International Human Rights and Comparative Mental Disability Law: The Universal Factors

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INTERNATIONAL HUMAN RIGHTS LAW AND
COMPARATIVE MENTAL DISABILITY LAW: THE
UNIVERSAL FACTORS

Michael L. Perlin*

INTRODUCTION

An examination of comparative mental disability law1 reveals that there are at least five dominant, universal, core factors that must be considered carefully in any evaluation of the key question of whether international human rights standards have been violated. Each of these five factors is a reflection of the shame that the worldwide state of mental disability law brings to all of us who work in this field. Each is tainted by the pervasive corruption of sanism that permeates all of mental disability law.2 Each reflects a blinding pretextuality that contaminates legal practice in this area.3

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1. For these purposes, this phrase has multiple meanings. It means the statutory law “on the books” (or lack of statutory law “on the books”), the law as it is practiced on a daily basis in trial courts, the law as it is decided (or not decided) by judges, and the aspirational law that is articulated by scholars. See, e.g., Philip Harvey, Aspirational Law, 52 BUFF. L. REV. 701 (2004).

2. “Sanism” is 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. It infects both our jurisprudence and our lawyering practices. Sanism is largely invisible and largely socially acceptable. It is based predominately upon stereotype, myth, superstition, and deindividualization, and is sustained and perpetuated by our use of alleged “ordinary common sense” (OCS) and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process. Michael L. Perlin, “Half-Wracked Prejudice Leaped Forth”: Sanism, Pretextuality, and Why and How Mental Disability Law Developed as It Did, 10 J. CONTEMP. LEGAL. ISSUES 3, 4-5 (1999) [hereinafter Perlin, Half-Wracked Prejudice]. See generally MICHAEL L. PERLIN, THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL 21-58 (2000) [hereinafter PERLIN, HIDDEN PREJUDICE].

3. “Pretextuality” defines the ways in which courts accept (either implicitly or explicitly) testimonial dishonesty and engage similarly in dishonest (and frequently meretricious) decision making, specifically where witnesses, especially expert witnesses, show a high propensity to purposely distort their testimony in order to achieve desired ends. This pretextuality is poisonous; it infects all participants in the judicial system, breeds
Yet, there is – remarkably – some cause for optimism. For, by and large, the malignancy of these universal factors has recently been brought to light by trail-blazing “specialty” non-governmental organizations (NGOs)\(^4\) or, to a lesser extent, by “global” NGOs.\(^5\) This work has exposed the ways that the “practice” of mental disability law shocks the conscience of the world’s citizenry.\(^6\) Perhaps, this heroic work (there is no other adjective that is nearly as appropriate a descriptor) will eventually be redemptive as we seek to create new systems in which international human rights are honored, not ignored. Most recently, the adoption of the United Nations Convention on the Rights of Persons with Disabilities\(^7\) infuses new hope into all aspects of this enterprise.

In this Article, I will discuss each of these universal factors, and offer examples from selected regions of the world.\(^8\) As just indicated, these examples will come primarily \textit{not} from case law and sophisticated
cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blasé judging, and, at times, perjurious and/or corrupt testifying. Michael L. Perlin, “She Breaks Just Like a Little Girl”: Neonaticide, the Insanity Defense, and the Irrelevance of “Ordinary Common Sense,” 10 WM. & MARY J. WOMEN L. 1, 25 (2003). \textit{See generally PERLIN, HIDDEN PREJUDICE, supra note 2, at 59-76.}

4. That is, NGOs that specialize in mental disability law issues, such as Mental Disability Rights International (MDRI) and Mental Disability Advocacy Center (MDAC). For more information on the MDRI, see Mental Disability Rights International, http://www.mdri.org (last visited Feb. 12, 2007). For more information on the MDAC, see Mental Disability Advocacy Center, http://www.mdac.info (last visited Jan. 31, 2007).

5. That is, NGOs that campaign for international human rights on a worldwide basis, such as Amnesty International (Al), or on a regional basis, such as the Bulgarian Helsinki Committee. For more information on the Al, see Amnesty International, http://www.amnesty.org (last visited Feb. 12, 2007). For more information on the Bulgarian Helsinki Committee, see Bulgarian Helsinki Committee, http://www.bghelsinki.org/index_en.html (last visited Feb. 12, 2007). On the relative tardiness on the part of such NGOs to involve themselves in this effort, see Michael L. Perlin, “Darkness at the Break of Noon”: Deconstructing the Refusal of Mainstream Human Rights Agencies to Consider Human Rights Violations of Mental Disability Law (manuscript in progress).


