprivation of a person's liberty and a potential source of other violation of human rights, including the right to be free from torture and other forms of ill treatment and the rights to privacy among others. Indeed, Amanuel Hospital has an in-patient admission procedure based on objectively accepted psychiatric criteria inter alia, existence of a severe mental illness, threat of imminent harm or deterioration and necessity of institutional treatment.[364] But these procedures are alien to any legal guarantees for involuntary admission as decisions are made solely by psychiatric professionals with out leaving a room for the patient's view or to be represented by a legal counsel. There is no any indication in the record of the patients whether they are voluntarily or involuntarily admitted. This creates another lacuna on possible review by external bodies about the extent to which coercion is committed at admission and in effect the respect of the fundamental right to liberty and security of PWMDs is respected.

The CRPD has altogether rejected coercive mental health care when it provides that care should be provided to PWDs on the basis of free and informed consent, on an equal basis with others. It also requires health professionals to provide care of the same quality to PWDs as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of PWDs through training and the promulgation of ethical standards for public and private health care.[365] However, if we have to be realistic, this undertaking may not take us far as coercion free psychiatric care may not be to the best interest of the patient as the latter may not some times have the insight about their conditions and the

[361] Psychotic persons have a disorder that develops a paranoia that causes them to believe people around them are conspiring to harm them and they perceive the move for treatment by a close person as a conspiracy against them.
[362] Interview with Dr Lulu, B., Medical Director, Amanuel Hospital, on July 2, 2012, Addis Ababa , Ethiopia
[363] Alem, A., 'Human rights and psychiatric care in Africa specifically in Ethiopian', Supra at note215, pp 93-96
[364] Interview with Dr Lulu, B., Supra at note 362
[365] CRPD, Supra at note 355, article 25

State may have a duty to take care of them from an imminent danger to themselves and the community. A person who has lost his conscious, or who has a suicidal temptation, unless he is watched out seriously, it may result in some thing unwanted which may amount to violation of right to life for not taking proper care.[366] This gap could be rather rectified by a complaint or review body so that both interests can be maintained.[367]

The determination as to whether the person should be admitted involuntarily, while initially a medical or psychiatric determination, it should be ultimately subject to judicial review to ensure that the determination is consistent with legal standards.[368] Human rights standards, therefore, demand that

> "PWMDs who are involuntarily admitted to a psychiatric facility must have the right to a fair and timely review of their detention by a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law".[369]

Further, the continuing necessity of a person's internment must be reviewed at periodic intervals by an independent tribunal. The review body shall,

> "in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account and issue a decision on the involuntary commitment of a person as soon as and shall periodically review the cases of involuntary patients."[370]

These human rights protections provide a procedural check on the admissions process and ensure that no one is forced to remain in a psychiatric facility if he no longer meets a health justification as that amounts to denial of liberty and security of a person.

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[366] The right to life imposes the positive duty protecting individuals beyond respect of the right on the State. One of this may be to take care of individuals from losing their life out of suicide while it can stop it. The UN Human Rights Committee, states in this respect that "the right to life has been too often narrowly interpreted. The expression 'inherent right to life' cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures." General Comment on article 6, Report of the Human Right Committee, 37th Session, Para. 93-94

[367] Héyer, G., Supra at note 352, pp 66

[368] MI principles, Supra at note 351, Principle 17, Para1

[369] Ibid.

[370] Ibid. Principle 17, Para 2, Independent review of psychiatric commitment is guaranteed by the MI Principles, Principle 16, the ICCPR, article 9. The MI Principles and international conventions protecting arbitrary detention require that states make the minimal investments necessary to ensure adequate, independent review of psychiatric commitments.

In Ethiopia, where there is no any legislative guarantee on admission proceedings, there are no judicial reviews for involuntarily admitted persons. For what is 'an insult to the injury', there is no even review of the decision of a psychiatrist to involuntary admission by another psychiatrist nor a board of psychiatrists. The decision of a psychiatrist to commit a patient serves as a rubber stamp and it is not reviewable. One may wonder here that while there is a clamor that there are no enough in-patient facilities, how a psychiatrist dares to admit a person involuntarily. In fact it is not news that the availability of in-patient services is seriously inadequate in the country. But this does not ensure that the human rights of persons to liberty and security are not endangered. For instance, a psychiatrist does not consider family and professional conflicts with the patient when the latter appeared before him involuntarily escorted by a family member or professional associate.[371] This amounts to a violation of the due process which in effect is arbitrarily stripping off one's liberty and security against the fundamental guarantees.

4.2.2 Seclusion and Restraint

After a person is interned to a psychiatric facility, another circumstance that would expose PWMDs to lose liberty and security is the solitary confinement and chaining of the patient as a form of control or medical treatment. These measures are known as seclusion and restraint often practiced in psychiatric facilities based on clinical assumptions. Seclusion and restraint may take different forms including environmental restraints by imposing barriers to free personal movement that confine patients to specific areas in seclusion rooms; physical restraints using appliances, usually chains and cuffs that inhibit free physical movement and cannot be removed by the person to whom they are applied, such as hand restraints and cage beds and finally chemical restraints by pharmaceuticals that are prescribed for the main purpose of inhibiting specific behavior, such as aggression.[372] The three kinds of restraints and seclusion may be used either alone or in a combination depending on the clinical objectives aimed to be met. However these measures may serve a purpose in the treatment process of the patient and the security of other residents, unless they are effectively regulated, they have the potential to cause serious human rights violations on PWMDs.

[371] Interview with Dr Lulu, B., Supra at note 364

[372] Gutheil, T. 'Observations on the theoretical bases for seclusion of the psychiatric inpatient', American Journal of Psychiatry, Vol. 135, (1978), pp 325-328; Moosa, J., 'The use of restraints in psychiatric patients', South African Journal of Psychiatry, Vol. 15, No. 3, (2009).

The Special Rapporteur on Torture noted that seclusion and restraint of mental health patients is a method that tends to be avoided by modern psychiatric practice, though this form of restraint is still being used.[373] The Rapporteur recalled that the Basic Principles for the Treatment of Prisoners adopted and proclaimed by General Assembly by Resolution 45/111, in particular its principle7[374] shall be applicable to those in psychiatric institutions and confined.[375] While it is clear that the restraint of violent or agitated patients may be necessary in some circumstances, the Rapporteur stressed that this should always be conducted in accordance with accepted guiding principles. Therefore initial attempts to restrain agitated or violent patients should, as far as possible, be non-physical through verbal instruction and that where physical restraint is necessary, it should in principle be limited to manual control."[376] The MI Principles also corroborates this position when it states that:

> "physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff."[377]

Amanuel Hospital has not set any written guidelines in regulating the use of seclusion and restraint on which forms of restraint and seclusion to be used, in regulating when and how to administer restraint and seclusion and the duration of the measure.[378] This lack of standards has a series of implications which directly affecting the proper implementation of the measures per se. There are no registers kept for this purpose which have to be signed and completed by the relevant medical practitioner who follows up the restrained and secluded person. In the absence of any record, it is hardly possible to know if all other means short of seclusion are exhausted and if the less restrictive method is availed before employing the most restrictive one. Moreover,

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[373] Report of the Special Rapporteur on the question of torture and other cruel, inhuman or degrading treatment or punishment, in accordance with Assembly resolution 57/200 of 18 December 2002, Para49

[374] General Assembly resolution 45/111, 14 December 1990, Principle 7 reads as :"efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged"

[375] Report of the Special Rapporteur, Supra at note 373, Para 50

[376] Ibid. Para 51

[377] MI Principles, Supra at note 370, Principle 11, Para11

[378] However the research is limited to two mental health facilities, we can comfortably say that all other mental health facilities in Ethiopia do not have a guideline on seclusion and restraint as they are often guided by the Amanuel Hospital in many aspects of mental health service.

the lack of the record will complicate to monitor the frequency and duration of seclusion and restraint. This is exacerbated by the lack of consistent communications between the psychiatrist who ordered the seclusion or restraint and the clinical staff who follows it up. So a nurse or another staff close by may restrain him or send to a seclusion room out of mere intuition without a written order by the psychiatrist and any guidelines to follow. Moreover, there are no guarantees for timely and comprehensive assessments and reevaluation of patients under restraint and seclusion to identify persons at risk, including complete bio-psychosocial evaluations, detailed past psychiatric history and careful physical examination.

While the seclusion rooms are closed, the medical director of Amanuel Hospital mentioned that restraints are seldom practiced only in some situations as a last resort after therapeutic measures are exhausted.[379] Despite this, handcuffed patients are seen here and there together with others wandering in the Hospital compound and a few patients are seen chained with their beds in the wards. The survivors of restraint accuse that any nurse or a person following up a patient may order to be handcuffed with out getting a direction from a psychiatrist.[380]

Moreover, Amanuel Hospital is situated next to the Ethiopian Commodity Exchange (ECX), the largest grain market in the country on a slummy area which is highly trafficked with loaded and unloaded lorries all through the day and the night. This endangers the life and security of the inmates of the hospital as there are complains on the hospital that patients are absconding from the compound. In fact, there is construction underway to shift this hospital to the Kotebe area in Addis Ababa. However it is unlikely to see immediate transfer as the construction is taking longer time longer than what was imagined. Apart from the access to health point of view, the construction and renovation of institutions for PWMDs partly proves that Ethiopia is yet lingering on the medical model of addressing disability than to work on the social model.

At the Gefersa Rehabilitation Center, the manager divulged that restraining patients with big chains has been pervasive when they arrived to takeover the center before six months.[381] What they did immediately was to abandon the system of restraint altogether and collect back all the chains in use believing that they could manage the aggressive patients using medication. While

[379] Interview with Dr Lulu, B., Supra at note 371
[380] Interview with Abraham, K., an inmate at Amanuel Hospital, interviewed on July 19, 2012.
[381] Interview with Brother Eric, manager of the Gefersa Rehabilitation Center, interview held on July 10, 2012, Gefersa.

this is commendable, it has however opened for underground restraint with out the knowledge of any professional care taker. The representative of the inmates witnessed that when anyone disturbs his ward mates at the night time, the mates would chain him to his bed using the bed sheets and they would bring to the nurses in the morning.[382] This clandestine and haphazard restraint of the inmates lends a room for serious deprivation of their rights. There are even cases that the inmates drag those who are disturbing out to spend the whole night wandering in the compound which exposes for more threats to life and security of the inmates.[383] These situations really constitute a threat to the life and security of the inmates. Therefore, the move towards total abandonment of restraint at the Gefersa Center proved ineffective and rather counter productive as it does not spare the residents from infringement of their liberty and security.

Finally, the arbitrary internment of PWMDs in to psychiatric facilities may have an effect on the rights of children. When we send parents to psychiatric facilities, the right of children to live with their parents and to be intact in family relationships would obviously be affected and come under strain.[384] Especially minor children may feel misery and deprivation when their parents are interned to psychiatric facilities involuntarily.

4.3 Freedom from Torture and all forms of Ill Treatment

The prohibition of torture and cruel, inhuman or degrading treatment or punishment is among the most serious obligations reflected in a host of international instruments, including a specialized convention on the subject.[385] The prohibition of torture in particular has the status of a peremptory norm of international law that can never be derogated even in emergency situations. As such, it must be regarded as having attained the status of customary international law and, moreover, there is ample authority for the proposition that the prohibition of torture be assigned *jus cogens* status.[386] While the ICCPR does not contain any definition of for torture, the CAT has

[382] Interview with Shibabaw, W., a representative for inmates at Gefersa Rehabilitation Center, interview held on July 10, 2012, Gefersa
[383] Ibid.
[384] Article 8(1) of the CRC requires States Parties to guarantee children to family relations as one element of recognition and respect of the identity of children be preserved.
[385] The CAT, UDHR, ICCPR, ACHPR have all prescriptions on the prohibition of torture. The FRDE Constitution too though it does not indicate torture explicitly, the prohibitions against other forms of ill treatment under article 18 are considered as sufficient guarantees against torture.
[386] The *jus cogens* status of the torture prohibition has been recognized by the Committee against Torture, the treaty body that monitors the Convention against Torture, and provides authoritative interpretations of CAT obligations. See also U.N. Committee Against Torture, Convention Against Torture and Other Cruel, Inhuman or Degrading

come up with a definition to be availed for that Convention which is in fact used for further analysis of the concept.[387] There is always an argument over the distinction between torture on the one hand and cruel, inhuman, and degrading treatment or punishment on the other hand. But the Human Rights Committee has asserted that it does not

> "consider it necessary to develop a list of prohibited acts or to establish sharp distinctions between different kinds of punishment or treatment; the distinction depends on the nature, purpose and severity of the treatment applied".[388]

The first instrument that prohibits torture and cruel, inhuman, or degrading treatment or punishment in contemporary human rights law is the UDHR, which states: "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."[389] Article 7 of the ICCPR reaffirms this when it clearly sets out that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation." The ICCPR went on to guarantee that all individuals deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.[390] The CRPD on the other hand reaffirming the above prohibitions requires states to take effective measures to prevent PWDs, on an equal basis with others, from being subjected to such treatment.[391] The prohibition set out in article 15 of the CRPD is reinforced by article 17 that simply and decidedly guarantees the physical and mental integrity of PWDs.[392] The protection from degrading treatment is reinforced for persons in psychiatric facilities under the MI Principles which states that "every patient shall be protected

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Treatment or Punishment: General Comment No. 2: Implementation of article 2 by States Parties, P 1, U.N. Doc. CAT/C/GC/2 (Jan. 24, 2008); See also Bassiouni, M. & Daniel, D., An appraisal of torture in international law and practice: The need for an international convention for the prevention and suppression of torture, (1977), p. 67-88; Rosalyn, H., 'Derogations under human rights treaties', British Year Book of International Law, Vol. 48, (1978), pp 282

[387] CAT, Supra at note 385, article 1

[388] General Comment No. 20 on article7 of the ICCPR, Para 4, The common elements pertaining to all acts within the torture and ill-treatment prohibition include: (i) meeting a minimum threshold level of severity; (ii) subjective and objective assessment; (iii) physical and or mental suffering fall within the scope of protection; (iv) the protection is not confined to the criminal investigation and judicial process; See generally Gabrielle, M. & Olivia, S. (eds.), Torture and other offenses involving the violation of physical and mental integrity of the human person, in substantive and procedural aspects of international criminal law, (2000), pp 226-27,

[389] UDHR, Supra at note 385, article 5.

