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International Human Rights Protections for Institutionalized People with Disabilities: An Agenda for International Action

by

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Introduction

This paper describes the widespread pattern of human rights violations against institutionalized people with disabilities and proposes action to improve rights enforcement under international human rights conventions, such as the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social, and Cultural Rights (ICESCR), and the Convention on the Rights of the Child (CRC). While the adoption of a specialized international human rights convention on the rights of people with disabilities may be able to improve on existing protections, there is also an urgent need for new strategies to make better use of protections under existing international human rights conventions.

The observations and recommendations in this report derive from seven years of work by Mental Disability Rights International (MDRI). MDRI has investigated conditions in sixteen countries on three continents, and we have published reports on the treatment of children and adults with disabilities in Uruguay (1985), Hungary (1987), Russia (1999), and Mexico (2000).[1] MDRI has presented these reports to the UN Human Rights Committee, the Inter-American Commission of Human Rights and the European Committee for the Prevention of Torture, resulting in international attention to human rights violations by the United States, Mexico, and Hungary. We have pressured countries to bring about reform by publicizing abuses through the international press, and we have collaborated closely with grassroots activists to bring about sustainable change

[1]Copies of these reports are available at this conference. Information about ordering MDRI reports is available on the web at www.MDRI.org.

in their own countries. MDRI has been invited by governments, service providers, international development organizations, and UN agencies - such as WHO and UNICEF - to provide technical assistance on legal and service system reform.

I. Pattern of Abuses and the Human Rights Challenge

A. Summary of MDRI's Worldwide Findings

Since 1993, MDRI has documented living conditions in psychiatric hospitals, orphanages, nursing homes, specialized institutions for people with developmental or physical disabilities, as well as prisons and jails in sixteen countries,[2] primarily in Central and Eastern Europe and Latin America. The patterns of abuse MDRI has found in these diverse regions are, in many ways, strikingly similar. People with mental and physical disabilities are commonly detained in closed, segregated institutions -- out of public view and often in remote parts of a country far from population centers. People may remain in these custodial facilities for life, living cut off from family, friends, and community. In some cases, they are detained without any legal process to protect against arbitrary detention. Even when legal procedures for civil commitment exist, they are often circumvented or ignored. For example, people with mental disabilities are often placed under the "guardianship" of a mental health administrator and then "voluntarily" committed to an institution. Many people are declared mentally incompetent without legal representation or due process protections, and placement under guardianship functionally strips them of any legal right to make the most basic decisions about their own lives.

Large numbers of people are improperly detained in institutions because of the lack of community-based services and support systems. In many of the countries MDRI has visited, authorities report that *the majority* of people could live in the community if appropriate services were available. A small percentage of institution populations are made up of individuals who present a danger to themselves or others or who are in need of treatment that can only be provided in an institution. Many people without disabilities are placed in institutions because they are marginalized in society and have no community support network, but they become increasingly socially isolated and acquire mental disabilities by living in an institution. This is particularly true for large numbers of children placed in orphanages or residential schools.

Behind the closed doors of institutions, people are subject to inhuman and degrading treatment. In Mexico, Hungary, Armenia, and Kosovo, MDRI found people detained in squalid conditions -- in some cases left naked, covered in their own feces. People are routinely strapped to benches, beds, or wheelchairs -- largely due to the lack of

[2]MDRI has observed conditions in institutions in the following countries: Argentina, Armenia, Azerbaijan, Costa Rica, the Czech Republic, Hong Kong, Hungary, Kosovo/ Yugoslavia, Lithuania, Macedonia, Mexico, Romania, Russia, Slovakia, Ukraine, and Uruguay.

staff to provide basic care. In Uruguay, MDRI found electro-convulsive therapy (ECT) used on people with mental retardation as a form of behavior control. In Uruguay, Hungary, and Romania, overdose, poly-pharmacy, and the failure to monitor side effects of medications expose hundreds of people to unnecessary and life-threatening dangers. In some institutions, people are literally left to starve or freeze to death. In Armenia, for example, MDRI visited an institution that reported an annual mortality rate of 30%.