8. Certain nations will appear in this Article in what may appear to be a disproportionate number of times. This is simply a reflection on the reality that extensive studies have been done about very few nations. My experience in this field — I have done trainings, advocacy workshops and site visits in at least seven Central and Eastern European nations, five Central and South American nations, and two Asian nations — suggests to me that the findings on which I report here typify the situation in many other nations as well.
jurisprudential analyses as we might find in other substantive areas of the law (in good part, because there is so little case law and sophisticated analysis to be found), but from reports done by advocacy agencies and NGOs such as the ones to which I have just referred.

I. AN OVERVIEW

The state of mental disability law in many parts of the world today reveals a pattern and practice of ongoing abuses that is “reminiscent of the state of American mental health facilities 35 or more years ago.” Early institutional rights cases in the United States revealed persistent and pervasive mistreatment of persons with mental disabilities. As recently as 1958, state hospitals were characterized by the president of the American Psychiatric Association as “bankrupt beyond remedy.” Three years later, a witness testified at a Congressional hearing that “[s]ome [state hospital] physicians I interviewed frankly admitted that the animals of nearby piggeries were better housed, fed and treated than many of the patients on their wards.” When the chairman of the legal action committee of the National Association of Retarded Children (now The ARC) characterized the Pennhurst State School as “Dachau, without ovens,” there was never any accusation of exaggeration.

10. See, e.g., 2 Michael L. Perlin, Mental Disability Law: Civil and Criminal, ch. 3 (2d ed. 1999).
And so it is elsewhere today. A 2002 report on conditions in social care homes in Hungary bears witness:

These abuses include the use of locked bed cages in Hungarian psychiatric facilities, also known as net beds, in which patients are restrained at night, and perhaps for periods during the day. They include the use of unmodified electroconvulsive therapy administered for punitive purposes. They also include the isolation of patients in overcrowded social care homes located in rural areas, thereby cutting off patients from people in their communities. They include as well abusive practices by guardians, who instead of seeking to promote the best interests of their wards, commit them to these isolated social care facilities on a “voluntary” basis.

Many facilities offer unsanitary living conditions containing rooms that smell of urine and feces. Patients lack privacy, living in rooms that are incapable of being locked. They lack conjugal rights. Their ability to communicate with those outside is highly restricted or forbidden altogether, and both incoming and outgoing mail is opened by facility staff. Phone calls are either limited or not permitted. These facilities do not offer adequate medical or dental care for their patients. Patients frequently remain uninformed concerning their rights and often lack the ability to complain about their treatment.\(^1\)

In some parts of the world, these conditions are fatally accepted. By way of example, there is a belief that “the right of a psychiatric patient to receive modern treatment to alleviate suffering is not something within the capacity of most African countries.”\(^6\) By way of further example, Uruguayan researchers were told by hospital officials that informing patients about their treatment would be logistically difficult and would actually worsen the patients’ conditions.\(^7\) Although the Iron Curtain has long ago fallen, “[i]n some countries, prosecutors still retain the Stalin-esque power to order detention in a psychiatric institution without prior medical opinion.”\(^8\)

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15. Winick, supra note 9, at 537-38.


Reflect again on the American experience. There has been a major revolution over the past 35 years that has, on many levels, transformed U.S.-based public mental health care. The question to consider is this: Can and will these transformational experiences be replicated elsewhere? These are the five core factors that we must consider.

II. THE CORE FACTORS

A. Core Factor #1: Lack of Comprehensive Legislation to Govern the Commitment and Treatment of Persons with Mental Disabilities, and Failure to Adhere to Legislative Mandates

A recent report by the World Health Organization (WHO) revealed that 25% of all nations in the world have no mental health law. "In Ethiopia, for example, there is no mental health legislation and involuntary hospitalization and treatment only requires informed consent from the escort bringing the individual to the hospital." A more recent study of 12 European and Western nations found that only half of those had a specific mental health act, and that none of the existing acts used "current psychiatric terminology." On a site visit in

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20. Professor Winick believes that this replication has already begun: In some ways, the American experience is now being replicated in Eastern Europe. Organizations, such as Mental Disability Rights International, are championing the rights of those with mental illness in these countries, dramatizing the existence of abuses and asserting their rights in the courts. Thus, we are seeing the beginning of a transformation of mental health law in Eastern Europe from a medical to a legal model.

Winick, supra note 9, at 539.