[390] ICCPR, Supra at note 385, article 10.

[391] CRPD, Supra at note 365, article 15; Article 1 of the CRPD also provided *inter alia* that the purpose of the Convention is to promote respect for the inherent dignity of persons with disability, (which includes persons with mental disabilities).

[392] Still, articles 15 and 17 of the CRPD must be understood by reference to the CRPD general principles in article 3, along with other substantive articles relating to legal capacity, informed consent, and similar topics.

from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort".[393]

All the above guarantees on the freedom from torture and all other forms of ill treatment shall be therefore applicable to persons who are interned at psychiatric facilities who are prone to these sorts of treatments as evidenced in many institutions.[394] As it is pointed out some where above, the Human Rights Committee has submitted that "it is appropriate to emphasize that article 7 of the ICCPR protects, in particular (…) patients in (…) medical institutions".[395] While treatment of PWMDs after admission are issues to be dealt independently, involuntary admission and lack of any review body shall be scrutinized if they do amount to the violation of the above undertakings by themselves. In this regard, the Special Rapporteur believes that the internment of mentally sane individuals in a psychiatric institution may amount to a form of ill-treatment and in certain circumstances, to torture.[396] In fact, while a person is healthy, it is degrading to be treated like an insane person and to be subjected to unjustified medications and be cared together with PWMDs This illusion and confusing treatment may even expose one to a psychiatric disorder.

Another case of torture that is often perpetrated at psychiatric facilities is 'nonconsensual psychiatric and medical interventions' which have been contemplated as torture or cruel, inhuman or degrading treatment and prohibited by all the instruments which deal with torture.[397] On this point, the Special Rapporteur on Torture emphasized that certain practices such as irreversible treatments, including sterilization or psychosurgery, experimental treatment without informed consent which are expressly forbidden by the MI Principles, shall be prohibited, as they may amount to a form of ill-treatment or even, in certain circumstances, to torture. However, the right to informed consent and the right to refuse treatment may be restricted, but only under

[393] MI Principles, Supra at note 377, Principle 8, Para2

[394] See Mental Disability Rights International (MDRI), 'Human rights & mental health': Mexico, (2000), pp 13-41; MDRI, 'Children in Russia's institutions': Human rights and opportunities for reform, (1999), pp 10-23; MDRI, 'Human rights & mental health': Hungary, (1997), available at http://www.mdri.org/PDFs/reports/Hungary.pdf; MDRI, 'Human rights & mental health': Uruguay, (1995), pp 16-48. All these reports corroborate that egregious human rights violations are pervasive in psychiatric facilities.

[395] The Human Rights Committee, Supra at note 358, General comment 9 on article 10 of the ICCPR, Para 4

[396] Ibid. Para 48

[397] Article 15 of CRPD, in line with the terms of article 7 of the ICCPR expressly prohibits medical or scientific experimentation on persons with disabilities without their free consent. Moreover, article 15 of the CRPD, read together with article 17 (respect for mental and physical integrity), article 19 (right to independent living in the community), and article 12 (legal capacity), in particular, require the application of a highly robust informed consent regime. Therefore, the right to informed consent to treatment is one of the fundamental tenets of the right to autonomy of an individual.

limited circumstances specified in international standards.[398] As it is described by the Special Rapporteur on the Right to Health, strict protections are needed to protect the right to informed consent for PWMDs. In the Rapporteur's experience, decisions to administer treatment without consent are often driven by inappropriate considerations, in the context of ignorance or stigma surrounding mental disabilities and expediency on the part of staff.[399] This is inherently incompatible with the right to health, the prohibition of discrimination on the ground of disability, and other provisions in the MI Principles. In such circumstances, the Rapporteur recommends that it is especially important that the procedural safeguards protecting the right to informed consent are both watertight and strictly applied.[400]

Recently, the ECtHR issued a strong judgment on the rights of PWMDs to be free from arbitrary interference with their rights to liberty and to self-determination.[401] The Court found a violation of article 5(1) of the ECHR on the right to liberty. In doing so, it articulated principles upholding the rights of PWMDs to make choices about their own treatment and of the need for less restrictive alternatives to detention.[402]

The lack of consent and review on the admission of an involuntary patient will continue all through the treatment process as there are no systems to get the consent of the patient as treatments are solely administered based on the discretion of the psychiatrist and sometimes with the consent of a family member.[403] Therefore, psychiatrists are not required to ask for any form of consent to treatment from patients. The latter are not informed about risks or side-effects of

[398] MI principles, Supra at note 393, Principle 11

[399] Hunt, P., Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Commission on Human Rights, 61st session, Item 10, E/CN.4/2005/51, Para 89

[400] Ibid. Para 90-91

[401] ECtHR, the judgment in the case of *Plesó v. Hungary*, Application no. 41242/08, 2 October 2012

[402] In particular, the Court upheld the value of autonomy and self-determination, including the right to refuse treatment, for persons with mental disabilities, stating that "it is incumbent on the authorities to strike a fair balance between the competing interests emanating, on the one hand, from society's responsibility to secure the best possible health care for those with diminished faculties. The Court moreover found that the Hungarian courts had perceived the applicant's refusal to undergo hospitalization as proof of his lack of insight, rather than as "the exercise of his right to self-determination. Finally, the Court said that, "compulsory psychiatric treatment often entails a medical intervention in defiance of the subject's will, such as forced administration of medication, which will give rise to an interference with respect for his or her private life, and in particular his or her right to personal integrity", citing this as a reason for States to avoid compulsory hospitalization.

[403] Both of the medical directors of Amanuel Hospital and the Geferssa Rehabilitation Center mentioned that there is no generally accepted practice of informing people about the risks and side effects of treatment in or for providing them an opportunity to refuse or seek alternative forms of treatment.

treatment or any alternative choices for treatment that might have been available. At both Amanuel Hospital and Gefersa Center, there are no systems to get the consent of patients in the treatment even where the latter are able to share their views over the procedure of the treatment and the type of treatment. The testimony of one inmate at Amanuel Hospital goes like this:

> "I have been here for two months. It is only on the first day that I was asked by the doctor on my diagnosis and treatment. After that time, I have never been consulted about my treatment plan, alternative treatments and the progress I am showing even though I am able to give some opinions about my treatment. I am just a passive recipient of what is given here."[404]

In most cases, psychiatrists are under the impression that obtaining consent from family members is adequate.[405] Of course, patients may be sometimes unable to consent to their treatment depending on the severity of the illness they are suffering from. In these cases, getting the consent of the care-givers may suffice. But neither is there consulting families or care givers on the treatment plan and the possible repercussions of the treatments administered on a patient.[406] This means that inmates are at the mercy of whatever plans the psychiatrist or head nurse happened to consider suitable for them. This lack of consulting or getting the consent of the patients' and their family members or care givers gives a 'blank cheque' for the persons following up to administer the treatment what ever they think fit. In such cases, there are no guarantees if sterilization and abortion, which are irreversible forms of treatment, are not administered with out the consent of the patient.

Electro-convulsive therapy (ECT) is a form of treatment widely used to treat depressed patients, which is terrifying, especially if administered without anesthesia or muscle relaxants as the body shakes in a convulsion that can cause fractures. However, use of anesthesia and muscle relaxants in "modified electroshock" necessitates the use of more electricity to achieve a seizure, which can cause increased brain damage and might not be as effective as the treatment in its unmodified form.[407] This has been evidenced when some of the persons against whom ECT is

[404] Interview with Abraham K., Supra at note 380
[405] Interview with Dr Lulu B., Supra at note 379
[406] Mulu, H. and Nakachew, A. whom the author interviewed while caring their respective families confirm that neither patients nor family members have any say over the treatment plan and progress of the patients. Every thing is top down that the psychiatrists order and the nurses administer.
[407] Squire, L. and Slater, P., "Electroconvulsive therapy and complaints of memory dysfunction: A prospective three-year follow-up study", British Journal of Psychiatry, Vol.142, (1983), pp1-8; Zielinski, R., *et al.*,

administered have suffered form loss of memories long time after it is administered.[408] This may even cause a permanent loss of memory. Abrams R. has observed that:

> '... a patient recovering consciousness from ECT might understandably exhibit multiform abnormalities of all aspects of thinking, feeling, and behaving, including disturbed memory, impaired comprehension, automatic movements, a dazed facial expression and motor restlessness.'[409]

Boyle G. on the other hand reviewed the literatures on ECT and stated:

> 'there is considerable empirical evidence that ECT induces significant and to some extent lasting brain impairment. The studies … suggest that ECT is potentially a harmful procedure, as indeed are most naturally occurring episodes of brain trauma resulting in concussion, unconsciousness and grand mal epileptic seizures, Accordingly, the continued use of ECT in psychiatry must be questioned very seriously.' [410]

So whether it is modified or not, ECT causes a serious pain and should be regarded as a degrading treatment. At Amanuel Hospital modified ECT is a common way of treatment as it is taken as an effective way of treatment for the seriously depressed patients.[411] But there is no any contemplation over stopping this system of treatment.

Besides the above cases of torture and ill treatment, there are allegations that PWMDs are transported to the Butajira Mental Health Research Center from Amanuel Hospital after the hospital released them. These persons are taken there when their treatment is unsuccessful and where there is no one to take them back home. The allegations submitted that researches and medical experimentations are carried out over these patients against their dignity and their physical and mental integrity. Unfortunately, the efforts of the author to verify these allegations were not successful. The Human Rights Committee has a strict proscription on this point as it states that:

"Cardiovascular complications of ECT in depressed patients with cardiac disease", American Journal of Psychiatry, Vol.150, (1993), pp 904-909.

[408] The Royal College of Psychiatrists, 'Information on ECT: pros and cons of ECT treatment', available at www.rcpsych.ac.uk/mentalhealthinfo/**treatments**/**ect**.aspx , accessed on July 13, 2012

[409] Abrams, R., Electro-convulsive therapy, 3rd ed., Oxford University Press, New York, (1997), pp 214.

[410] Boyle, G., 'Concussion of the brain with electroconvulsive shock therapy (ECT)': An appropriate treatment for depression and suicidal ideation, Australian Clinical Psychology, (1986), pp 23

[411] Dr Yonas, B., a practicing psychiatrist considers the move against the ECT as against the effective treatment of persons with mental illness. He is astounded with the change he has observed after he administered ECT for the patients. He thus considers it a 'miraculous diagnosis' and he supports the continuation of it as long as it is administered in a modified form using anesthesia.

> "article 7 expressly prohibits medical or scientific experimentation without the free consent of the person concerned. . . The Committee also observes that special protection in regard to such experiments is necessary in the case of persons not capable of giving valid consent and in particular those under any form of detention or imprisonment. Such persons should not be subjected to any medical or scientific experimentation that may be detrimental to their health."[412]

The Ethical Principles for Medical Research Involving Human Subjects of the World Medical Association Declaration of Helsinki further addresses the limited conditions under which such research may be conducted. Principle 24 provides that research subjects who are legally incompetent or physically or mentally incapable of giving consent should not be included in research unless the research is necessary to promote the health of the population represented and this research cannot instead be performed on legally competent persons.[413] If the above allegations are true, it is a clear violation of the guarantees under the ICCPR and the CRPD.

The Human Rights Committee has referenced both forced abortion and involuntary sterilization as violations of article 7 of the ICCPR.[414] These practices would obviously trigger violations of article 15 of the CRPD too, as the latter has imposed similar prohibitions against forced medications and medical experiments. The Special Rapporteur on Torture has also noted that

> "given the particular vulnerability of women with disabilities, forced abortions and sterilizations of these women if they are the result of a lawful process by which decisions are made by their 'legal guardians' against their will, may constitute torture or ill-treatment."[415]

The better view, however, and one consistent with article 12 of the CRPD and its framework of supported decision-making is that such practices must be presumed to fall afoul of article 15 in the absence of free and informed consent.

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[412] Human Rights Committee, Supra at note 395, General Comment 20, para.7; Ethiopia, a signatory to both the ICCPR and CAT has an obligation to protect individuals from thee set of practices which tantamount to torture and other forms of ill treatment.

[413] The World Medical Association, Inc., World Medical Association Declaration of Helsinki: The ethical principles for medical research involving human subjects, available at http://www.wma.net/e/policy/17-c_e.html, accessed on July 15, 2012

[414] Human Rights Committee, Supra at note 358; See also Janet, E., 'Shared Understanding or consensus-masked disagreement? The anti-torture framework in the CRPD', Loyola of Los Angeles International and Comparative Law Review, Vol. 33, No 27, (2010), available at: http://digitalcommons.lmu.edu/ilr/vol33/iss1/3 accessed on ,July 21, 2012

[415] Manfred, N., Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 'Report on the promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development', pp 38, (2008), available at http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/101/61/PDF/G0810161.pdf, accessed on July 17, 2012

Moreover, the Committee against Torture pointing to overcrowding, inadequate living conditions, and lengthy confinement in Russian psychiatric hospitals considered it as "tantamount to inhuman or degrading treatment."[416] The Human Rights Committee too, called for the improvement of hygienic conditions and adequate treatment of the mentally ill in detention facilities in Bosnia and Herzegovina both in prisons and mental health institutions as a protection from ill treatment.[417] Against this, at Amanuel Hospital and Gefersa Rehabilitation Center, there are at average 20 patients in one ward. Even though patients should be provided with a comfortable environment which ought to be safe, clean and attractive, the bad odors at the wards in Gefersa Rehabilitation Center is horrifying even for a short time visit.