Women are particularly vulnerable to abuse within institutions. Women subject to sexual abuse are commonly misdiagnosed with major mental health disorders, institutionalized, and then re-traumatized through the coercive treatment they receive in institutions. Within institutions, woman are particularly vulnerable to sexual abuse by staff or other patients. Non-consensual sterilization, forced abortions, and the arbitrary denial of parental rights are common.

In the United States, MDRI is working with activists fighting aversive behavior modification procedures that cause pain, degradation, as well as physical and psychological damage. Aversive procedures include the use of electric shock, physical restraints or isolation, white noise at 95 decibels, slapping, pinching, putting ammonia capsules to the nose or squirting lemon juice, vinegar or hot pepper in the mouth.[3] These procedures induce extreme levels of suffering and meet the classic definition of inhuman and degrading treatment -- yet they are now permitted by US federal law and in some US states.

B. Human rights oversight and enforcement

Despite this widespread problem of discrimination and abuse, international human rights oversight and enforcement bodies rarely hold countries accountable for the treatment of people with disabilities in psychiatric institutions, orphanages, or other such institutions. Mainstream, non-governmental human rights groups, have rarely demanded enforcement of the rights of institutionalized people with disabilities. Concerned citizens do their best, within their own countries, to protest against abuse and to demand more appropriate services. Yet such groups rarely receive international funding or support, and they are left to struggle in isolation.

Human rights oversight and enforcement mechanisms to protect the rights of people with mental disabilities are limited or non-existent within most of the countries MDRI has investigated. Where legal protections for people with mental disabilities are established, as in Hungary, they are of little value without the establishment of enforcement mechanisms. These programs must reach out to the community to identify people in need of assistance, and they must document patterns of abuse that can be remedied through legal reform and policy changes. Active efforts are also needed to ensure the inclusion of people with disabilities in human rights monitoring and policy-making. Training programs must also be established for grassroots NGOs made up of

[3]Nancy R. Weiss, THE APPLICATION OF AVERSIVE PROCEDURES TO INDIVIDUALS WITH DISABILITIES: A CALL TO ACTION (1999).

consumers or family members to expose them to the policy options that are available and to mechanisms within their own countries for bringing about legal or policy reform.

Internationally recognized human rights for people with mental disabilities will remain an empty promise until advocacy groups receive the support they need to act on the national level to document abuses, bring them to public attention, work through their own domestic court systems, and ultimately appeal to the international community for support. In order to bring attention to the violation of human rights in institutions, the Special Rapporteur and this Expert Committee should develop a strategy to promote disability rights advocacy groups worldwide.

C. Rights in Institutions and the Community

Human rights in institutions cannot be examined in isolation from conditions in the community. A large number of people are improperly detained in institutions because of inadequate community-based services. Barriers to community integration -- including the lack of community based service and support systems, as well discrimination and the lack of legal protections in the community -- can make it difficult or impossible to protect the rights of people in institutions. Any effort to improve services in institutions or in the community will involve competition for limited funding.

Responses to human rights violations in institutions present serious dilemmas. Dangerous conditions in institutions must be immediately remedied. But major repairs to buildings and new investments in staff and services may have the unintended effect of reinforcing outmoded, segregated models of services -- often at the expense of new investments in community-based alternatives. There must be a delicate balance between the funding needed to protect the rights of people within institutions on a temporary basis while new investments are made in the creation of community-based programs.

In the cases when international development programs respond to the concerns of people in psychiatric institutions or orphanages, program planners are often unaware of the potential for people with disabilities to live in the community. People with disabilities and advocacy organizations representing them are rarely consulted in the design and implementation of programs. Very often, disability activists are struggling within their countries to obtain funding for support systems that will permit them to keep people with disabilities out of institutions. Yet these efforts are frequently ignored by international charity programs that direct funds to orphanages or other institutions.