23. Joanna Rymaszewska & Stanislaw Dabowski, Rules and Regulations for Involuntary Placement or Treatment of Mentally Ill Persons - Results from a Structured Survey Instrument in 12 European Countries, and Results from a Quality Assurance Project
Estonia, in December 2000, done in conjunction with the Estonian Psychiatric Patients Advocacy Association, I asked administrators of the psychiatric hospital in Tallinn (the nation’s capital) for a copy of the Estonian mental health law. No one knew where it could be found.24

Other nations’ mental health laws are incomplete, outmoded, or unclear. The 1999 Psychiatric Care Law of the Kyrgyz Republic has no “definitions” section.25 “In a [WHO] study of Costa Rica, Honduras, Nicaragua, and Panama, researchers found that in practice most compulsory psychiatric hospitalizations had no approval by a judge regardless of the laws of the country and that no patient was entitled to refuse treatment.”26 In the Kyrgyz Republic, again, the 1999 law “lacks any provisions mandating the reporting and investigation of alleged patient abuse and/or neglect at psychiatric facilities.”27 Elsewhere in the same law, the term “emergency case” – discussed in an article on psychiatric decision making in cases – is never defined.28 On a site visit to Nicaragua,29 a colleague and I were shown the Nicaraguan mental health law which, in its entirety, was one brief paragraph.30

27. KYRGYZ REPORT, supra note 25, § 4.1.3. The authors continue:

The Law should be amended to include mandatory reporting and investigation of alleged patient abuse and neglect provisions. Reporting and investigating allegations of patient abuse and neglect is a key element in ensuring that abusive and/or negligent staff will be identified and disciplined or have their employment terminated, as is appropriate. These requirements also serve to stop and prevent patient abuse and neglect.

Id. § 4.1.1.

28. Id. § 4.1.1.
The new United Nations Convention on the Rights of Persons with Disabilities\textsuperscript{31} obligates all state parties "[t]o adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the present Convention."\textsuperscript{32} The extent to which this obligation is honored will reveal much about the Convention's ultimate "real world" impact.

Often, when there are laws on the books, they are simply ignored. Jennifer Fischer, in her multi-nation analysis of the global state of right-to-refuse treatment, reports: "Although some countries require consent to treatment, hospital staff routinely ignore it, and testimony from patients and former patients indicates that staff rarely provide adequate information about the treatment."\textsuperscript{33} Consider this report by Amnesty International on conditions in Romania:

Many of the people placed in psychiatric wards and hospitals throughout the country apparently do not suffer an acute mental disorder and many do not require psychiatric treatment. Their placement in psychiatric hospitals cannot be justified by the provisions of the Law on Mental Health and they should also be considered as people who have been arbitrarily deprived of their liberty. They had been placed in the hospital on non-medical grounds, apparently solely because they could not be provided with appropriate support and services to assist them and/or their families in the community. Often, because of their disability they are more vulnerable to abuse, which apparently is not taken into consideration by hospital staff as in most places such residents were not segregated from people who have different needs for care.\textsuperscript{34}

Similarly, a study of conditions in Uruguay revealed that in practice, there appears to be little or no attention paid to the mental health law. "Many patients do not have a diagnosis in their chart, nor an explanation of why they were committed in the first place. Patient records do not contain individualized treatment plans nor any medical

\begin{thebibliography}{99}

31. U.N. Convention, \textit{supra} note 7; \textit{see generally} Dhir, \textit{supra} note 7.

32. Id. art. 4.1(a).

33. Fischer, \textit{supra} note 16, at 185 (citing Lewis, \textit{supra} note 18, at 295); \textit{see generally} Perlin, \textit{supra} note 18.


\end{thebibliography}
These conditions continue. As recently as October 2006, the European Human Rights Court awarded a Hungarian man a verdict of two million Hungarian forint following his illegal detention for three years in a Hungarian psychiatric hospital (in a case in which a local Hungarian court failed to offer any suggestions as the reasons for his detention). These violations are clearly not a "thing of the past."

Such conditions clearly violate international human rights law. Amnesty International has charged that the Romanian practice "amounts to arbitrary detention and denial of fair trial rights, including Articles 9 and 14 of the International Covenant on Civil and Political Rights (ICCPR) and Articles 5 and 6 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR)." Oliver Lewis’s study of a cluster of Eastern European nations similarly finds persistent and unrelenting violations of Article 5 of the ECHR, and notes that in many nations, public psychiatric hospital staffs are not even aware of the existence of these international human rights provisions. Such findings, sadly, reflect what the norm in many areas of the world is.

B. Core Factor #2: Lack of Independent Counsel and Lack of Consistent Judicial Review Mechanisms Made Available to Persons Facing Commitment and Those Institutionalized

The development of mental disability law in the United States


36. This is the equivalent of $10,312.62 (USD), as of February 27, 2007. See Quick Currency Converter, http://xe.com (last visited Feb. 27, 2007).


38. See also Press Release, Mental Disability Advocacy Center, EU Opens Door to Bulgaria, Disabled People Shut in Institutions, Victim Seeks Justice at European Court (Oct. 4, 2006), available at http://www.mdac.info/documents/PR_MDAC_BHC_20061004_eng.pdf (last visited Feb. 27, 2007) (reporting on a recent case brought in the European Court of Human Rights by MDAC on behalf of a Bulgarian individual detained and medicated against his will in a local hospital notwithstanding the opinion of five psychiatrists who recommended outpatient treatment) [hereinafter Bulgarian Case].