In both the Amanuel Hospital and the Gefersa Rehabilitation Center, the inmates spend their day being closed in the hospital's compound with no means of refreshment, or being provided with a television as the only means of entertainment. Most of them are thus seen smoking cigarettes and wandering here and there, and sometimes engaging in brawls which may be a threat to the life and security of the patients. While this may not constitute degrading treatment per se, the cumulative effect may be degrading, as the social and other skills of institutionalized individuals deteriorate on this kind of dulling environment. Indeed, the Human Rights Committee has noted that the duration of a practice will be taken into account when determining if it constitutes degrading treatment.[418]

Last but not least, the practice of continuously dressing patients in pyjamas at both Amanuel Hospital and Gefersa Rehabilitation Center is not conducive to strengthening personal identity and self-esteem as individualization of clothing should form part of the therapeutic process.[419] For these inmates who are accommodated in overcrowded conditions with few activities at their

[416] Committee against Torture, Conclusions and Recommendations on the Report Submitted by Russian Federation under article 19 of the ICCPR, 37th session, (2007), Para. 18

[417] The Human Rights Committee, Supra at note 412, Concluding comment on the initial report of Bosnia and Herzegovina on the ICCPR, 88th session (2006), Para. 19.

[418] Eric, R. & Clarence, J., 'The role of international human rights in national mental health legislation, www.mdri.org/pdf/WHO%20chapter%20in%20English_r1.pdf, pp 56, as cited in Department of Mental Health and Substance Dependence, WHO, (2004).

[419] The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) guidelines and recommendations of the 1999 report emphasize that this practice is not conducive to strengthening personal identity and self-esteem, and that the individualisation of clothing should form part of the therapeutic process. Although this standard is not directly applicable to Ethiopia, it serves as a reminder for psychiatric facilities here which are practicing the continuous wearing of pyjamas.

disposal, when they are obliged to wear institutionalized clothing throughout the day, 'the cumulative effect of such conditions is profoundly anti-therapeutic and is degrading.'[420]

4.4 The Right to Legal Capacity

Legal capacity is a status right that entitles one to act and become responsible for his acts equally with others. It is thus an inherent right that is fundamental to the dignity of PWDs and the exercise and enjoyment of all other rights.[421] The right is both a substantive right, and a transversal principle conferring the power to exercise all other rights by one's own will.[422] Specifically, it is instrumental to enforce the right to independent living and movement, self-determination, marriage and parenting rights and obligations, health care decisions requiring free and informed consent and the right to vote and participation in public life among others. Enforcement of these set of rights by an individual presupposes recognition and protection of legal capacity by states. A limitation against legal capacity of an adult person has therefore a direct effect to limit on the free and effective exercise of these rights. As such, it is an important right to be protected from arbitrary limitations or exclusions based on disability.

In protecting PWDs from arbitrary limitation on their capacity, the CRPD states "States Parties reaffirm that PWDs have the right to recognition everywhere as persons before the law".[423] The recognition of everyone everywhere as a person before the law under the UDHR and ICCPR imports that every one has the legal capacity to act as a person with out any discrimination.[424] The CRC also suggests evolving legal capacity of children which equally applies to children with disabilities[425] which is reaffirmed under the CRPD.[426] The CEDAW made first explicit mention of legal capacity, which guaranteed equality between women and men which also applies to

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[420] This is confirmed by the CPT in its visit to Turkey as it reported that institutionalized clothing for mental health patients is anti-therapeutic when it is practiced in dulling environments, Ref.: CPT/Inf (99) 2 [EN] - Publication Date: 23 February 1999, Para. 177

[421] International Disability Alliance**,** Position paper on the implementation of the CRPD and other instruments, April 25, 2008; See also Tina M., Supra at note 350

[422] Article 12 of the CRPD gives recognition of equal legal capacity for persons with disabilities on an equal basis with other persons.

[423] Ibid. Article 12(1)

[424] UDHR Supra at note 389, article 6 and ICCPR cited above at note 390, article16

[425] CRC, Supra at note 383, article 12

[426] CRPD, Supra at note 424, article 7(3) and 3(h)

women with disabilities.[427] These show that similar concerns on the recognition of legal capacity for every one is not an innovation of the CRPD, but it has laid its basis on agreed texts, while it introduced series of measures for the effective enforcement of the right to PWDs

Among the measures, States Parties are required to ensure that

> "all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests."[428]

The heart of the contention with the respect of the right to legal capacity goes to the circumstances where PWMDs may be in need of substituted decision where their incapacity prevents them from making a decision which cannot be filled by any support. Sometimes PWMDs may be unable to understand or retain the information relevant to the decision, or unable to make a decision based on that information irrespective of the necessary support extended. It is the position of those states which reserved on article 12(2) of the CRPD which the author buys it too, that someone should decide in the place of such persons in these circumstances.[429] If all the measures that should be taken as a support mechanism are exhausted, and if the person is perhaps not yet capable of exercising his legal capacity in making a decision, what we can do to guarantee the interest of the person is to substitute him. It is therefore too legalistic to assume the full capacity of PWMDs and to assume every decision has to be decided personally. But states should avoid plenary guardianship which totally stripped off the legal capacity of persons on all matters indefinitely as they should be tailored based on the need.

PWMDs living in institutions have been often determined by a court to be legally incapacitated, and they are placed under guardianship who makes decisions regarding personal and financial

[427] CEDAW, Supra at note 125, article 15
[428] CRPD, Supra at note 426, article12(4)
[429] Australia and Canada are among the States Parties to the CRPD which have reserved on the regime of legal capacity undertaken under the CRPD, *See* U.N. Enable, Contributions by governments: Canada, available at http://www.un.org/esa/socdev/enable/rights/ahc7canada.htm , accessed on July. 23, 2012

matters.[430] Because of guardians' wide-ranging decision-making powers, the practice of guardianship has often resulted in neglectful or even exploitative situations. The plenary guardianship may improperly deny people of their right to make basic decisions about their life. It is a common practice in many countries for individuals with a psychiatric diagnosis or mental retardation to be considered "mentally incompetent" without any form of legal process.[431] Where legal process is used, an individual with limited disabilities and many practical abilities may be placed under plenary guardianship. In some countries, guardianship procedures have been used to circumvent laws that would protect against improper involuntary detention in a psychiatric facility.[432] The MI Principle has noted the importance of recognizing different degrees of incapacity, and of preserving the autonomy of PWMDs to the highest possible degree. To this end, it requires specific indications on what matters the person is incapable to make decisions and cautions against the automatic deprivation of a person's other rights.[433]

The failure to secure the consent in the admission and treatment of PWMDs is a presumption of incapacity in which the insight of the patient is presumed absent to participate in his treatment plan and procedures. This is a violation of the fundamental right of PWMDs to be recognized as a person before the law on an equal basis with other persons. This is also a violation of the right to self-determination of persons. The CRPD imposes an obligation to support persons PWMDs in the way to pass their decision on issues that matter their life. Setting aside this obligation, the practice shows a total substitution of the persons in the decision making process.

Court requests from Amanuel Hospital on views about the capacity of a person are limited to a dichotomous determination of whether a person is capable or incapable, without specifying exactly what kind of disability the person suffers from, what kind of decisions he can make by himself, the powers the guardian should get and what legal capacity the PWMDs retains.[434]

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[430] Hurme, S., "Current trends in guardianship reform", Maryland Journal of Contemporary Legal Issues, *(*1995-1996), pp 82-183.

[431] The new Hungarian Constitution for instance allows a court to remove the right to vote and work based on a person's perceived disabilities. The Committee on CRPD in its concluding observation on the report of Hungary said that people under guardianship should have the right to consent to and refuse medical treatment, to access justice, to vote, to marry, to work, and to choose where to live.

[432] Eric R. & Clarence J., Supra at note 418, pp 46

[433] MI Principles, Supra at note 398, Principle 2

[434] In one case (file number 68303), Ato Nasser Dormollo has applied at the Federal First Instance Court on 11/08/98 E.C. for an interdiction of Ato Ismael Qaid owing to the mental disorder of the latter. The Court that received the application has caused the person to appear before the court and considered that he has a disorder. It is

Determination of the detailed situations of the persons in question would have created a room for at least partial guardianship under which the PWMDs retains some legal capacity. Unfortunately, the judge can not limit the guardianship over specific duties and cannot review any recommendation of the hospital. Once a guardian is appointed, there is no further requirement of periodic psychiatric/ judicial review about the change in capacity of the person interned in the hospital. This gives unlimited unchecked power for the guardian until total recovery. People subject to such total guardianship are thus denied their legal capacity and autonomy, subjecting them to an almost complete denial of legal rights in the community.

This plenary guardianship system, 'one-size-fits-all', practices are inappropriate for two main reasons: (1) capacity often fluctuates throughout a person's life, sometimes in a remarkably short space of time such as days or, sometimes, hours, and (2) capacity is specific to a particular decision.[435] Some one for example, probably may have the capacity to decide on personal welfare issues such as clothes and food, but may not have capacity to understand complex medical procedures or financial transactions. This requires the guardianship to be tailored to each person's individual needs, and to extend only to those areas in which his functional capacity justifies very serious restrictions of their rights. Against this, the courts preferred to limit bluntly the person at issue of all his decision-making powers for an unlimited period of time based on

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also substantiated by a medical report from Amanuel Hospital. The report from the hospital dated 18/09/98 confirmed that the person is an inmate of the hospital and recommended by the board decision that the person should be interdicted and a guardian be appointed with a guardian. It is absurd that the hospital recommended for 'guardianship', which is a court function to decide over it, with out indicating the level of the disability and the decisions that may be affected by the disability. Based on the poor report produced from the hospital, the court has finally interdicted the person, and appointed the applicant as the guardian. Therefore, the report submitted neither by the hospitals nor by judges does give any room for consideration of the functional limitations of the person in order to put a limit over the power of the tutors and authorizing the interdicted person to be reserved with some functions, if any. They all are general reports in that either they recommend for total interdiction or not interdiction.
In another case (file number 174258), W/ro Teebe Mesfin has submitted an application for interdiction of her daughter, Shalom Bezabih, on the date 14/12/2002 E.C before the Federal First Instance Court, as the latter has suffered from a mental health problem since 1997 E.C. The court has requested the Armed Forces Teaching General Hospital, at which the patient was admitted, to explain on the health condition of the patient. The court did not request on the particular aspects of the disability and the capacity that may be affected by the disability. In response, the board of the hospital issued a certificate that the said patient is admitted at the Hospital to the psychiatric department and was treated and has been having psychiatric follow-up accordingly since 12/8/1999 E.C. and recommended that 'she needs regular psychiatric follow-up and close family care and support'. The report of the hospital did not specify the level of the disability suffered by the patient; rather it simply explained that she needs family support and psychiatric follow-up.

[435] Tina, M., 'The Paradigm of supported decision making', Presentation in the Working Group on legal capacity and related issues of the International Disability Caucus, 2009; Mental Disability Advocacy Centre, 'Analysis of the Russian legal capacity system for persons with mental disabilities': Towards implementation of Article 12 of the CRPD, 2010; Jose, J. 'Legal capacity of persons with disabilities in the light of the CRPD', 2011

the ill-formed reports. This practice is against article 12 of the CRPD and article 371 of the Ethiopian Civil Code, in which the latter requires the court to pass decisions of interdiction tailored based on the functional limitations of the person.[436]

The denial of the legal capacity of the PWMDs interned in a psychiatric facility has also other far reaching consequences in the treatment process. Every patient has the right to participate in treatment planning as fully as possible.[437] The patient shall be present when the treatment plan is being written and contribute by identifying his preferred interventions, unless he refuses to do so.[438] The quality of the patient's participation in treatment may significantly affect her recovery process. This opportunity is reduced to meaningless by imposing non-consensual treatment as there is no any system for consent to treatment at Amanuel Hospital and Gefersa Rehabilitation Center. It is in limited cases that the care givers are communicated about the treatment plan. This is another trait of denial of the legal capacity of PWMDs in psychiatric institutions.

4.5 The Right to Legal Counsel

The right of access to legal counsel is traditionally guaranteed in connection with the right to fair trial in the determination of a criminal charge against a person.[439] As interpretations make clear however, a legal counsel should be provided for all detained persons, because access to a legal counsel is an important means of ensuring that the rights of detained persons are respected.[440] The Human Rights Committee has recognized that the right to counsel means the right to an effective counsel and that should be provided immediately up on detention.[441]

[436] Article 371 of the Ethiopian Civil Code permits courts, in pronouncing the interdiction or after such decision, to limit the effects of the interdiction by authorizing the interdicted person to do certain acts himself and to limit the tutor of the interdicted person from performing certain acts without the concurrence of the interdicted person.

[437] MI principles, Supra at note433, Principle 9, Para. 2.

[438] Geller, J., 'At the margins of human rights and psychiatric care in North America', *Acta Psychiatr Scand Suppl*. Vol. 399, (2000), pp87-92

[439] ICCPR, Supra at note 424, article 14(3)(d)

[440] The Human Rights Committee, Supra at note 417, General Comment No 13, Para 11, The Committee understands the right to legal assistance to be extended for all detained persons who can not defend themselves and could not afford a private lawyer. As submitted above, the Committee in its General Comment No 8, on the right to liberty and security of persons, it has subscribed admission to psychiatric facilities to detention that amounts to denial of liberty of a person. Thus, a person admitted to a psychiatric facility is entitled to be represented by a legal counsel of his own choice, if he is not in a position to hire his own lawyer.

[441] Ibid.