In Romania, Russia, Armenia, and Kosovo, MDRI has found extensive efforts to fix-up institutions - at the expense of community-based alternatives sought by local activists.[6] In Romania, following the death of Ceaucescu, the international response to

[6] *See, e.g.* Holly Burkhalter and Eric Rosenthal, *The Way to Save Russia's Orphans*, WASHINGTON POST, August 4, 1999; Eric Rosenthal, Elizabeth Bauer, Mary F. Hayden, and Andrea Holley, Implementing the Right to Community Integration for

the widely publicized abuses in orphanages was followed by a massive increase in the total orphanage population -- from 80,000 in 1989 to 120,000 in 1996.[7] While there are now extensive programs to support the community integration of children from Romanian orphanages, family ties broken by placement in the early 1990s are difficult to reestablish, and new resources are needed to make up for the mistakes of earlier years.

Human right standards must be used to hold international development organizations - particularly UN agencies - accountable. As a strategy for reporting is developed, development and assistance programs funded by UN agencies such as WHO, UNICEF, and UNDP should also be monitored for compliance with international disability rights standards.

II New guidelines to the interpretation of human rights conventions

International covenants provide important protections for institutionalized people with disabilities, but these covenants have been under-utilized to monitor state practice and hold countries accountable for abuses against people with disabilities. One of the limitations of existing conventions is that they have no specific provisions relating to the concerns of institutionalized people with disabilities. Appendix A of this report examines the generally disappointing jurisprudence in the European system of human rights with regard to institutionalized people with disabilities, as well as one important new case from the Inter-American Commission of human rights that may point the way towards a new approach to the interpretation of human rights conventions. In the March 1999 case of *Victor Rosario Congo,* the Inter-American Commission of Human Rights recognized that a UN General Assembly resolution, the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (the "MI Principles"), can serve as an authoritative interpretation of the American Convention on Human Rights. [8]

UN General Assembly resolutions can help in the application of convention-based rights by providing detailed guidelines to the requirements of general protections. Following the precedent established by the Inter-American Commission, the convention-based UN Committees that issue General Comments on the conventions could adopt the

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Children with Disabilities in Russia: A Human Rights Framework for International Action, 4 HEALTH AND HUMAN RIGHTS 83 (1999).

[7] *Id.* at 89.

[8] Report 29/99, Case 11,427, Ecuador, adopted by the Commission in Sess. 1424, OEA/Ser/L/VII.102 Doc. 36, March 9, 1999, p.8. The Inter-American Commission cited the analysis in Eric Rosenthal and Leonard S. Rubenstein, *International Human Rights Advocacy under the 'Principles for the Protection of Persons with Mental Illness,'* 16 INT'L J. L. & PSYCHIATRY 257 (1993) (describing the us of the MI Principles as a guide to the interpretation of international human rights conventions).

MI Principles and other disability rights instruments as authoritative interpretations of binding conventions.

The UN Special Rapporteur and this Expert Committee can play a very important role in promoting this new interpretation. The detail that these standards provide would both: (1) clarify governments' responsibilities under international human rights conventions (2) provide the basis for detailed reporting by governments under the mandatory reporting requirements of international human rights conventions and (3) provide a universal standard of assessment that would permit grassroots and international human rights activists to document abuses and hold governments accountable.

Rather than drafting new reporting standards, the Special Rapporteur should build on the human right principles already adopted by the UN General Assembly. There are specific areas in which UN General Assembly resolutions do not provide detailed protections against common practices that violate the rights of institutionalized people with disabilities. The Special Rapporteur and this Expert Committee should propose new international standards with regard to these areas of practice.

III. Increased recognition and enforcement of UN disability rights resolutions

UN General Assembly resolutions on the rights of people with mental and physical disabilities provide important protections for institutionalized people with disabilities. In addition to the MI Principles, the 1971 *Declaration on the Rights of Mentally Retarded Persons* (the MR Declaration) and the 1993 *Standard Rules on Equalization of Opportunities for Persons with Disabilities* (the StRE) are important to the protection of rights of institutionalized people. MDRI has found each of these three instruments very useful in monitoring conditions around the world and in assessing compliance with international human rights conventions. This section analyses some of their strengths and weaknesses and proposes a few of the areas of concern that require the development of stronger international standards.