39. ROMANIAN MEMORANDUM, supra note 34.

40. Lewis, supra note 18, at 295.
tracks – inexorably and almost absolutely – the availability of appointed
counsel to persons facing commitment to psychiatric institutions, to
those being treated in such institutions, and to those seeking release
from such institutions.\textsuperscript{41} Without the availability of such counsel, it is
virtually impossible to imagine the existence of the bodies of
involuntary civil commitment law, right to treatment law, right to refuse
treatment law, or any aspect of forensic mental disability law that are
now taken for granted.\textsuperscript{42} Similarly, especially in the area of involuntary
civil commitment law, the presence of regular and on-going judicial
review has served as a bulwark of protection against arbitrary state
action.\textsuperscript{43}

Put simply, neither of these protections – accessible, free counsel
and regular judicial review – is present in most of the world’s mental
disability law systems. It is rare for even minimal access to counsel to
be statutorily (or judicially) mandated, and, even where counsel is
legislatively ordered, it is rarely provided. Moreover, the lack of
meaningful judicial review makes the commitment hearing system little
more than a meretricious pretext.

Again, the Kyrgyz Republic provides an instructive example. The
1999 Psychiatric Care Law of the Kyrgyz Republic does not specifically
provide for appointing counsel in involuntary civil commitment
proceedings.\textsuperscript{44} As the Mental Disability Advocacy Center (MDAC)\textsuperscript{45}
report on that nation indicates:

The right to an attorney is essential to ensure that the rights of the
patient are protected in the involuntary civil commitment process. It is
not enough to have legislation that allows an individual to instruct an
attorney to represent them, as many are simply unable to pay for an
attorney. The law should be modified to clearly state that an
individual who is subject to the involuntary commitment process has a
right to representation by an attorney and if they cannot afford it, an

\textsuperscript{41} See 1 PERLIN, supra note 10, § 2B-2, at 192-95; see also, e.g., Michael L. Perlin,
\textit{Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases},
16 LAW & HUM. BEHAV. 39 (1992); Michael L. Perlin, \textit{"You Have Discussed Lepers and
Crooks": Sanism in Clinical Teaching}, 9 CLINICAL L. REV. 683 (2003); Michael L. Perlin,
\textit{"And My Best Friend, My Doctor/ Won’t Even Say What It Is I’ve Got : The Role and
Significance of Counsel in Right to Refuse Treatment Cases}, 42 SAN DIEGO L. REV. 735, 738
(2005) (discussing the “meaningful and complex performance standards for counsel in such
cases” set by the Montana Supreme Court in \textit{In re the Mental Health of K.G.F.} 29 P.3d 485
(Mont. 2001)).

\textsuperscript{42} See, e.g., 1 PERLIN, supra note 10, ch. 2; 2 id. ch. 3; 4 id. chs. 8-9.

\textsuperscript{43} See, e.g., 1 id. ch. 2C.

\textsuperscript{44} KYRGYZ REPORT, supra note 25, § 4.1.2.i.

\textsuperscript{45} See supra note 4.
attorney will be provided to them free of charge.\textsuperscript{46}

The new U.N. convention mandates that "States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity."\textsuperscript{47} The extent to which this Article is honored in signatory nations will have a major impact on the extent to which this entire Convention "matters" to persons with mental disabilities.

The absence of judicial review is stark, and it is here that the gap between law-on-the-books and law-in-action\textsuperscript{48} is the starkest. Putting aside those jurisdictions in which there is not even a written promise of judicial review,\textsuperscript{49} in many of those nations where judicial review \textit{appears} to be mandated by statute, it in fact does not exist.\textsuperscript{50}

Elsewhere, Oliver Lewis tells us that "[m]ainstreaming ‘mental disability rights’ into our regular human rights agenda is a crucial step towards thinking seriously about protecting the rights of people with mental disabilities."\textsuperscript{51} It is impossible to fulfill this aspiration unless counsel is regularly provided and meaningful judicial review is instituted.

\textsuperscript{46} KYRGYZ REPORT, supra note 25, § 4.1.2.i (footnote omitted). \textit{See also} Larry Gostin, \textit{Human Rights in Mental Health: A Proposal for Five International Standards Based upon the Japanese Experience}, 10 INT’L J.L. & PSYCHIATRY 353, 360 (1987) ("It is a basic jurisprudential principle that all people are entitled to a full and impartial judicial hearing prior to a loss of liberty.").

\textsuperscript{47} U.N. Convention, supra note 7, art. 12.3. Elsewhere, the Convention commands: States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.