Under the first section of this chapter, on the right to liberty and security, it is pointed out that admission to psychiatric facilities amounts to detention for all practical purposes. This therefore imports a duty upon States Parties to provide a legal counsel for these persons who may be involuntarily admitted and treated in mental health facilities.[442] This is because, with out the involvement of a legal counsel, it will be hard to prove if the PWMDs have consented for admission, especially where they are involuntarily admitted. The role of the counsel is not however limited to representation of the persons at admission proceedings. Even after admission, there is a need to provide with legal counsel, because without the availability of such counsel, it is virtually impossible to imagine the existence of valid consent of the patients towards treatment, right to apply against involuntary admission to a review body, right to accept or to refuse treatment, or any aspect of forensic mental disability law. Especially where the persons lack capacity, their wishes and feelings should be given a room through the involvement of a legal counsel. As submitted above, there are tendencies to deny the legal capacity of PWMDs in psychiatric facilities. In such cases, appointment of a guardian or a tutor may not be sufficient to represent the persons on their rights in their stay in the facilities. In order to fill such gaps, the CRPD requires States Parties to take appropriate measures to provide access by PWDs to the support they may require in exercising their legal capacity.[443] One of such supports is to provide a legal counsel to help them effectively exercise their other human rights.

Lack of independent counsel and consistent judicial review mechanisms to PWMDs in psychiatric facilities is therefore another aspect of human rights violation. And the failure by the States Parties to provide a legal counsel is a violation of both the ICCPR, which mandates that they should provide a legal counsel for detained persons, and the CRPD, which requires States Parties to extend all necessary support for PWDs to fully exercise their legal capacity.

In Ethiopia, neither at Amanuel hospital nor at Gefersa Rehabilitation Center, there is any guarantee for legal counsel. There is currently no plan to employ a legal counsel at both institutions to ensure that all inmates who wish to be represented at admission, during treatment and release are put in touch with a legal counsel.[444] This left PWMDs at the psychiatric facilities prone to various forms of human rights violations ranging from involuntary admission to

[442] Ibid.
[443] CRPD, Supra at note 428, article 12(3)
[444] Interview with Dr Lulu, B., Supra at note 404 and Brother Erick, Supra at note 380

involuntary treatment and denial of legal capacity due to the absence of any legal counsel to represent them in the proceedings that determine all these issues.

4.6 The Right to Rehabilitation

The other right of PWMDs that is usually infringed at psychiatric facilities is the right to rehabilitation guaranteed under the CRPD.[445] The CRPD specifically requires States Parties

> "to take effective and appropriate measures including through peer support, to enable PWDs to attain and maintain maximum independence, full physical, mental, social and vocational ability and full inclusion and participation in all aspects of life".[446]

This in turn requires states to train professionals who can work in habilitation and rehabilitation services and making available assistive devices and technologies designed for PWDs.[447] The failure to provide PWDs appropriate services to ensure their integration into community life and enhance their independence runs thus afoul to the right to rehabilitation, guaranteed under the CRPD. Especially PWMDs who are interned in psychiatric facilities are as a matter of course delineated from the mainstream society and need to be rehabilitated as they lose ties either for short or extended time. This engenders obligations up on states to provide inmates with rehabilitative activities so that they can remain intact with the community and facilitate easy integration up on discharge from the facilities. This may include providing skill trainings and formal education and leisure time activities in the facilities.

At Amanuel Hospital and Gefersa Rehabilitation Center, a significant number of persons are seen lying in their beds or on the institution grounds, completely idle. In the absence of any support at rehabilitation, PWMDs lose ties with their families and communities over time and become more dependent on institutions. As a result, the system of indifferent institutionalization

[445] CRPD, Supra at note 443, article 26; See generally Janardhana, N. & Naidu, D. 'Inclusion of people with mental illness in community based rehabilitation: need of the day'. International Journal of Psychosocial Rehabilitation, Vol. 16 No. 1, (2012), pp 117-124; Corrigan, P. et al, 'Mental illness stigma and the fundamental components of supported employment', Journal of Rehabilitation Psychology, Vol. 52, (2007), pp 451-457

[446] Ibid. Article 26(1)

[447] Ibid. Article 26(2); Tsang, H., 'Applying social skills training in the context of vocational rehabilitation for people with schizophrenia', Journal of Nervous and Mental Disease, Vol.189, (2001), pp 90-98; Provencher, H. *et al*, 'The role of work in the recovery of persons with psychiatric disability', Psychiatric Rehabilitation Journal , Vol. 26, (2002), pp132-144

diminishes rehabilitation, contributes to the chronicity of illness and increases disabilities, making it all the more difficult for these individuals to reintegrate into the community. The Gefersa Rehabilitation Center, counter to its name, does not have any leisure time facility for rehabilitation; *inter alia*, with no free to access radio, newspapers and any skill trainings. The residents of this Center are often provided with little or no appropriate stimulation, like sporting activities or refreshment services. Moreover, there are no any religious institutions in the compound to help the patients freely practice their religion or belief. Thus, the environment at the facility is dulling that it does not help much in rehabilitating PWMDs that were meant to be rehabilitated. While the Center has no proper fencing, the mobility of the inmates is surprisingly *laissez faire* that the inmates do even import khat in and many of them spend their day chewing khat[448]. This is another challenge to rehabilitation as this exposes them to substance abuse. Few of them are seen at the immediate highway wandering and begging for money and food. These persons may abscond altogether and may not come back to the Center in the absence of any organized follow up on their movements outside of the compound. This may ultimately lead them to remain on the streets in the absence of any viable communication between the families and the Center to follow up their whereabouts.

As pointed out above, at Amanuel Hospital, the inmates spend their day being closed in the hospital's compound with no activities, or being provided with a television as the only means of entertainment. In this kind of dulling environment, the social and other skills of institutionalized individuals deteriorate. Therefore, a patient who spends longer time at this hospital may finally forget his social and technical skills, which limits his chance of rehabilitation.

Both at Amanuel Hospital and Gefersa Rehabilitation Center, with family visitors being rare, communication with the outside world must be maintained through letters and phone calls. The author did not find any evidence of phone communications and postal service at Gefersa Rehabilitation Center.[449] Many of the patients at Amanuel Hospital request any passerby a favor to get a phone call to families. All inmates are permitted to use public-payphones although there

[448] Interview with Shibabaw, W., Supra at note 383

[449] Even though many of the inmates at Gefersa Rehabilitation Center do not afford a family visit, the schedule for family visit, unlike other facilities of public health, is at working days of the week. This will affect the tendency of the families to come to the Center as they would be occupied with their own routine life. This severs the relationship between the inmates and their families, which ultimately affects the right to rehabilitation of the persons with mental disabilities as their familial link is severed.

is only one to cater for more than 360 residents, and to use mobile phones although this is only feasible for those who can afford to pay the bill. This limitation on the inmates to keep contact with families would obviously affect their rehabilitation process and easy integration in to the community up on release from the institutions.

Here, rehabilitation may suffer from financial arguments as it is a budget intensive project. However, if there is the political will, the budget flowing to other administrative works can be diverted to the rehabilitation services that can fill the gaps with fund. For instance, Amanuel Hospital in its 2003 and 2005 E.C budget years, has allocated 90% of its budget to administrative and medical matters, leaving rehabilitation services with less consideration.

4.7 The Right to Privacy

Privacy is a broad concept ranging from informational and physical to proprietary and decisional circles of a person's life.[450] Apart from the investigative intrusion in crime suspects, it is an ideal of biomedical ethics for the conduct of clinical research and administrative practices relating to physical and behavioral health. There is wide consensus about the importance of medical confidentiality, modesty and bodily integrity in all health settings; but substantial philosophical disagreement about the limits of personal autonomy or individual choice in fields relating to human reproduction and genetics.[451] Be this as it may, privacy is protected as a right under many provisions in international, regional and national human rights instruments.[452] The relatively detailed standards on the content of the right are forwarded by the Human Rights Committee commenting on article 17 of the ICCPR.[453] The Committee recognized that the protection of privacy is necessarily relative as all persons live in society but any intrusion to any one's private

[450] Allen, A., "Privacy and medicine", The Stanford Encyclopedia of Philosophy, (2011), Edward N. (ed.), available at http://plato.stanford.edu/archives/spr2011/entries/privacy-medicine/, accessed on July 21, 2012.

[451] Ibid.

[452] Article 12 of the UDHR and article 17 of the ICCPR, which state that "no one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence...", Very similar wording is used in article 14 CMW protecting migrant workers and their families from arbitrary interference with their family life and privacy and Article 16 CRC protects the right to privacy; Article 22 of the CRPD also imposes a duty on states to respect the privacy of persons with disabilities against arbitrary or unlawful interference with his or her privacy, family, home or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation, regardless of place of residence or living arrangements. The ACHPR does not explicitly set out the right to privacy, but Article 18 attaches particular importance to the state's duty to protect the family. Finally, the FDRE Constitution has a guarantee for the privacy of individuals under its article 26

[453] Human Rights Committee, Supra at note 442, General Comment 16, The right to respect of privacy, family, home and correspondence, and protection of honour and reputation, (article 17), 32nd session, 1988, Para 7

life should be essential in the interests of society as understood under the Covenant.[454] The Committee therefore requires states to take effective measures

> "to ensure that information concerning a person's private life does not reach the hands of persons who are not authorized by law to receive process and use it, and is never used for purposes incompatible with the Covenant."[455]

Under article 22 of the CRPD too, there is a guarantee that "no person with disabilities, regardless of place of residence or living arrangements, should be subjected to arbitrary or unlawful interference with his or her privacy". The Convention recognizes that PWDs have the right to the protection of the law against such interference or attacks.

PWMDs interned in psychiatric facilities whose liberty is limited as a matter of course are prone to intrusion with their privacy. Therefore the other most pervasive violation of human rights in psychiatric facilities is the violation of the right to privacy. The inmates may be forced to live for years in common wards where their privacy may be compromised and may not find a moment of privacy. They may have no secure place to put their personal possessions and have no privacy when bathing or toileting. Intimate meetings with friends, family, or even a spouse may be restricted. The MI Principles taking this in to account has set standards of respect of their privacy.[456] The WHO's Guidelines designed to assess the application of the UN Principles recognizes the indicators for respect of the right to privacy in psychiatric facilities inter alia, whether toilets and bathrooms can be locked from the inside, whether body inspection and urine screening respect the full privacy of the person.[457] The importance of providing patients with lockable space in which they can keep their belongings should be underlined as the failure to provide such a facility can impinge upon a patient's sense of security and autonomy. All personal data relating to an inmate should be considered to be confidential. Such data may only be collected, processed and communicated according to the rules relating to professional confidentiality and personal data collection.

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[454] Ibid.
[455] Ibid.
[456] MI principles, Supra at note 437, Principle13 (1) protects the right to privacy, freedom of communication, and private visits.
[457] Guidelines for the promotion of the rights of persons with mental disorder , WHO/MNH/MND/95.4, Geneva, (1996) available at www.who.int/mental_health/media/en/74.pdf , accessed on July 6, 2012

At Amanuel Hospital and Geferssa Rehabilitation Center, there are many evidences that show violations of the right to privacy. The use of large-capacity dormitories at average 20 persons deprives patients of all privacy. There is no provision of lockers and bedside tables, individualization of clothing. Inmates hide their few personal possessions in their clothing because there is no other safe place to keep them. Diagnoses are routinely discussed in front of other residents. Inmates at Gefersa Rehabilitation Center must use the toilet and take showers supervised by staffs. The Center's workers say this is necessary to prevent patients from harming themselves or others however it may be embarrassing to the inmates.

The inmates at both institutions are discouraged from forming romantic relationships with one another within the institution. Many staff members were adamant that inmates were not interested in forming intimate relationships; saying that they are asexual as a matter of course. As a result of this distorted view, inmates' right to sexual autonomy is extensively prohibited, and there are no efforts to educate them about relationships and healthy sexual behaviour.

4.8 The Right to Community Integration

The other guarantee for PWMDs is the right to live and be treated in the community.[458] This includes the right to participation in political and public life. In the case of PWMDs in psychiatric facilities, this is to mean, at least that they should not live for life in institutions and they should be integrated to the community when they have recovered and promoted to coexist and live independently in the community. This requires creating a concerted effort towards reunion with families and former employers so that they can comeback to their previous life. This may not be welcomed by families and employers due to the deep prejudice and stereotype in which the community hardly accept that these persons have recovered and can maintain their

[458] CRPD, Supra at note 447, under article 19 as part of a guarantee to live independently, States Parties have undertaken to 'take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that;
a. Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
b. Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
c. Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs'.
The MI principles, Supra at note 456, Principle 3 states that: 'Every person with a mental illness shall have the right to live and work, to the extent possible, in the community.'

normal life.[459] Some families even hesitate to recognize that the person belonged to their family.[460] The recent efforts of the Gefersa Rehabilitation Center to reunite the relatively recovered persons to families have been less successful for the consistent denial and rejection by the families and the employers.[461] As a result many inmates in this Center have lived for about 20-30 years with no hope of going back to their families. The recently admitted inmate at the Center has at least lived for two years. Those first inmates interned in the Center at its establishment are found there in not few numbers with about thirty years with no prospect of leaving the Center as they have nobody to welcome outside. These people are surely fit to live in the community as they personally witness.[462] They tell the stories of their former mates who left the Centre who are now living in the streets completely insane as they have no families to take care of them. This is an alarm for them not to leave the Center. A testimony of one of the inmates goes as:

> *"*I have stayed for 22 years in this Center. Before ten years, after I recovered somewhat, I left this Center and tried to join with my families at Addis Ababa. I found my father and mother dead. I became a refugee with my aunt, albeit short lived. She finally pushed me out of her home and I returned to this Center. Now I have adapted myself to this Center as my home, and I have no any hope to leave."[463]

These persons are still subjected to long-term and even permanent institutionalization in this Center in an isolated environment set apart from established communities. This has placed a formidable obstacle against the right to integration of PWMDs interned in psychiatric facilities in to the community, and the right to be treated in a least restrictive environment. The newly developed admission standard by the Center sets down that a person will be admitted only if there is a family pledge that they will take the person back after three moths. This limits the