A. Strengths and weaknesses of UN standards

The 1991 *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (the MI Principles) provide detailed minimum standards for treatment and living conditions in mental health facilities and they establish due process protections regulating commitment or detention in institutions. MDRI has relied on the MI Principles to assess human rights conditions in the mental health systems and mental retardation facilities of sixteen countries, and we have found that the MI Principles provide the detail needed to touch upon the major human rights concerns we have identified, including such widespread practices as: arbitrary commitment to institutions, coercive treatment and improper medication in institutions, misuse of physical restraints, and deprivation of humane and dignified living conditions.

The MI Principles also broadly establish a right to live, work, and receive treatment in the community or in "the least restrictive environment...appropriate to the patient's health needs and the need to protect the physical safety of others."[9] This right is of profound importance in countries that detain people in institutions because of the absence of community-based services. Enforcement of this right would require many states to restructure service systems, shifting funds away from the exclusive support of institutions toward the creation of support systems in the community.

The 1971 "Declaration on the Rights of Mentally Retarded Persons" (the MR Declaration) is not as fully developed as the MI Principles, but it provides a number of important rights. The MR Declaration establishes that a person with mental retardation cannot be deprived of the rights due all other citizens except through a process that includes "proper safeguards against every form of abuse." Any such restriction of rights "must be based on an evaluation of the social capability of the mentally retarded person," must be subject to periodic review, and is subject to appeal to higher authorities. While lacking specific due process protections, the MR Declaration prohibits the common practice of declaring a person "mentally incompetent" and appointing a guardian without any legal process. Additional, clearly defined, minimum standards of due process are needed to protect against abuse of the guardianship process - one of the most common forms of discrimination against people with mental retardation MDRI has found around the world.

B. Need for further analysis

A detailed expert analysis is needed to determine exactly which provisions of the MI Principles, the StRE and the MR Declaration would interpret specific articles of international human rights conventions. For example, MI Principle 11(11) sets forth minimum standards for the protection against the improper use of seclusion and physical restraints, which could be recognized as minimum standards to protect against a violation of the protection against "inhuman and degrading treatment" in article 7 of the ICCPR. MI Principles 15 and 16, regulating voluntary and involuntary commitment to psychiatric facilities, could be recognized as a guide to the requirements of article 9 of the ICCPR protecting against arbitrary detention.

A detailed analysis is needed because many of the protections under the MI Principles, the StRE, or the MR Declaration are difficult to link to any one, specific convention based protection. One of the most important emerging principles in international standards is the right to community integration. This principle is recognized in the MI Principles, the StRE, the MR Declaration, and in a number of other international instruments, including the draft Inter-American Convention on the Elimination of Discrimination Against People with Disabilities.[10] Yet it is not clear

[9] Principle 9(1).

[10] *See* Rosenthal, Bauer, Hayden and Holley, *supra* note 6, at 89.

whether this right would be directly recognized under the ICCPR or the ICESCR. It could be argued, for example, that it is inherently discriminatory (in violation of ICCPR article 2(1) or ICESCR article 2(2)) to provide mental health services exclusively in a closed, segregated institution for people who are capable of living in the community. To what extent would a country be required to modify existing mental health and social services systems to provide appropriate, community-based services? The Special Rapporteur and this Expert Committee should take a strong stand on the right to community integration and should propose guidelines to the interpretation of convention-based protections against discrimination, referencing the MI Principles and other UN General Assembly standards.

MDRI has found that there are a few major gaps in the MI Principles. While they call generally for enforcement, they do not specify in any detail how human right oversight and enforcement mechanisms should be established. It is also necessary to adopt standards for rights enforcement in the community. Even though human right violations in institutions may be more extreme, abuses in community-based programs can be more difficult to identify because they are diffused through many small programs. Abuses in community programs can feed on public fears and misperceptions of deinstitutionalization and can undermine public support for reform.

The practice of aversive behavior modification programs that may cause extreme levels of suffering or indignity are not clearly prohibited by international human rights standards. There is a need for a protocol defining the aversive procedures that would violate the protection against inhuman and degrading treatment. Appendix B of this report is a standard proposed by TASH, an international disability rights group based in the United States.