\textit{Id.} art. 13.1

\textsuperscript{48} I discuss this in an international human rights law context in Perlin, \textit{supra} note 19, at 425.

\textsuperscript{49} \textit{See, e.g.}, KYRGYZ REPORT, supra note 25, § 4.1.4 ("There are simply no provisions in the 1999 Psychiatric Care Law for judicial review.").

\textsuperscript{50} \textit{See} Lewis, \textit{supra} note 18, at 295.

After a person has been detained by a psychiatrist, most countries’ legislation provide for a review by a judge, as required by Article 5(4) ECHR, which provides that "[e]veryone who is deprived of his liberty [...] shall be entitled to take proceedings by which the lawfulness of detention shall be decided speedily by a court and his release ordered if the detention is not lawful." However, \textit{no country in the region is in compliance with Article 5(4)}.

\textit{Id.} (emphasis added).

C. Core Factor #3: A Failure to Provide Humane Care to Institutionalized Persons

The justification for the entire enterprise of inpatient psychiatric hospitalization rests on one thin reed: that meaningful, ameliorative individualized treatment is available at the facility to which the individual has been committed, and that that treatment is logically geared to improving the individual’s condition so that optimally he can be released.52

The international record of providing such treatment is, to be charitable, abysmal. Notwithstanding a wide array of international human rights instruments guaranteeing patients a broad panoply of rights, including, by way of examples: “the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient’s health needs and the need to protect the physical safety of others[,]”53 the right to such treatment that is “directed towards preserving and enhancing personal autonomy[,]”54 and the right to be free from unnecessary physical restraints or involuntary seclusion.55 The quality of services made available to persons in psychiatric hospitals in much of the world is so substandard as to easily meet the “shock the conscience” standard often employed in U.S. courts in determining whether specific conditions of institutionalization violate due process and/or the cruel and unusual punishment clause of the Eighth Amendment.56

Consider, for example, the “critical” conditions that investigators discovered at Romanian hospitals:

The majority of the patients in the women’s psychiatric ward of the Târnăveni general hospital were accommodated in 2003 in two large rooms which were kept constantly locked. There were around 100 patients in the so-called “upper locked ward” and about 50 patients in the “lower locked ward.” Adjacent to the latter was the ‘lower locked side ward’ where about 10 women with very severe disabilities were held with no access to running water and the toilet had no plumbing. Patients did not have access to basic toiletries and had only one

52. See generally Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972). See also 2 PERLIN, supra note 10, § 3A-3.1, at 24 (characterizing Wyatt as “one of the most influential mental disability law cases ever filed”).


54. Id. princ. 9(4).

55. Id., princ. 11(11).

56. See, e.g., supra text accompanying note 6.
opportunity a week to shower. All women on the wards were expected to shower within two hours when hot water was available on Fridays and no towels were provided. Staff did not ensure that women in the "lower locked ward" and "lower locked side ward" were appropriately dressed. Patients often walked around scantily clothed or naked and very few had shoes. The hospital floor was often cold and wet. In the "lower locked side ward" the floor was often covered in faeces and urine because many patients held there were incontinent. Some patients spent the entire day in urine-soaked or faeces-covered clothing and bedding. Patients did not have an adequate and varied diet. In the "lower locked ward" and "lower locked side ward" the patients were made to take their meals in the dormitory area, although there was a dining area close by. They were served through a small opening in the door and were not supervised by the staff during the meal. They were not provided with cutlery and ate using their hands. Metal bowls used at mealtimes were often thrown by patients at each other, frequently resulting in injuries.\footnote{57}

What is more, conditions continued to get worse. "Also in January 2004 the conditions had reportedly deteriorated in the psychiatric hospital in Turceni, which cares for 105 patients and residents in a crumbling, damp building, smelling of urine and filth. The patients were suffering from lice and wore pajamas that were dirty and tattered."\footnote{58}

Consider here Article 22 of the new U.N. Convention: "No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy . . . ."\footnote{59} What impact will this article have on cases that might be brought in the future to ameliorate conditions such as those described here?

Elsewhere, "cage beds" are routinely used to house patients in spite of the fact that such "treatment" (the word must be placed in quotations) has been roundly condemned by the United Nations Human Rights Commission and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT).\footnote{60} In the Czech Republic, researchers – led by officials of the MDAC – found

\footnote{57. \textit{Romanian Memorandum}, supra note 34, at 4.}
\footnote{58. \textit{Id.} at 5.}
\footnote{59. U.N. Convention, supra note 7, art. 22.}
\footnote{60. See, e.g., Press Release, Mental Disability Advocacy Center, Harry Potter Joins the Fight to End Czech "Cage Bed" Use (July 16, 2004), \textit{available at} http://www.mdac.info/documents/czech%20cage%20bed%20press%20release.pdf#search='cage%20bed%20in%20CPT (last visited Feb. 11, 2007).}
“cases of individuals, including young children, kept in cage beds for practically the entire day—every day—except when they needed to use the toilet.” 61 These practices were subsequently decried by a member of the European Parliament who demanded abandonment of the use of such beds as a prerequisite for the Czech Republic’s admission to the European Union.62