[459] Bruce, G. et al, 'The social rejection of former mental patients: Understanding why labels matter', American Journal of Sociology, (1987), Vol. 92, No. 6, pp1461-1500.
[460] Interview with Brother Eric, Supra at note 444
[461] Ibid.
[462] Interview with Zegeye, H., an inmate at Gefersa Rehabilitation Center, interviewed on July 9, 2012, Gefersa. The interviewee believed that he is healthy enough to live in the community but he is living in the Center for he has no body to welcome him as a family or employer. This is a manifest lack of a system for community integration for persons with mental disabilities. The greater challenge that has frustrated the manager of the Center is this lack of a system for community integration in which even after the persons have recovered and fit to live and be treated in the community
[463] A personal testimony of a 35 years old inmate at the Center, interviewed on July 9, 2012, Gefersa.

access to other persons who can not afford this family pledge. Moreover, in a center which is understaffed, it does not seem realistic that a person shall be discharged in three months.[464]

4.9 Conclusion

The human rights conditions in the psychiatric facilities in Ethiopia under study divulged that, behind the closed doors, PWMDs are languishing under severe human rights conditions. These violations of human rights are committed at the state established institutions which admit persons for treatment. The lack of guarantees against involuntary admission amounts to denial of the liberty and security of persons. This is against the guarantees of due process of law under the host of instruments that Ethiopia has ratified, inter alia, the ICCPR, ACHPR and the CRPD and the FDRE Constitution. The non-consensual treatments and the continued use of ECT are considered ill treatments or at the worst torture. The degrading conditions and ill treatments in the institutions are thus afoul to the prohibition to torture and all other forms of ill treatment. The arbitrary deprivation of privacy coupled with denial of the legal capacity of the inmates is a failure of the State in protecting and respecting the human rights of PWMDs. The lack of rehabilitative services and a system for community integration has destined the life of these persons at institutions with little or no hope of joining back the mainstream society and engage in an independent life. This too, contravenes the obligations Ethiopia has undertaken towards PWMDs under the CRPD.

And for what is worse, there is a complete lack of any type of human rights oversight and monitoring body in terms of overseeing and reporting these human rights violations in the country. Though the National Human Rights Commission has the mandate to supervise these facilities, it has never paid a visit to any of these facilities. This is an insult to the injury for PWMDs in psychiatric facilities as there is little prospect of airing out their sufferings to the international community and the human rights bodies of the UN and the AU. This gives leverage for the institutions to keep on working out of mere intuition without considering the human rights they are violating of PWMDs. Much of these are committed out of ignorance of the persons at duty about the human rights of PWMDs.

[464]This Center has now only two psychiatric nurses and three health assistants. To fill this gap of the human resource, the manager said that the he has asked the Ministry of Health and the Ministry of Civil Service for recruitment of one psychiatrist, 16 psychiatric nurses, a psychologist and an occupational therapist.

CHAPTER FIVE

5. CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The international standardization of human rights is traced to1948 with the adoption of the UDHR. Consequently, the international community has developed a series of international and regional undertakings aimed to respect, protect and fulfill human rights. Unfortunately, a tool to advance the rights of PWDs including PWMDs for longer time has not been developed in the necessary pace. This lack of safeguard in the international human rights regime added to the pervasive discriminations and stigma they face in the community exposed these persons to various forms of violations on their freedom and human dignity.

Gradually, the international community moved on to recognize the concerns of PWDs and adopt various forms of human rights instruments at the UN level. Regional human rights systems have also adopted additional human rights protections to their respective geographic regions. Especially the adoption of the CRPD is considered a 'new dawn' to the protection of PWDs, which equally applies to PWMDs in introducing a new paradigm towards the approach and protection of the rights of PWDs with new sets of measures. These systems have incrementally formulated a body of law that protects and promotes the human rights of PWMDs. These series of agreements have collectively helped the development of recognizable human rights standards at the international and regional levels with a potential to put an end to ongoing human rights violations against PWMDs.

In this study four research questions are raised. These are the obligations of Ethiopia towards the protection of the human rights of PWMDs based on international and regional human rights systems, the level of access to mental health care services as a human right in Ethiopia, the human rights conditions of PWMDs in psychiatric facilities and the system of discharge from the psychiatric institutions and community integration of PWMDs. These issues are addressed in their order based on desk and field research. Reliable methodologies involving interviews and personal observations constitute to probe the relevant information to answer the research questions. Based on this, the following conclusions are drawn.

Ethiopia has a good record of adopting international and regional undertakings since the formation of the UN. It is a signatory to the core UN human rights instruments and the African human rights instruments which engender binding obligations on States Parties. Among these, many of them impose directly or indirectly the obligation to respect, protect and fulfill the rights of PWMDs. Ethiopia has thus agreed to respect, protect and fulfill the rights enunciated there in through the measures of implementation, especially in the CRPD, which is the pertinent human rights instrument on the rights of PWMDs. While there are some domestic laws before ratification by Ethiopia of these international and regional human rights instruments, there have been also newly adopted and amended laws which have a direct implication on the respect of the rights of PWMDs.

Despite the concerns of PWMDs have received a new momentum and dozens of agreements are undertaken, PWMDs around the world are exposed to a wide range of human rights violations. The stigma and the discrimination they face pushed them out of the society and PWMDs could not receive the care they require. In some communities, PWMDs are pushed to the edge of town out of the view of the community. In Ethiopia too, the human rights conditions of PWMDs remains dire and bleak. Mental illness and disabilities contribute a significant burden of disease and disabilities respectively globally, more so in Ethiopia. These figures are even worse in Ethiopia, where no community-level intervention exists to reduce the burden of mental illness and disabilities. As in many other countries, the prejudice against PWMDs is the main reason underlying the problems with their human rights. Another important reason is the economic difficulties.

Among other rights, the right to access to mental health services suffers from many problems with far reaching implications on human rights of PWMDs. There is an enormous disparity between mental health and general health services, disproportionate to the burden and disability arising from mental illness. The absence of neither any special law nor a policy on mental health and the treatment of PWMDs in psychiatric facilities coupled with the lack of awareness about mental illness has exposed to discrimination of and stigma towards PWMDs. As a result, it is not surprising that the majority of PWMDs remain untreated, despite the fact that an effective treatment exists. Due to the inadequacy of services, many individuals who were unable to access these institutional facilities were left to roam the streets and paths of the cities and villages and

face the mocking and ridicule of others. It is estimated that over 85 per cent of PWMDs in Ethiopia do not receive any sort of care. Those with family support were taken to religious organizations and traditional healers with an effort to get a cure which would often subject their patients to all manner of treatment which often proved harmful. And many more go through life believing that it is normal to suffer as they do.

In fact the obligation to provide highest attainable standard of health is supposed to be progressively realized as it is resource dependent. But in Ethiopia, the amount of budget allocated to the sector is significantly disproportionate to the burden of disease and disabilities caused by mental illnesses. The disparity is also visible when compared to the budget allocated for physical health. It is less than 1% of the total health budget forwarded to the mental health services, while 15-17% of diseases in the country are caused by mental illnesses. As a result of this lack of budget, the number of facilities and human resource giving mental health care are very much limited in the country. The existing ones are concentrated in the capital city and in some few cities of the country. Besides the geographic inaccessibility, the lack of access to information has caused limited awareness towards modern mental health care in the community. Even though the public psychiatric facilities are offering an affordable service, the private ones are expensive which are not economically accessible for many of the service seekers.

The reason the government continues to give limited attention to mental health in the health services might be attributed to the perception that mental illnesses do not have imminent risk of death or disabilities. Quite to the contrary, mental illnesses are killing and disabling many people equally with other physical illnesses. The Ethiopian government has therefore failed to provide accessible mental health services to PWMDs. Perhaps most importantly, this failure will cause the substantial burden of untreated mental illnesses, thereby importing other human rights violations for one of the most vulnerable and marginalized subgroups in the society. This is failure to comply with the international obligations and constitutional guarantees to the "highest attainable standard of health", a right that includes access to quality mental health care.

In general, mental health services in Ethiopia are at an alarming stage and the government has not fulfilled its obligation to meet the rights of PWMDs to have access to mental health care which is not encumbered with geographic, economic and information barriers. This is a violation

of the obligations undertaken under the international and regional human rights instruments including the ICESCR, CRPD and ACHPR.

While the concern of access to mental health services is not resolved, the facilities which are giving psychiatric care are not free from scrutiny either. It is found out in this study that PWMDs in psychiatric facilities are not in better condition. A number of human rights violations of PWMDs are perpetrated at the institutional level and result in suffering that are very difficult or even impossible to repair.

In the first place, there is no any legislation in place to determine lawfulness of involuntary admission of PWMDs to psychiatric facilities, which is equated to detention. This is a violation of due process rights which is a basic constitutional guarantee for every individual. There is no independent hearing available after one has been involuntarily placed in a hospital against his/her will either. The lack of any legislative guarantees in psychiatric settings for PWMDs causes a number of implications that imports human rights violations. The lack of any guarantee against involuntary admission facilitates denial of the liberty and security of persons. A person who is interned involuntarily shall stay in the institution for indefinite time until a psychiatrist decides for his release. The misuse of physical restraints in these facilities is another form of the violation of the right to liberty and security of PWMDs. There are no protections against torture and other forms of degrading treatment or punishment. The administration of treatments that violate human dignity through unmodified ECT and non-consensual medications constitute a degrading treatment to say the least and, at worst, torture. The failure to protect PWMDs from degrading conditions and ill treatments in the institutions are afoul to the prohibition of torture and all other forms of ill treatment.

The lack of rehabilitative services and a system for community integration has destined the life of these persons at institutions with little or no hope of joining back the mainstream society and engage in an independent life. This too, contravenes the obligations Ethiopia has undertaken towards PWMDs under the CRPD. Because, these persons forgot any of their skills they had or not developed one when they left the institutions. This will compromise easy integration and rehabilitation as they will be with no economic means to survive in the community. The arbitrary deprivation of privacy coupled with denial of the legal capacity of the inmates is another trait of failure of the government in protecting and respecting the human rights of PWMDs.

The above situations are aggravated due to the complete lack of any type of independent human rights oversight and monitoring body in terms of overseeing and reporting these human rights violations in the country. This is an insult to the injury for PWMDs in psychiatric facilities as there is little prospect of airing out their sufferings to the international community and the human rights bodies of the UN and the AU. This gives a "blank cheque" for the institutions to keep on working out of mere intuition without considering the human rights they are violating of PWMDs.

State responsibility triggers in these cases where it fails to exercise due diligence in fulfilling the rights, in bringing an end to practices that infringe human rights of PWMDs and its failure to providing sanctions against perpetrators and remedies to victims. This shows a violation of the three typologies of obligations engendered from the human rights undertakings. The failure to stop perpetration of the various forms of human rights violations including denial of liberty and security, torture, ill forms of treatments, denial of legal capacity, arbitrary deprivation of privacy in psychiatric facilities is a failure of the 'duty to protect' from its own machineries. The arbitrary and involuntary detention at psychiatric facilities deprives the rights to liberty and security of PWMDs which constitutes the violation of the 'duty to respect'. Finally, the failure of the government to provide an adequate standard of mental health services for PWMDs is a violation of the 'duty to fulfill' which requires governments support affirmative efforts to ensure, for example, that they adequately provide mental health services in the community setting, make efforts to educate the public about mental disability. Thus, individuals could hold the government accountable pursuant to the right to health for failing to provide an adequate standard of health with in the economic capacity of the State and for its failure to impose or enforce sufficient standards and regulations on the conditions of PWMDs living in mental health care facilities and rehabilitation facilities.

In a nutshell, the human right of PWMDs in Ethiopia is an area that lost relevant attention by the policy makers and health planners of the government and the psychiatric facilities which are extending care and support. This has left them to languish as marginalized and vulnerable sections of the society and there is no green light to change this reality around the government and the psychiatric facilities. The health budget of the country is still being directed at preventing communicable disease and other endemics and pandemics. It is less than 1% of the health sector

budget that is directed to mental health. Civil societies and international funding organizations are preoccupied with the communicable diseases. The psychiatric facilities are apathetic about the human rights of their inmates. These people living behind the closed doors are suffering from multiple forms of human rights violations while the government and other concerned bodies at the regional and international level give deaf ears. This continued neglect of this group of people will obviously impact on the general human rights record of the country.