IV Need for Support of Independent Advocacy and Monitoring

An international strategy should not rely solely on self-reporting by States, and Special Rapporteur Bengt Linqvist does not have the resources alone to document in detail the abuses that exist in institutions of almost every country of the world. There is no substitute for the locally-based expertise, cultural sensitivity, and fact-finding ability that grassroots organizations and international disability rights NGOs can bring to hold governments - and the international community - accountable. Grassroots disability rights advocacy groups, unfortunately, receive little recognition or support within their own countries or from the international community. In MDRI's experience, groups made up of people with psychiatric or developmental disabilities, as well as groups made up of related family activists, have even fewer resources available to them than do groups made up of people with physical disabilities. The UN Special Rapporteur and this Expert Committee must devise a strategy to approach government foreign assistance agencies, international development organizations, and civil society programs to support, assist, and train grassroots human rights organizations throughout the world.

Appendix A The Promise and Limitations of Existing International Conventions

While there is an obvious lack of any specialized human right convention to protect people with disabilities, existing UN international human rights conventions provide many protections that apply to institutionalized people with disabilities. International human rights conventions provide the possibility of direct enforcement, public education through mandatory reporting requirements by States Parties, and political pressure to conform with internationally accepted rights protections. International human rights conventions have been seriously underutilized by the disability rights community. Any new effort to build on existing human rights protections must be based on a realistic understanding of their limitations as well as their strengths.

A. Lack of specific protections for people with disabilities

One major limitation on existing human rights conventions is that they do not provide specific references to people with disabilities. Thus, States Parties to these conventions are not required to report on the treatment of people with disabilities in or outside of institutions. The general protections of existing human rights conventions lack the specificity needed to direct the attention of UN oversight agencies, governments, or health and social welfare providers as to their obligations with regard to institutionalized people with disabilities.

General Comments issued by UN convention-based committees should provide the detailed guidance necessary to spell out a country's obligations in a particular area of practice. The General Comments also serve as reporting guidelines under the convention. Unfortunately, the General Comments pertaining to the rights of institutionalized people with disabilities are extremely limited.

Without direct reference to the rights of people with disabilities in the main human rights conventions, most governments and service providers are unaware that issues such as commitment to psychiatric facilities, guardianship, informed consent to treatment, the use of seclusion or physical restraint, the right to privacy or other dignified living conditions are matters subject to the protection of international human rights law. In many countries, the treatment of people in institutions is not regulated by domestic law, and institutional authorities are under the impression that these are matters left entirely to their discretion. Even in countries where domestic laws govern the rights of institutionalized people, the failure of the international community to scrutinize treatment practices in institutions reinforces the widespread perception that treatment practices in institutions are matters of exclusively domestic concern.

B. Jurisprudence in the European and Inter-American systems

The European and American conventions on human rights provide roughly parallel protections. Regional human rights systems in Europe and the Americas have the most effective enforcement mechanisms and present the greatest opportunities for individual and systemic rights enforcement. The European and American courts of

human rights can hear cases on the application of human rights to individual circumstances, presenting not only an opportunity for individual enforcement but also for the authoritative interpretation of international human rights protections under general conventions.

1. European System

The European Commission and Court of Human Rights have heard numerous cases on the rights of institutionalized people with disabilities.[11] As a result of this process, it has been established that treatment practices within institutions raise fundamental human rights concerns. The European Court has contributed greatly to the interpretation of article 5 of the European Convention of Human Rights (ECHR) protecting the right to liberty and security of the person. The Court has, for example, required States Parties to the ECHR to follow procedures set forth in their own domestic laws and to provide individuals with a right to review by a court or other independent authority.[12]