The use of cage beds is not limited to the Czech Republic.63 And the justification for their continued use is a textbook example of the way that pretextuality dominates this entire subject matter area.64 Oliver Lewis describes an experience in Slovakia:

The author observed the long-term use of caged beds in one Slovak home: seven women were each placed in a caged-bed for most of the day. The reasons given for using a cage bed on a 21-year-old woman with intellectual disabilities was that “she is aggressive.” When asked whether it was surprising that a person caged for long periods of time would become aggressive, staff maintained that in any case she was easier to handle. The reason given for another woman’s placement in a cage bed was that she had high blood pressure: “she might fall out of bed.”65

Conditions in South America are not so different. These are the findings of Mental Disability Rights International (MDRI) on a recent investigation of the Neuro-Psychiatric Hospital of Paraguay:

The [hospital] cells are completely bare, save for a wooden platform jutting out from the cell wall. Holes in the cell floors that should function as latrines are crammed and caked over with excrement. The cells reek of urine and feces, and the walls of the cells are smeared with excrement.

Each boy spends approximately four hours of every other day in an outdoor pen, which is littered with human excrement, garbage, and broken glass. . . . [Other] conditions included:

62. Id. (quoting Member of Parliament John Bowls).
64. See supra note 3.
• unhygienic conditions, including the presence of open sewage, rotting garbage, broken glass, and excrement and urine on sidewalks, patios, and in wards throughout the institution;
• sub-custodial and dangerous levels of staffing;
• an absence of almost any treatment interactions of any kind;
• frequent shortages of food and medicines; [and]
• lack of medical, dental, and psychiatric support on a timely basis.66

And these findings substantially track other findings made by the same NGO in Mexico five years earlier:

At Ocaranza [a psychiatric hospital], people were penned into small areas of residential wards where they were left to sit, pace, or lie on the concrete floor all day. Without activities or attention, they rocked back and forth or self-stimulated in other ways. Some patients regularly urinated or defecated on the floor, in areas where others often sit or walk through with bare feet. Residents of Ocaranza were brought straight from this ward to the dining area without an opportunity to wash their hands or clean themselves. Those able to get to a bathroom did not have access to toilet paper. People on the ward were given medications with water from a common bucket, using one cup passed from one person to another.

The children’s ward at the Jalisco psychiatric facility was even worse. Children were left lying on mats on the floor, some covered with urine and feces. During both MDRI’s 1998 and 1999 visits, flies were everywhere and the smell was overwhelming. Self-abuse was common and basic medical care was lacking. Without adequate supervision, children were observed eating their own feces and physically abusing themselves without attention from staff. The institution does not have the behavior programs necessary to prevent children’s self-abusive behavior. According to staff, some children were left completely without habilitation, self-care skills training, or activities to keep them busy.67

On a site visit to a Nicaraguan public hospital in 2003, I observed male patients walking in wards totally naked (with both male and female staff

Female patients were brought outside the hospital for lunch. They were wearing doctor’s office-type gowns, exposing their breasts and buttocks. Food was passed around in large bowls, and there were no utensils. Each patient had to reach in and scoop out food (some sort of vegetable stew) with her hands.68

Cages, astonishingly, are also used outside of institutions. An Amnesty International investigation in Bulgaria documented women locked in a cage outside one institution. “The cage was full of urine and [feces] and the women covered in filth. One woman was unclothed on the lower half of her body and many sores were visible on her skin.”69

And, on the same visit to Nicaragua in 2003, I visited a home in which two mentally disabled persons (aged 23 and 32) were permanently confined to outdoor rooms that were built as cages to prevent them from leaving the premises. At the time, in an interoffice memorandum, I characterized that visit as “the saddest sight of my professional life.”70

The conditions discussed in this section “eerily reflected the conditions at Willowbrook State School in New York City when they were exposed to a stunned nation some thirty years ago by the then-fledgling investigative reporter Geraldo Rivera.”71 But it is not sufficient to say that Central and Eastern Europe, and Central and South America are simply “thirty years behind” the United States. Consider what has transpired during those thirty years:

- the United Nations General Assembly has adopted the “Mental Illness Principles”;72
- the European Court on Human Rights (ECHR) has decided multiple cases reaffirming basic and fundamental rights in the commitment and institutionalization process;73
- mental disability-focused NGOs such as MDRI and MDAC have called the world’s attention to the examples of inhumane