5.2 Recommendations

International human rights law creates obligations on States to protect the rights of all PWMDs including the right to health and all other human rights that every individual is entitled with. In order to promote and protect the rights of PWMDs to access the best attainable standard of health and their civil and political rights be respected at psychiatric facilities, different stakeholders should be reminded of what should be done within their respective mandates. These bodies are the government of Ethiopia, the psychiatric facilities: Amanuel Hospital and Gefersa Rehabilitation Center

I. Recommendations to the National Government

- Comprehensive and timely disaggregated data on prevalence of mental illness and disabilities need to be developed and made available to the stakeholders to provide indicators of need for this significantly marginalized group.
- The Ministry of Labor and Social Affairs currently does not classify PWMDs in the category reserved for PWDs and there is no special legal protection and social safety net mechanism in place in Ethiopia for individuals with such disabilities. The government should therefore harmonize and standardize the definition of PWDs with article 1 of the CRPD to include PWMDs.
- The government should work to change attitudes and raise awareness towards mental disabilities though print and broadcast media and different forms of public mobilization. The commemoration of the World Mental Health Day should be widely celebrated across big cities every year. The education of the public should be given prominence in the promotion of the rights of PWMDs as many aspects of mental disabilities require the active collaboration of the community. Community rehabilitation of the mentally ill is an important example. Community understanding is thus important in actions aimed at

reducing stigma and discrimination. In Ethiopia, the family remains an important resource for the support and care of PWMDs and these families should not suffer rejection and lack of understanding by the community. Therefore, the government should strive in educating and changing public attitudes towards mental illness and disabilities and in advocating for the rights of PWMDs

- An enforceable mental health law consistent with international human rights standards should be adopted; this law should protect against arbitrary involuntary admissions and should provide a right to a hearing in all cases of involuntary treatment. Individuals should have a right to counsel at these hearings. These laws and policies should promote the rights of PWMDs to empower themselves to make choices about their lives, provide them with legal protections and ensure their full integration and participation into the community. The right to independent and periodic reviews of all involuntary commitment orders, the right to an individualized treatment plan and all other internationally recognized mental disability rights instruments should be addressed by this law or policy. Persons should also have access to complaints mechanisms in cases of human rights violations.
- The government should support the creation and strengthening of mental health service users and families organizations. Such groups are in the best position to highlight problems, specify their needs and help find solutions to improving mental health in the country and have a crucial role to play in the design and implementation of policies, plans, laws and services.
- The government should dedicate more health budget to mental health. Investment in mental health will be useful in bridging the service gap in these areas, enabling the provision of care at different levels. Budgeting for increased training of mental health personnel, improved infrastructure, hiring more staff, and providing medications and other resources must be prioritized if we are to bring change on the burden of mental ill health and mental disabilities.
- All institutions should be opened up to public oversight in accordance and independent human rights monitoring agency should be created to conduct on-site inspections, inspect patient records; publish their findings and report to the House of Peoples Representatives. As part of a system of independent human rights oversight, provisions should be made

for reporting violent incidents, as well as every death in institutions to a human rights oversight body. The oversight body should have the power to investigate the causes and circumstances surrounding a death.

- The government should encourage NGOs to create a mechanism for collaboration between these agencies, since there is extensive overlap in the population of persons who receive services from the two government agencies.
- CSOs and Charities registered as foreign and Ethiopian residents are prohibited from engaging in human rights and advocacy works based on the CSOs and Charities Proclamation. This has substantially reduced the capacity of CSOs working on human rights and advocacy work. But as shown above in the study, PWMDs are vulnerable sections of the society and many CSOs are not working actively on the rights of PWMDs. The government should therefore amend the law so that foreign and Ethiopian resident CSOs and Disabled Persons Organizations (DPOs) could work on the promotion of the human rights of PWMDs.
- Finally, in order to shift from an institutional-based system to a community-based system of care i.e. deinstitutionalization, the government should embark building community awareness and treatment mechanism based on the mental health strategy document adopted at the national level.

II. Recommendation to Psychiatric Facilities

Immediate action should be taken to end the human rights violations taking place in institutions identified in the study.

These include:

- The arbitrary involuntary internment of PWMDs should be stopped. For persons who can not consent to admission, a review body should be established to oversee the need for involuntary internment.
- Enforceable standards protecting a broad array of rights in institutions, such as protections against involuntary admissions, improper seclusion and restraint should be established in accordance with international human rights standards; until such time as

the Ethiopian parliament adoptes such a law. These policies should be widely disseminated to staff and patients in institutions.

- Unmodified ECT should be banned in all circumstances; ECT should be used only with the informed consent of the patient and with the right to refuse the treatment.
- The use of ECT should be stopped where there is no clinically proven justification in accordance with internationally accepted professional standards.
- The improper use of physical restraints, such as tying to beds and other inhuman forms of restraints should be stopped; professional attention and behavior programs should be provided to assist all aggressive inmates.
- Rehabilitation services and low-cost interventions to provide freedom of movement, stimulation, human interaction and recreation should be provided. All persons admitted in institutions should be provided with regular activities and opportunities to participate in recreation, sports, cultural life, and other forms of stimulation. Skill trainings should be provided for those capable of doing so. Recruiting outside volunteers and NGOs to assist in these activities can be particularly valuable.
- Adequate access to telephones and writing materials, envelopes and stamps so that inmates can have private conversations in order to remain in contact with friends and family, and retain/regain contact with their communities should be ensured. Moreover, there should not be interference of any kind with correspondence to/from residents of the institutions.
- All staff working within the respective institutions should be provided with human rights training; the National Human Rights Commission, NGOs working on human rights, including representatives of PWMDs and former inmates and family members, should be involved as trainers.
- Human rights committees should be created at each institution that includes current and former inmates, as well as members of the community. These committees should have full access to all parts of institutions and they should be provided with funding independent of the institutions.

BIBLIOGRAPHY

I. Books.

- Abrams, R., Electro-convulsive therapy, 3rd ed., Oxford University Press, New York, (1997)
- Albert, B. (ed.), In or out of the mainstream? Lessons from research on disability and development cooperation, Leeds: The Disability Press, (2006)
- Andrew, B. *et al*, From exclusion to equality, Handbook for parliamentarians on the CRPD and its Optional Protocol, United Nations Office of the High Commissioner for Human Rights, Geneva, (2007)
- Barnes, C. and Mercer, G. (eds.), Implementing the social model of disability: Theory and research, (2004)
- Benedetto, S. (eds.), Increasing access and use of psychotropic medicines, WHO, (2005)
- Brand, D. and Heyns, C. (eds.), 'Socio-economic rights in South Africa', Pretoria: Pretoria University Law Press, (2005)
- Breslin, M., and Yee, S, (eds)., Disability rights law and policy- international and national perspectives, Ardsley, Transnational, (2002)
- Bryan, A., Black's law dictionary, 8th ed., (2004)
- Campbell, J., and Oliver M. Disability politics: understanding our past, changing our future, London, Routledge, (1996), as cited in World report on disability, (2011)
- Catherine, A. *et al* (eds.), Disabilities, Insights from across fields and around the world, Vol. 1, (2009)
- Charlton, J., Nothing about us without us, Berkeley, Los Angeles, London: University of California Press, (1998)
- Coleridge P., Disability, liberation and development, Oxfam and ADD, London, (1993)
- Desjarlais, R, *et al*, World mental health, problems and priorities in low-income countries, New York: Oxford University Press, (1996)
- Doris F., Disability rights movement: from charity to confrontation, Temple University Press, (2000)

- Elwan, A. Poverty and disability: A survey of the literature, a background paper for the World Development Report, World Bank, December 18, 1999.
- Eric, R. & Clarence J**.** Human rights in national mental health legislation, Department of Mental Health and Substance Dependence, WHO, (2004);
- Frank, G. and Glied A., Better but not well: Mental health policy in the United States since 1950, Baltimore: The Johns Hopkins University Press, (2006)
- Gabrielle, M. & Olivia, S. (eds.), Torture and other offenses involving the violation of physical and mental integrity of the human person, in substantive and procedural aspects of international criminal law, (2000)
- Gearty, C. and Mantouvalou, V., 'The case for social rights, debating social rights', Oxford: Hart Publishing (2010);
- Giampiero, G. and Francesca, O. (eds.), Training manual on the human rights of persons with disabilities, Ulaanbaatar, (2007)
- Hales, G. (ed.), Beyond disability: Towards an enabling society, London: Sage in association with the Open University, (1996)
- Horowitz D., 'The Courts and social policy', Washington D.C., Brookings Institution, (1977).
- Ingstad, B. and Whyte, S. (eds.), Disability and culture, Berkeley, California, (1995), University of California Press;
- Joseph, P., People with disabilities forging a new civil rights movement, Three Rivers Press, (1994)
- Kleinman, A, and Cohen, A., World mental health: problems and priorities in low income countries. New York: Oxford University Press, (1995)
- Len B., (ed.) 'Disability and society: Emerging issues and insights', (1996), Longman
- Liz, C., Including all of our lives: Renewing the social model of disability, Encounters with strangers, Ed. Jenny Morris, Women's Press, (1996)
- Luke, S. 'Public perceptions of disabled people evidence from the British social attitudes survey', (2009)
- Marianne S., Understanding the UN Convention on the Rights of Persons with Disabilities, 3rd edition: (2010),

- Marrianne, S., A Hand book on the human rights of persons with disabilities, understanding the UNCRDP, July, 2010
- Melton *et al*., Psychological evaluations for the courts: A Handbook for Mental Health Professionals and Lawyers, (1997)
- Melvyn, F., *et al*, The WHO resource book on mental health, human rights and legislation, Geneva, (2005
- Moore, S., Social welfare alive, UK, Stanely Tornes Ltd, (2002)
- Paterson, K., The social model of disability and the disappearing body: Towards a sociology of impairment disability and society, (1997)
- Raymond L., 'The development and critique of the social model of disability', University of East Anglia, January, (2001)
- Shakespeare, T. and Watson, N., The social model of disability: Elsevier Science Ltd, Vol. 2, (2001)
- Stone, A., The disabled state, (1984)
- The World Health Report, Mental health: New understanding, new hope, Geneva, WHO, (2001)
- Thomas, C. Female forms: experiencing and understanding disability. Buckingham, Open University Press, (1999)
- Thomas, C., Sociologies of disability and illness: Contested ideas in disability studies and medical sociology, Basingstoke, Palgrave Macmillan (2007)
- Thomas, S., 'Ideology and insanity: Essays on psychiatric dehumanization of man', Syracuse University Press, (1991)
- Vikram, P. *et al*., "Stressed, depressed or bewitched? A perspective on mental health, culture and religion," in 'Development for Health', Oxford, UK: Oxfam (UK and Ireland), (1997)
- Watson ,N. *et al,* The Routledge handbook of disability studies, London: Routledge, (2012)
- Whiteneck, G. Conceptual models of disability: Past, present and future**,** Washington, DC (2006)

II. Articles

- Alem, A., *et al*, 'The prevalence and socio-demographic correlates of khat chewing in Butajira, Ethiopia', *Acta Psychiatrica Scandinavica, Supplementum*, Vol. 397, (1999)
- Alem, A., 'Human rights and psychiatric care in Africa, in particular in Ethiopia', *Acta Psychiatrica, Scandinavica* ISSN 0902-4441, Munksgaard , (2000)
- Alem, A. *et al*, 'Community-based mental health care in Africa: mental health workers' views', World Psychiatry. February, Vol. 7, No.1, (2008)
- Amita, D., 'Constructing a new human rights lexicon: Convention on the Rights of Persons With Disabilities', *Sur International Journal on Human Rights*, Vol. 5, No. 8, São Paulo, June, 2008
- Au, K., and Man, D., 'Attitudes toward people with disabilities: a comparison between health care professionals and students', *International Journal of Rehabilitation Research*, Vol. 29, No. 2, (2006)
- Awas, M. *et al*, 'Major mental disorders in Butajira, Southern Ethiopia', *Acta Psychiatrica Scandinavica, Supplemen*t, Vol. 99, (1999)
- Brandt, R., 'The mental health of people living with HIV/AIDS in Africa: a systematic review', *African Journal of AIDS Research*, Vol. 8, No. 2, (2009)
- Brisenden, S., "Independent living and the medical model of disability", *International Journal of Disability and Society*, Vol. 1, No. 2, (1986)
- Bruce, G. *et al*, 'The social rejection of former mental patients: Understanding why labels matter', *American Journal of Sociology*, Vol. 92, No. 6, (1987)
- Champine, P., 'The sanist will', *New York Law School Law Review*, Vol. 46, No.547, (2003)
- Corrigan, P. *et al*, 'Mental illness stigma and the fundamental components of supported employment', *Journal of Rehabilitation Psychology*, Vol. 52, (2007)
- Debora D., 'Disability, human rights and justice', *Sur International Journal on Human Rights*, Vol. 6, No. 11, December, 2009
- Demyttenaere, K. *et al*, 'WHO world mental health survey consortium: Prevalence, severity, and unmet need for treatment of mental disorders in the WHO', World Mental Health Surveys, *Journal of the American Medical Association*, (2004)

- Fekadu, A. *et al,* 'Alcohol and drug abuse in Ethiopia: past, present and future', *African Journal of Drug and Alcohol Studies*, Vol. 6, No.1, (2007)
- Gable, L. and Gostin, O., 'Global mental health: changing norms, constant rights', *Georgetown Journal of International Affairs*, Vol. 1, (2008)
- Gable, L. and Gostin, O., 'Mental health as a human right', *Wayne State University Law School Research Paper*, No. 09-15
- Geller, J., 'At the margins of human rights and psychiatric care in North America', *Acta Psychiatr Scand Suppl*. Vol. 399, (2000)
- Gloppen, S., 'Legal enforcement of social rights: Enabling conditions and impact assessment', *Erasmus Law Review*, Vol. 2, Issue 04 (2009)
- Goldman, H., 'Implementing the lessons of mental health service demonstrations: human rights issues', *Acta Psychiatr Scand* :, Munksgaard, Vol. 101, (2000)
- Gostin, L. and Gable, L., 'Mental health as a human right: People and groups at risk', *Maryland Law Review*, Vol. 63(1), (2004)
- Gostin, O., 'From a civil libertarian to a sanitarian', *Journal of Law and Society*, Vol. 34 (2007)
- Gutheil, T. 'Observations on the theoretical bases for seclusion of the psychiatric inpatient', *American Journal of Psychiatry*, Vol. 135, *(*1978)
- Héyer, G. 'On the justification for civil commitment', *Acta Psychiatr Scand*, Vol. 101, (2000)
- Hunt, P., and Mesquita, J., 'Mental disabilities and the human right to the highest attainable standard of health', *Human Rights Quarterly*, Vol. 28, (2006)
- Hurme, S., "Current trends in guardianship reform", *Maryland Journal of Contemporary Legal Issues*, *(*1995-1996)
- Jacob, K., *et al*., 'Mental health systems in countries: where are we now?' *The Lancet*, Vol. 370, (2007)
- Janardhana, N. & Naidu, D. 'Inclusion of people with mental illness in community based rehabilitation: need of the day', *International Journal of Psychosocial Rehabilitation*, Vol. 16 No. 1, (2012)