While the European Court has stated that special scrutiny is required to protect especially vulnerable people in institutions,[13] the European Court has, in practice, been extremely deferential to institutions when reviewing allegations of inhuman and degrading treatment under article 3 of the ECHR. In the case of *B. v. United Kingdom*, for example, the European Commission found a case inadmissible under article 3 because the facts alleged did not amount to inhuman and degrading treatment.[14] In the case, the applicant, a patient at Broadmoor psychiatric hospital in the United Kingdom, claimed that he was "detained in grossly overcrowded conditions, lacking in adequate sanitory (e.g. toilet and washing) facilities, and in constant atmosphere of violence. He alleged that dormitory beds were only 6-12 inches apart, and there was no privacy and little fresh air or exercise. The applicant claimed he had received no treatment whatsoever and almost never saw a doctor."[15] The European Commission noted that:

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[11] *See* Lawrence O. Gostin, *Human Rights of Persons with Mental Disabilities: The European Convention of Human Rights*, 23 Int'l J. Law & Psychiatry 125 (2000).

[12] Rosenthal and Rubenstein, *supra* note 8, at 277.

[13] The Court in *Herczegfalvy v. Austria* stated that, "The position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with." Judgment of 24 September 1992, 244 Eur. Ct. H.R. (Ser.A), para. 82, 15 E.H.R.R. 437 (1993).

[14] App. No. 6870/75, Second Partial Decision of the Commission as to Admissibility, 10 Dec. & Rep. 37 (Euro. Comm'n H.R. 1977).

[15] Gostin, *supra* note 11, at 151.

> The physical conditions in Broadmoor Hospital are admittedly unsatisfactory and have been criticized by different official bodies over the number of years. While hospital staff...may do their best to cope with these inadequacies, this does not exclude the possibility that the physical conditions of detention could in themselves give rise to a question under Article 3.

In the case of *B. v. United Kingdom*, the Commission unfortunately determined that the degree of suffering induced by poor conditions did not rise to the level of a violation of the convention. Many other cases have similarly alleged inhuman and degrading treatment in psychiatric institutions in Europe, including the detention of individuals in prolonged physical restraints, but the European Commission and Court of human rights have time and time again found that practices are not sufficiently extreme to constitute a human rights violation.[16]

It is significant that the Commission in *B v. United Kingdom* recognizes that conditions in institutions may violate the rights protected under the ECHR *even if* staff "do their best" to assist patients. In many circumstances, abuses against people with mental disabilities are not caused by any intentional infliction of pain and suffering by mental health providers but are the result of inappropriate care due to lack of resources or the administrative convenience of the institution. Unlike "torture," which is usually understood to be limited to cases where pain is inflicted on purpose,[17] "inhuman and degrading treatment" has no intent requirement.[18]

2. Inter-American system

Jurisprudence in the American system of human rights is much more limited with regard to the rights of institutionalized people with mental disabilities, but it presents

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[16]Gostin, *supra* note 11, at 152. In the case of *A v. United Kingdom*, the Commission did accept a friendly settlement of a claim of inhuman treatment , however, in which it accepted that the requirements of the convention were met by the establishment of minimum standards for institutional conditions, including the provision of clothing, mattresses, portable latrines, and toilet paper, as well as safeguards against the improper use of seclusion and physical restraints.

[17]The Convention against torture and Other Cruel, Inhuman or Degrading Treatment or Punishment" defines torture as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind....It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions." Article 2(1).

[18]See Rosenthal & Rubenstein, *supra* note 8, at 273.

much greater hope than does the European system. In March 1999, the Inter-American Commission of Human Rights issued its first decision on the rights of a person with a mental disability, *The Case of Victor Rosario Congo*.[19] Mr. Congo, a person with a mental disability, died of "dehydration" in pre-trial detention after he was beaten by a guard, placed in isolation, and denied adequate medical and psychiatric care. The Commission found that Mr. Congo's mental state degenerated as a result of being held in isolation and that holding him in seclusion under these circumstances constituted inhuman and degrading treatment in violation of article 5 of the American Convention. The Commission did not find that Congo was deliberately deprived of food and water but that state authorities failed to take appropriate measures, given his mental health condition, to ensure that he received adequate food and water. The Commission found that Ecuador's failure to provide appropriate care for Mr. Congo violated its duty to protect his life under article 4(1).