68. Hospital officials had advance knowledge that we were coming. This was in no way a surprise visit.
71. Perlin, supra note 19, at 424-25.
72. MI Principles, supra note 53.
73. See generally European Court of Human Rights, http://www.echr.coe.int/echr (last visited Feb. 4, 2007); PERLIN ET AL., supra note 21, at 451-782 (ECHR case law).
treatment discussed above, 74

- “global” NGOs such as Amnesty International have, finally, acknowledged that violations of the rights of persons institutionalized because of mental disability are, indeed, international human rights violations; 75

- the World Health Organization has published a Resource Book on Mental Health, Human Rights and Legislation; 76

- academics and activists have begun to create theoretical frameworks through which these problems can be addressed; and

- most recently, and potentially most importantly, the U.N. has adopted a new Disability Rights Convention. 77

Yet, until governments of all nations authentically commit themselves to ameliorate – with transparency – conditions in public institutions, all that has transpired in courtrooms, legislatures, and the writings of scholars will amount to little more than “paper victories.” 78

The U.N. Convention calls for “respect for inherent dignity” 79 and “non-
Subsequent articles declare "freedom from torture or cruel, inhuman or degrading treatment or punishment," "freedom from exploitation, violence and abuse," and a right to protection of the "integrity of the person." The extent to which these are given life will significantly determine whether the "victories" just referred to are more than "paper" ones.

D. Core Factor #4: Lack of Coherent and Integrated Community Programs as an Alternative to Institutional Care

In 1999, the U.S. Supreme Court held, in the case of Olmstead v. L.C., that the Americans with Disabilities Act (ADA) entitled plaintiffs – residents of Georgia Regional Hospital – to treatment in an integrated community setting as opposed to an unnecessarily segregated state hospital. In writing the majority opinion, Justice Ginsburg stressed that "[u]njustified isolation . . . is properly regarded as discrimination based on disability," and ordered that states be required to maintain "a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings," thus explicitly endorsing the ADA's "integration mandate."

For years, U.S. litigators had sought the creation of constitutional rights to community treatment and/or aftercare, but these efforts were, ultimately, uniformly unsuccessful (although courts were not reluctant to enforce statutory provisions mandating such care). The ADA, however, offered advocates new tools to use in these efforts. Although early descriptions of the ADA as an "Emancipation Proclamation" for

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80. Id. art. 3(b).
81. Id. art. 15.
82. Id. art. 16.
83. Id. art. 17.
86. Id. at 597, 605-06.
persons with disabilities\textsuperscript{90} were probably overstated,\textsuperscript{91} the Supreme Court's decision in \textit{Olmstead} did make it clear that – under U.S. federal statutory law, at least – the community integration principle was now part of the American legal fabric.\textsuperscript{92}

It is not the same everywhere.\textsuperscript{93} The Kyrgyz investigation, again, revealed that, in that nation, there were only "three instances of outpatient care."\textsuperscript{94} Hospital authorities in Uruguay told researchers that "between one third and two thirds of the total inpatient population need not be committed but are held because they have nowhere else to go."\textsuperscript{95} In other nations, "[h]undreds of thousands of people with mental health problems, intellectual disabilities, alcohol problems, drug addiction (and people with no health problems at all, so-called 'social cases') are housed together in [large residential institutions that] have become known as 'social care homes'. . . . These are institutions from which residents are rarely discharged."\textsuperscript{96}

There may, however, be some modest cause for optimism. First, activists and advocates have begun to sketch out legal theories through which the right to community integration may be located in international human rights law. In their report excoriating conditions in mental institutions in Kosovo, Eric Rosenthal and Eva Szeli


\textsuperscript{91} See Perlin, supra note 11, at 250 ("It is [the] omnipresence of sanism – and its evil twin, pretextuality – that continues to temper my enthusiasm about the ADA as a civil rights statute and \textit{Olmstead} as an implementing (or, perhaps, motivating) decision.").


[The fact that disability rights activists have placed such a high priority on the enactment of legislation expanding the Medicaid program is itself telling. It reflects a recognition by disability rights activists that the ADA alone is not sufficient to achieve community integration for people with disabilities. Social welfare law remains important as well.

\textit{Id.} at 69-70.


\textsuperscript{94} KYRGYZ REPORT, supra note 25, \textsection 7.2.2 (emphasis added).

\textsuperscript{95} Moncada, supra note 35, at 617. For one example of how American courts have sought to deal with this dilemma, see \textit{In re S.L.}, 462 A.2d 1252, 1258 (N.J. 1983) (creating "discharged pending placement" category). \textit{But see}, Perlin, supra note 87, at 1050 ("[I]t is clear that this status has been used in significantly anti-therapeutic ways.").