- Janet, E., 'Shared Understanding or consensus-masked disagreement? The anti-torture framework in the CRPD', *Loyola of Los Angeles International and Comparative Law Review*, Vol. 33, No 27, (2010)
- Jarlath, C., 'The UN disability convention and its impact on European equality law', *The Equal Rights Review*, Vol. 6, (2011)
- Jeff, F. *et al*, 'How definition of mental health problems can influence help seeking in rural and remote communities', *Australian Journal of Rural Health*, Vol. 8, Issue 3, (2000)
- Jerry, A., **'The Development of the disability rights movement as a social problem solver',** *Disability Studies Quarterly*, Vol. 23, No. 1, (2003)
- Jheelan, N., 'The enforceability of socio-economic rights', *European Human Rights Law Review*, Issue 2, (2007)
- Johannes, R., et al, 'Relationships between psychiatric conditions and behavior problems among adults with mental retardation', *American Journal on Mental Retardation*, Vol. 109, No. 1, (2004)
- John, W., 'The death penalty and persons with mental disabilities: A lethal dose of stigma, sanism, fear of violence, and faulty predictions of dangerousness', *Mental and Physical Disability Law Reporter*, Vol. 29, No. 5, September/, October 2005
- Jugal, K., *et al*, 'Myths, beliefs and perceptions about mental disorders and health-seeking behavior in Delhi, India', *Indian Journal of Psychiatry*, Vol. 53, No. 4, Oct-Dec 2011,
- Kanter, S., 'The promise and challenge of the CRPD', *Syracuse Journal of International Law*, Vol. 34, (2007)
- Kebede, D. and Alem, A, 'Major mental disorders in Addis Ababa, Ethiopia', *Acta Psychiatrica Scandinavica, Supplementum*, vol. 397, (1999)
- Kendell, R. and Jablensky, A., 'Distinguishing between the validity and utility of psychiatric diagnoses', *American Journal of Psychiatry*, Vol. 160 No. 1, (2003)
- Kumar, A., and Nevid, JS., 'Acculturation, enculturation, and perceptions of mental disorders in Asian Indian immigrants', *Cultur divers ethnic minor psychol*, Vol.16 No. (2), (2010)

- Lance, G. *et al*, 'Mental health and due process in the Americas: Protecting the human rights of persons involuntarily admitted to and detained in psychiatric institutions': *Wayne State University Law School Legal Studies Research Paper Series* No. 08-302005
- Leckie, S., 'Another step towards indivisibility: Identifying the key features of violations of economic, social and cultural rights, *Human Rights Quarterly*, Vol. 20, (1998)
- Lisa, J. and Roxana, C., 'Expanding the definition of the right to mental health: attending to victims of political violence and armed conflict in their communities of origin', *Essex Human Rights Review*, Vol. 2, No. 1
- Makanjuola, R., 'Yoruba traditional healers in psychiatry, Healers' concepts of the nature and etiology of mental disorders', *African Journal of Medicine and Medical Sciences*, Vol. 16, (1987)
- Maser, JD, Akiskal HS, 'Spectrum concepts in major mental disorders', *American Journal of Psychiatry*, Vol.25, No. 4, (2002)
- Mégret, F., 'The Disabilities Convention: Human rights of persons with disabilities or disability rights*?'*, *Human Rights Quarterly*, Vol. 30, (2008)
- Mike O., 'The social model in action: If I had a hammer', in Stone, A., 'The globalization of disability rights law', *Syracuse Journal of International and Comparative Law*, vol. 30, (2003)
- Moosa, J., 'The use of restraints in psychiatric patients', *South African Journal of Psychiatry*, Vol. 15, No. 3, (2009)
- Mulatu, M., 'Prevalence and risk factors of psychopathology in Ethiopian children', *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 34, (1995)
- Negash, A., *et al*., 'Prevalence and clinical characteristics of bipolar disorder in Butajira, Ethiopia', *Journal of Affective Disorders*, Vol. 87, No. (2-3), (2005)
- Paul, H., 'Mental disabilities and the human right to the highest attainable standard of health', *Human Rights Quarterly*, Vol. 28, (2006)
- Perlin, M., 'Mental health and human rights: Evolution and contemporary challenges', *New York Law School Legal Studies Research Paper Series*, No. 28, (2007/08)
- Perlin, M.,"Things have changed:" Looking at non-institutional mental disability law through the sanism filter, *New York Law School Journal of Human Rights*, Vol. 19, (2003)

- Phil, B. and Buchanan, P., 'Myth of mental health nursing and the challenge of recovery', *International Journal of Mental Health Nursing*, Vol. 20, (2011)
- Provencher, H. *et al*, 'The role of work in the recovery of persons with psychiatric disability', *Psychiatric Rehabilitation Journal* , Vol. 26, (2002)
- Raja, S., *et al*, 'Mapping mental health finances in Ghana, Uganda, Sri Lanka, India and Lao PDR', *International Journal of Mental Health Systems*, Vol. 4, No.11, (2010)
- Rosenthal, E. and Rubinstein, L. 'International human rights advocacy under the Principles for the protection of persons with mental illness', *International Journal of Law and Psychiatry*, Vol. 16, (1993)
- Saraceno, B. *et al*, "Barriers to improvement of mental-health services in low-income and middle-income countries" *The Lancet*, Vol. 369, (2007)
- Saxena, S. *et al.*, "Resources for mental health: scarcity, inequity, and inefficiency", *The Lancet*, Vol. 370, Issue 9590, (2007)
- Seena, F. and Martin, G., 'The population impact of severe mental illness on violent crime', *American Journal of Psychiatry*, Vol. 163, (2006)
- Shah, S., 'Dangerousness and civil commitment of the mentally ill: Some Public Policy Considerations', *American Journal of Psychiatry*, Vol.132, (1975)
- Shakespeare, T. and Watson, N., "The social model of disability: an outdated ideology?", University of Newcastle, *Journal of Social Science and Disability*, Vol. 2, (2002)
- Shany, Y., 'The international justiciability of economic, social and cultural rights', The *Hebrew University of Jerusalem, Faculty of Law*, Research Paper No. 9-06, August 2006
- Smith, M., 'Role of the popular media in mental illness', The Lancet, Vol. 349, (1997)
- Soder, M., 'Tensions, perspectives and themes in disability studies', *Scandinavian Journal of Disability Research*, Vol.11, No.2, (2009)
- Squire, L. and Slater, P., "Electroconvulsive therapy and complaints of memory dysfunction: A prospective three-year follow-up study", *British Journal of Psychiatry*, Vol.142, (1983)
- Steven, R. and Peter, J., **'**Uncovering the social world of mental illness', *University of California, Annual review of psychology*, Vol. 51, (2000)
- Thara, R. and Vikram, P., 'Role of non-governmental organizations in mental health in India', *Indian Journal of Psychiatry*, (2010)

- Theresa, D., 'International disability law - A new legal subject on the rise': The interregional experts' meeting in Hong Kong, December 13-17, 1999, *Berkeley Journal of International Law*, Vol. 18, (2000)
- Tina, M., 'Justiciability of economic, social, and cultural rights in the Inter-American system of protection of human rights: Beyond traditional paradigms and notions', *Human Rights Quarterly*, Volume 29, Number 2, May 2007
- Tina, M., 'The CRPD and the right to be free from nonconsensual psychiatric interventions', *Syracuse Journal of International law*, Vol. 34
- Tobias, R., and Helen, C., 'The UN Convention on the Rights of Persons with Disabilities in Africa: Progress after 5 years', *International Journal of Human rights*, Vol. 14
- Tsang, H., 'Applying social skills training in the context of vocational rehabilitation for people with schizophrenia', *Journal of Nervous and Mental Disease,* Vol.189, (2001)
- Wapnick, K., 'Mysticism and schizophrenia', Californian *Journal of Transpersonal Psychology,* Vol. 1, (1969)
- Wiles, E., 'Aspirational principles or enforceable rights: The future for socio-economic rights in national law' *American University International Law Review*, Vol. 22, (2006-7)
- Zielinski, R., *et al*., "Cardiovascular complications of ECT in depressed patients with cardiac disease", *American Journal of Psychiatry*, Vol.150, (1993)

III. Documents

- African (Banjul) Charter on Human and Peoples' Rights, Adopted 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58, (1982)
- African Charter on the Rights and Welfare of the Child, OAU Doc. Cab/Leg/24.9/49 (1990), entered into force Nov. 29, 1999
- CAT, adopted by the UN General Assembly in resolution 39/46 of 10 December 1984 at New York
- CED, International Convention for the Protection of All Persons from Enforced Disappearance, Adopted by General Assembly resolution 61/177 of 20 December 2006
- CEDAW, adopted by the UN General Assembly in resolution 34/180 of December 1979 at New York

- CERD, adopted by the UN General Assembly in resolution 2106 A (xx) of 21 December 1965 at New York
- Council of Europe Commissioner for Human Rights, "Persons with mental disabilities should be assisted but not deprived of their individual human rights", Viewpoints, 21 September 2009
- Council of Europe, Recommendation 1235 (1994) On Psychiatry and Human Rights, Section 1-4
- Council of Europe, Recommendation Rec. (2004)10 Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (2004)
- Council of Europe: Convention on Human Rights and Biomedicine, Done at Oviedo, Spain, April 4, 1997
- CRC, adopted by the UN General Assembly in resolution 44/25 of 20 November 1989 at New York
- CRPD, United Nations Convention on the Rights of Persons with Disabilities adopted by General Assembly resolution 61/106 of 13 December 2006
- General Assembly resolution 45/111, 14 December 1990
- HSDP I (1997/98-2001/2002), HSDP II (2002/ 03 - 2004/ 05), HSDP III(2005/6-2009/10), HSDP IV**(**2010/11 – 2014/15), FDRE
- ICCPR, adopted by the UN General Assembly in resolution 2200 A (XXI) of 16 December 1966 at New York
- ICESCR, adopted by the UN General Assembly in resolution 2200 A (XXI) of 16 December 1966 at New York
- Inter-American Convention on Human Rights, IACHR, Nov. 22, 1969
- **International Year of Disabled Persons, U.N. Doc. A/RES/36/77 (1081)**, December 1981
- Mental Health Strategy Document, FDRE, Ministry of Health (2011-2015)
- Optional Protocol to the CRPD, adopted by General Assembly resolution 61/106 of 13 December 2006
- Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care, G.A. res. 46/119, 46 U.N. GAOR Supp. (No. 49) at 189, U.N. Doc. A/46/49 (1991)

- Proclamation No. 568/2008, Right to Employment of Persons with Disability Proclamation, FDRE, 2008
- Protocol to The African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted in adopted in 2003
- Standard Rules on the Equalization of Opportunities for Persons with Disabilities, General Assembly resolution 48/96 of 20 December 1993
- Standard Rules on the Equalization of Opportunities for Persons with Disabilities, Adopted by the United Nations General Assembly, forty-eighth session, resolution 48/96, annex, of 20 December 1993
- The Americans with Disabilities Act (ADA), (1990) as amended
- The Constitution of the Republic of South Africa, 1994
- The Ethiopian Civil Code, Proclamation No. 165 of 1960
- The European Convention for the Protection of Human Rights and Fundamental Freedoms, Rome, 4.XI.1950
- The FDRE Constitution, Proclamation No. 1/95, (1995)
- The FDRE Criminal Code, Proclamation No. 214/ 2004, (2004)
- The Maastricht Guidelines on Violation of Socio-economic Rights, Maastricht, January 22-26, 1997
- The UK Mental Health Act, (2007)
- The Vienna Declaration and Program of Action, A/CONF.157/23, on the World Conference on Human Rights, 14 - 25 June, 1993
- UDHR, adopted and proclaimed by the UN General Assembly in resolution 217 A (III) of 10 December 1948 at Paris
- UN General Assembly, 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health', UN Doc. A/RES/58/173
- WHO, 'International classification of impairment, activities and participation': A manual of dimensions of disablement - Beta-1 Draft, (WHO), Geneva, (1997)
- World Health Organization(WHO), International Classification of Functioning, Disability and Health(ICF), Geneva, (2001)

IV. Research and Discussion Papers

- Alston, P., 'Disability and the International Covenant on Economic, Social and Cultural Rights, in human rights and disabled persons': Essays and relevant human rights instruments, Vol. 94
- Barnes, C., 'The social model of disability: Myths and misrepresentations, coalition': the Magazine of the Greater Manchester Coalition of Disabled People, Manchester: Greater Manchester Coalition of Disabled People, (1996)
- Boyle, G., 'Concussion of the brain with electroconvulsive shock therapy (ECT)': An appropriate treatment for depression and suicidal ideation, Australian Clinical Psychology, (1986)
- Boyle, P. and Callahan, D. 'Minds and hearts: priorities in mental health services', Hastings Center Reports, Vol. 5, (1993)
- Double stigma, double challenge': Mental health and HIV/AIDS in Central and Eastern Europe and the Newly Independent States an advocacy and information document, Global Initiative on Psychiatry, (2006)
- Field, M., *et al* (eds.) Workshop on disability in America: A New Look Summary and Background Papers. Washington, DC: The National Academies Press, (2006)
- Hiwot, A., "The rights of children with intellectual disabilities to access education in Addis Ababa", Unpublished, Addis Ababa University, (2011)
- Justin, D., 'From privileges to rights: People labeled with psychiatric disabilities speak for themselves', National Council on Disability, Washington DC, (20004)
- Katherine, G. *et al*, 'Convention of the Rights of Persons with Disabilities: Its implementation and relevance for the World Bank', Special Protection Discussion Paper, No. 0712, June, 2007
- Ken D., 'The social model of disability – setting the terms of a new debate', The Derbyshire Coalition of Disabled People, (1996)
- Kumpuvuori, J. and Katsui, H., 'Disability, human rights and human security: case study on human rights advocacy activities of organizations of persons with disabilities in Uganda and Finland', Spanda foundation quarterly newsletter. Vol. 3, No.1
- Lawrence O., 'International human rights law and mental disability', Hastings Center Report, March-April 2004,