The Congo decision is important because the Inter-American Commission made clear that it will adopt "special standards to the determination of whether the provisions of the Convention have been complied with in cases involving persons suffering from mental illness...."[20] In addition, the Inter-American Commission recognized the use of the Principles for the Protection of Persons with Mental Illness (MI Principles) as a guide to the interpretation of the American Convention:[21]

> [T]he Commission considers that in the present case the guarantees established under article 5 of the American Convention must be interpreted in light of the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. These principles were adopted by the United Nations General Assembly as a guide to the interpretation in matters of protection of human rights of persons with mental disabilities, which this body regards as a particularly vulnerable group. "[22]

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[19]Report 29/99, Case 11,427, Ecuador, adopted by the Commission in Sess. 1424, OEA/Ser/L/VII.102 Doc. 36, March 9, 1999, p.8 n.7.

[20]*Id.* at para. 53.

[21]An analysis of the MI Principles as a guide to the requirements of international human rights conventions was first raised in Rosenthal & Rubenstein, *supra* note 8. In *The Case of Victor Rosario Congo*, the Inter-American Commission cited this analysis in para. 54 n.8.

[22]*Id.* at para. 54. In a footnote, the Commission added: "The UN Principles for the Protection of Persons with Mental Illness 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. Mental Health Principle 23 establishes that each State must adopt the legislative, judicial, administrative, educational, and other measures that may be necessary to implement them." *Id. at* fn. 8, *citing* Rosenthal & Rubenstein, *supra* note 8.

The recognition of the MI Principles as an authoritative guide to the interpretation of the American Convention is important within the Inter-American system and in the development of international human rights law. The recognition of the MI Principles by the Inter-American Commission constitutes state practice that raises the value of the MI Principles as a matter of customary international law. In the future, human rights bodies are more likely to follow the precedent established by the Inter-American Commission in using the MI Principles as a guide to the interpretation of the American and other conventions. The clear and detailed standards set forth in the MI Principles may help the Inter-American Commission - and possibly the European Court - avoid adverse decisions, such as *B v. United Kingdom***.**

The Inter-American Commission is sympathetic to hearing additional cases on the rights of people with mental disabilities. In March 2000, the Commission granted MDRI's request for a hearing on the findings of MDRI's report, *Human Rights & Mental Health: Mexico* (February 2000), which documented a broad pattern of abuses in Mexico's psychiatric facilities. This was the first hearing in this human rights oversight body about the protection of human rights in a mental health system as a whole. As a result of the hearing, the Inter-American Commission raised concerns about human rights in Mexico's psychiatric hospitals in the OAS's annual report on Mexico's human rights record.[23] This hearing demonstrates the value of regional human rights systems as tools for human rights monitoring and public education about the conditions of people with disabilities in closed institutions.

C. Protections for children with disabilities

The jurisprudence in the European human rights system is emblematic of the difficulties of applying general human rights conventions in the context of institutional care, particularly with regard to areas that have traditionally been left to medical discretion or domestic social policy. A contrast to this is Article 23 of the Convention on the Rights of the Child (CRC), which provides important, detailed protections for children with mental and physical disabilities.
The CRC provides a model of the kind of rights an international disability rights convention could provide - or of the kind of rights that could be guaranteed under existing international conventions if they were supplemented with detailed General Comments.

Article 23(3) provides that every child with a disability has "effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities...." The CRC provides that services mandated under the convention must be provided "in a manner conducive to the child's

[23]Inter-American Commission on Human Rights, Annual Report of the Inter-American Commission on Human Rights 1999 III, paras. 20-22, Doc. 6 rev, OEA/Ser.L.V/II.106 (April 13, 1999). The report is available at www.cidh.oas.org/annualrep/99eng.

achieving the fullest possible social integration and individual development." Throughout the CRC, there are detailed provisions for the protection of the family, recognizing that the family is the "natural environment for the growth and well-being of all its members and...should be afforded the necessary protection and assistance so that it can fully assume its responsibilities in the community."[24] It is arguable that to provide the "fullest possible social integration" for the vast majority of children with disabilities, and to protect the right of children to a family, services would themselves have to be provided in a family-like environment in the community and *not* in orphanages or institutions. The CRC unfortunately does not state the logical outcome of the protections it provides, which would require a fundamental alteration of many countries' social care systems. The convention does provide sufficient detail, however, to assess human rights in a social service system as a whole. In addition, it provides guidance to policy-makers, human rights activists, and international development agencies about the need to structure a response to the human rights problem in institutions that would emphasize community-based alternatives.[25]

Appendix B: TASH Statement on Aversive Procedures

TASH (formerly The Association for Persons with Severe Handicaps) is a US-based, international advocacy association of people with disabilities, their family members, and other advocates and people who work in the disability field. TASH has proposed the following statement that could be adopted by the international community to interpret the requirements of the International Covenant on Civil and Political Rights article 7 protection against inhuman and degrading treatment:

Throughout the world, individuals with disabilities are victim to what is termed "aversive interventions" to control behaviors that are associated with their disabilities. Aversive procedures use painful stimuli in response to behaviors that are deemed unacceptable their caregivers.. All aversive techniques have in common the application of physically or emotionally painful stimuli.

These techniques are inappropriately used, not only to control dangerous behaviors, but also to modify behaviors that are simply idiosyncratic (moaning or twisting one's hair), unusual (tics or rocking) or are inconvenient to caregivers (getting out of one's assigned seat or refusing to perform a task) . When an individual is at imminent risk of hurting him/herself or others, intervention is necessary to assure safety. Such intervention may include brief physical restraint but should not include aversive procedures. Individuals with disabilities who act in ways that are dangerous deserve at a minimum, the same protections afforded prisoners.

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[24]CRC, *preamble*.

[25]*See* Rosenthal *et. al.*, *supra* note 8.

Aversive procedures are often used as part of a systematic program for decreasing certain behaviors. They are used without the consent of the victim and typically, without the informed consent of a guardian. Aversive procedures have some or all of the following characteristics:

- Obvious signs of physical pain experienced by the individual;
- Potential or actual physical side-effects such as tissue damage, physical illness, severe physical or emotional stress, and/or death;
- Dehumanization of the individual;
- Significant discomfort on the part of family members, staff or caregivers regarding the necessity of such extreme strategies or their own involvement in such interventions;
- Obvious repulsion and/or stress on the part of observers who cannot reconcile such extreme procedures with acceptable standard practice;
- Rebellion on the part of the victim against being subjected to such procedure;
- Permanent or temporary psychological or emotional harm.

The types of aversive procedures used on persons with disabilities include, but are not limited to:

- Electric shock applied to the body (e.g. arm, leg, or hand) for the purpose of discouraging the specific behavior it follows by causing pain [not to be confused with electroconvulsive therapy (ECT) used to treat severe depression]
- Extremely loud white noise or other auditory stimuli
- Forced exercise
- Shaving cream to the mouth
- Lemon juice, vinegar, or jalapeno pepper to the mouth
- Water spray to the face
- Placement in a tub of cold water or cold showers
- Slapping or pinching with hand or implement
- Pulling the hair
- Ammonia capsule to the nose
- Blindfolding or other forms of visual blocking
- Placement in a dark isolated box or other methods of prolonged physical isolation
- Ice to the cheeks or chin
- Teeth brushed or face washed with caustic solutions
- Prolonged restraint through manual or mechanical techniques (e.g. face-down four- or five-point restraint using mechanical tie-downs or several staff applying physical pressure)
- Withholding of multiple meals/denial of adequate nutrition

Although it has been believed that such procedures are necessary to control dangerous or disruptive behaviors, it has now been irrefutably proven that a wide range of methods are available which are not only more effective in managing dangerous or disruptive behaviors, but which do not inflict pain on, humiliate, or dehumanize individuals with disabilities. Alternative approaches that are proven to be effective attempt to identify the individual's purposes in behaving as he or she does and offer support and education to replace dangerous or disruptive behaviors with alternative behaviors that will achieve the individual's needs.