- McDougall, J., and Tars, E., 'The justiciability of economic, social, and cultural right in the U.S, domestic implementation of the right to equal education', A plan for action, U.S. Racial Discrimination Program, October 2004
- Palmer, E., 'Judicial review, socio economic rights and the Human Rights Act(UK)', Human Rights Law in Perspective, Oxford and Portland, Oregon, Vol.10, (2007)
- Petros, K., "The right to health of mentally ill women to at Amanuel Mental Health Hospital", unpublished, Addis Ababa University, (2012)
- Sathiya, A., 'Mental health promotion in Ethiopia: Emerging issues', University of the Western Cape, Faculty of Natural Sciences, Cape Town, South Africa, (2010)
- Thomas, C., 'How is disability understood? An examination of sociological approaches': Disability and society, Vol. 19, No. 6, (2004)
- Tina, M., 'The Paradigm of supported decision making', Presentation in the Working Group on legal capacity and related issues of the International Disability Caucus, (2009)

V. Interviews

- Interview with Dr Welansa, A., Tadias Magazine, August 20, 2012, USA
- Interview with Dr Dawit, A., CEO, Amanuel Hospital, Addis Admas Weekly News paper, Vol. 12, No. 664, October 6, 2012, Addis Ababa
- Interview with Dr Melkamu A., former medical director and currently the emergency case team leader at Amanuel Hospital, on May16, 2012
- Interview with Dr Yonas, B., Amharic Reporter, 16 May, 2012, Addis Ababa
- Interview with Nujuma, B., Case team leader, Admission and liaison department, Amanuel Hospital, on July 23, 2012
- Interview with Tilahun, W., Head of pharmacy, Amanuel Hospital, on July 23, 2012
- Interview with Alehegne, A., Head of Ethiopian Mental health Society on April 10, 2012, Addis Ababa
- Interview with Dr Lulu, B., Medical Director, Amanuel Hospital, on July 2, 2012.
- Interview with Abraham, K., an inmate at Amanuel Hospital, on July 19, 2012
- Interview with Brother Eric, manager of the Gefersa Rehabilitation Center, on July 10, 2012, Gefersa
- Interview with Shibabaw, W., a representative for inmates at Gefersa Rehabilitation Center, on July 10, 2012, Gefersa

- Interview with Mulu, H., Amanuel Hospital on July 21, 2012
- Interview with Nakachew, A., Amanuel Hospital on July 21, 2012
- Interview with Zegeye, H., an inmate at Gefersa Rehabilitation Center, on July 9, 2012, Gefersa
- Interview with a 35 years old inmate at Gefersa Rehabilitation Center, on July 9, 2012

VI. Cases

- ACHPR, *Purohit and Moore Vs The Gambia* (2003) AHRLR 96 (2003), Communication 241/2001
- ECtHR, *Shtukaturov v. Russia,* application no. 44009, judgment of 27 March 2008;
- ECtHR, *Plesó v. Hungary,* application no. 41242/08, 2 October 2012
- Federal First Instance Court, Ethiopia, Ato Nasser Dormollo, an applicant for interdiction, file number 68303, 11/08/98 E.C
- Federal First Instance Court, Ethiopia, W/ro Teebe Mesfin, an applicant for interdiction, file number 174258, 14/12/2002 E.C
- IACtHr, *Victor Rosario Congo vs. Ecuador,* application number, 63/99, Para. 67
- The South African Constitutional Court, *Government of the Republic of South Africa Vs. Grootboom,* 2001 (1) SA 46 (CC), 2000 (11) BCLR 1169 (CC)
- The South African Constitutional Court, *Minister of Health and Ors Vs Treatment Action Campaign and Ors,* (2002) 5 SA 721 (CC); 5 July 2002

VII. Reports

- Erica, I., Rapporteur, 'Principles, guidelines and guarantees for the protection of persons detained on grounds of mental ill health or suffering from mental disorder', U..N. doc. E/CN.4/Sub.2/1983/17
- Helen, H., *et al (*eds.*),* 'Promoting mental health', A report of the WHO, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne, WHO (2005)
- Human Rights Commission Report of the Independent Expert to examine the question of a draft Optional Protocol to the ICESCR, (E/CN.4/2002/57
- Human Rights Watch, 'EU: A commitment to disability rights, EU ratifies international treaty; First Intergovernmental Group to Join, Press release, December 30, 2010

- Hunt P., 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health', E/CN.4/2005/51, 11 February 2005
- Hunt, P., 'Report of the Special Rapporteur to the Commission of Human Rights', Addendum: Mission to the World Trade Organization, E/CN.4/2004/49/Add.1
- International Disability Alliance**,** Position paper on the implementation of the CRPD and other instruments, April 25, 2008
- Manfred, N., Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 'Report on the promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development', (2008)
- MDAC, 'Human rights in psychiatric hospitals and social care institutions in Croatia', October 2011
- MDRI, 'Children in Russia's institutions': Human rights and opportunities for reform, (1999)
- MDRI, 'Human rights & mental health': Hungary, (1997)
- MDRI, 'Human rights & mental health': Mexico, (2000)
- MDRI, 'Human rights & mental health': Uruguay, (1995)
- Mental Health Atlas, Ethiopia, (2005)
- Report of the Special Rapporteur on the question of torture and other cruel, inhuman or degrading treatment or punishment, in accordance with Assembly resolution 57/200 of 18 December 2002
- Report of the UN high Commissioner for Human Rights on progresses in the implementation of the recommendations contained in the study on the Human Rights of Persons with Disability, A/HRC/14/75
- Secretary-General SG/SM/10797 HR/4911 L/T/4400, Supra at note 134, Para 49
- The Central Statistics Agency of Ethiopia, CSA, (2007)
- Theo B., Special Rapporteur of the Commission on Human Rights on the question of torture and other cruel, inhuman or degrading treatment or punishment, 3 July 2003

- Towards a common language for functioning, disability and health, WHO, (2002), Geneva; World Health Report 2001: Mental health: New understanding, new hope. Geneva, WHO, (2001)
- WHO, *Strengthening Mental Health Promotion*, Geneva, (Fact sheet no. 220), (2010), WHO; inequalities', WHO Regional Office of Europe
- World Disability Report, WHO, (2011)

VIII. General Comments, Decisions and Observations of Committees

- The Committee against Torture, Conclusions and Recommendations on the Report Submitted by Russian Federation under article 19 of the ICCPR, (2006)
- The Committee on the Rights of Persons with Disabilities, Communication No. 3/2011 lodged against the State of Sweden, HM v Sweden, (2011)
- The Human Rights Committee, Concluding Comment on the initial report of Bosnia and Herzegovina on the ICCPR, (2006)
- The Human Rights Committee, Concluding Observations on the report of Estonia on article 9 of the ICCPR, (2003)
- The Human Rights Committee, General Comment 16 on article 17 of the ICCPR, 'The right to respect of privacy, family, home and correspondence, and protection of honour and reputation', (1988)
- The Human Rights Committee, General Comment 20 on article7 of the ICCPR, Replaces general comment 7, 'Prohibition of torture and cruel treatment or punishment', (1992)
- The Human Rights Committee, General comment 9 on article 10 of the ICCPR, 'The rights of persons deprived of their liberty for humane treatment', (1982)
- The Human Rights Committee, General Comment No 13 on article 14 of the ICCPR, 'Equality before the courts and the right to a fair and public hearing by an independent court established by law', (1984)
- The Human Rights Committee, General Comment No 8 on article 9 of the ICCPR, 'Right to liberty and security of persons', (1982)

IX. WHO Resources

- Bertolote, J. and Sartorius, N., WHO initiative of support to people disabled by mental illness, Vol. 11, Supplement 2, (1996)
- Economic aspects of mental health, Evidence and Research Department of Mental Health and Substance Abuse, WHO, Geneva, (2006),
- Expert opinion on barriers and facilitating factors for the implementation of existing mental health knowledge in mental health services, Department of Mental Health and Substance Abuse, WHO, (2007)
- Guidelines for the promotion of the rights of persons with mental disorder , WHO/MNH/MND/95.4, Geneva, (1996)
- Gureje, O. *et al*. , Mental health policy development in Africa, Bulletin of the WHO, Vol. 78, No. 4, (2000)
- Improving health systems and services for mental health, Mental health policy and service guidance package, WHO, (2009)
- Improving health systems and services for mental health, WHO, (2009)
- Integrating mental health into primary care: A global perspective, WHO, Geneva, (2008)
- Investing in mental health, WHO, Department of Mental Health and Substance Dependence, Geneva, (2003)
- Kohn, R, et al, 'The treatment gap in mental health care', Bulletin of the World Health Organization, Vol. 82, (2004)
- Mental health gap action program for mental, neurological and substance use disorders in non-specialized health settings, WHO, (2001)
- Mental health systems in selected low and middle income countries: a WHO-AIMS cross-national analysis, WHO, (2009)
- Organization of services for mental health, Mental Health Policy and Service Package, WHO, Geneva, (2003)
- Pratap, S. *et al*(eds.), 'Research capacity for mental health in low and middle-income countries', Global Forum for Health Research and WHO, (2007)
- Promoting the rights of People with Mental Disabilities, Mental Health, Human rights and Legislation Information Sheet, Sheet1, Geneva, WHO, (2007)

- The World Health Report 2008: primary health care – now more than ever, WHO, Geneva, (2008)
- WHO Recommendation for Mental Health Services, Geneva, World Health Organization, (1996).

X. Internet Sources

- A neglected human rights crisis: persons with intellectual disabilities are still stigmatised and excluded, Viewpoints, 14 September 2009, available at: http://www.coe.int/t/commissioner/Viewpoints/090914_en.asp; accessed on September 2, 2012
- Allen, A., "Privacy and medicine", *The Stanford Encyclopedia of Philosophy, (2011),* Edward N. (ed.), available at http://plato.stanford.edu/archives/spr2011/entries/privacy-medicine/, accessed on July 21, 2012
- Anna L., 'The EU rights based approach to disability: Some strategies for shaping an inclusive society', School of Law and Centre for Disability Studies, University of Leeds, Handicap International, available at www.handicap-international.fr/bibliographie.../RBA**Disability**.pdf , accessed on January 21, 2012
- Attitudes to mental illness in England survey report, The health and social care information center, (2011), available at www.bedrepsykiatri.dk/media/321911/**mental_illness**_report.pdf, accessed on September 12, 2012
- Barnes, C., 'The Social Model of Disability: Valuable or Irrelevant?' in Bornemann, T., 'Barriers to improving mental health care in low and middle income countries, London school of psychiatry and tropical medicine', available at www.acmedsci.ac.uk/download.php?file=/images/.../MentalHe.pdf, accessed on May 28, 2012
- Disorder and Violence. New York: Oxford University Press, Executive Summary, (1999), available at www.macarthur.virginia.edu/risk.html, accessed on March 5, 2012
- End human rights violations against people with mental health disorders, December 10, (2006), International human rights day, Geneva, available at,

www.who.int/mediacentre/news/releases/2005/pr68/en/index.html , accessed on January 23, 2102

- Eric, R. & Clarence, J., 'The role of international human rights in national mental health legislation, available at www.mdri.org/pdf/WHO%20chapter%20in%20English_r1.pdf, accessed on May12, 2012
- Evolving definitions of disability, available at www.accessingsafety.org/.../understanding disability/ accessed on February 15, 2012
- Grant, C. 'The social model of disability', Scottish accessible information forum, (2009), available at www.saifscotland.org.uk, accessed on August 29, 2012
- Hisayo, K., and Richard W. 'Human rights-based approach to disability and health in development cooperation: Perspectives from the South', (2009), available at www.sylff.org/wordpress/wp-content/.../05/jip_1_final-report3.pdf, accessed on January 21, 2012
- Improving access to psychotropic medicines in low- and middle-income countries, Harvard School of Public Health, Press Release, June 18, 2012, available at www.hsph.harvard.edu/, accessed on June 18, 2012
- Living with disability in the UK, available at www.internationalstaff.ac.uk, accessed on August 29, 2012
- Oladimeji, A., **'**Economic, social and cultural rights: rights or privileges?' Groningen University, available at http://ssrn.com/, accessed on July 12, 2011
- Open Society Institute, Mental health and human rights: A resource guide, 4th edition, (2009), available at **www.equalpartners.info,** accessed on July 1, 2012
- Peter, J., 'Mental health in the era of HIV: Investigating mental distress, its determinants, conceptual models and the impact of HIV in Zambia', (2010**)** available at www.ajol.info/index.php/mjz/article/viewFile/76371/66827 accessed on May 12**,** 2012
- Porter, B. and Nolan, A., 'An updated appraisal on the justiciability of socio-economic rights', (2006), available at www.SocialRights.ca, accessed on August21, 2012
- Respect and rights-based action instead of charity for people with disabilities, Viewpoints, 20 October 2010, available at:

http://www.coe.int/t/commissioner/Viewpoints/081020_en.asp, accessed on September 2, 2012

- The Royal College of Psychiatrists, 'Information on ECT: pros and cons of ECT treatment', available at www.rcpsych.ac.uk/mentalhealthinfo/**treatments**/**ect**.aspx , *accessed on July 13, 2012*
- The World Medical Association, Inc., World Medical Association Declaration of Helsinki: The ethical principles for medical research involving human subjects, available at http://www.wma.net/e/policy/17-c_e.html, accessed on July 15, 2012
- Thornicroft, G., and Tansella, M., 'What are the arguments for community-based mental health care?' Copenhagen, WHO Regional Office for Europe (Health Evidence Network report; (2003)), available at http://www.euro.who.int/document/E82976, accessed at May 19, 2012