\textsuperscript{96} Lewis, supra note 18, at 297. \textit{See e.g.}, Bulgarian Case, supra note 38.
In addition to protecting rights within institutions, international law recognizes a right to community integration. Policies that promote community integration are not just good practice to promote mental health; they have also been recognized as a right under international human rights law. Under the MI Principle 3, "[e]very person with mental illness shall have the right to live and work, as far as possible, in the community." For people in need of mental health treatment, Principle 7 recognizes that "[e]very patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives." The right to community integration can only be limited where a person meets the formal standards for civil commitment, as set forth in Principles 15-17.

The right to community integration has recently been recognized as a legal obligation under the International Covenant on Economic, Social, and Cultural Rights (ICESCR). The United Nations Committee on Economic, Social, and Cultural Rights has adopted General Comment 5, which describes the obligations of governments to protect against discrimination under the covenant. To protect against discrimination, the General Comment 5 recommends that governments adopt legislation and policies that "enable persons with disabilities to live an integrated self-determined and independent life." The General Comment goes on to make clear, by citing the U.N.'s World Programme of Action concerning Disabled Persons, that anti-discrimination laws should not only require social policies that promote community integration but that these are individual rights. Governments are required to allocate resources accordingly. Thus, the right to protection against discrimination[] implies that the needs of each and every individual are of equal importance, that these needs must be made the basis for the planning of societies, and that all resources must be employed in such a way as to ensure, for every individual, equal opportunity for participation. Disability policies should ensure the access of [persons with disabilities] to all community services.97

At about the same time, Eric Rosenthal and Arlene Kanter looked specifically to *Olmstead* as a source for such rights, arguing that failing to provide opportunities for people with disabilities to live in the community, rather than in institutions, may violate a broad array of

recognized human rights. Drawing on the *Olmstead* reasoning, they concluded that "governments that provide services to people with disabilities exclusively in institutions, without providing meaningful alternatives in the community, may be found to violate international human rights law by providing services in a discriminatory manner."  

Indeed, a wide range of international human rights documents beyond the ICESCR and the MI Principles may offer additional support of these theoretical arguments. Again, in urging that a right to community integration be articulated under international human rights standards, Rosenthal and Kanter draw on:

References to community integration [found, variously,] in Article 23 of the Convention on the Rights of the Child, and in instruments and documents of the U.N. General Assembly such as the Declaration on the Rights of Mentally Retarded Persons, the 1991 Principles for the Protection of Persons with Mental Illness, the 1993 Standard Rules on Equalization of Opportunities for Persons with Disabilities; and General Comment 5 to the International Convention on Economic, Social and Cultural Rights, as well as in the Charter of Fundamental Rights of the European Union.

The time is right, they argue, for the broader application of the U.S. Supreme Court’s community integration mandate, together with rights recognized in various international human rights conventions and interpretations, concluding, “[p]erhaps the time has come.”

In at least one remarkable example, the theoretical arguments discussed above appear to have been successful. Within the past two years,


99. *Id.* at 876.

100. *Id.* at 877.

Another more recent example of an international instrument recognizing a right to community integration is the Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities, adopted by the Organization of American States (OAS). This Convention contains many important provisions, including the explicit recognition of a right to community integration. However, unlike other general human rights conventions, the OAS Convention does not create an immediate obligation on states to enforce the rights it establishes.

*Id.* at 879.

101. *Id.* at 881. Rosenthal and Kanter wrote their article prior to the publication of the U.N. Convention. It is certainly reasonable to expect that that Convention’s declaration of a right to “living independently and being included in the community” will also be a source of similar arguments in the future. U.N. Convention, *supra* note 7, art. 19.
MDRI and the Center for Justice and International Law (CEJIL) have signed an historic settlement with the Paraguayan government aimed at ending the improper detention of hundreds of people in the country’s state-run psychiatric hospital. Filed with the Inter-American Commission on Human Rights of the Organization of American States (OAS), the settlement is the first agreement in Latin America to guarantee the rights of patients to live and receive mental health services in the community.\textsuperscript{102}

Under the terms of this settlement, Paraguay must now produce a mental health reform plan to create community-based services for people who have been left to languish for decades in the locked institution. The plan will require the government to transition more than 400 patients detained in the hospital back into the community.\textsuperscript{103}

There is an authentic concern that, unless meaningful and broad-based community-based services are established in a comprehensive manner, the litigation that has been undertaken to reform institutional conditions can not possibly have long-term value. The Paraguay case.
is, as of the time that this Article is being written, the advocates' best hope.

E. Core Factor #5: Failure to Provide Humane Services to Forensic Patients

Virtually all studies and reports referred to in this article have focused on the status (and plight) of civil patients: those whose commitments to the mental health system were not occasioned by arrest or other involvement in the criminal court process. Depressingly, persons in the forensic system generally receive – if this even seems possible – less humane services than do civil patients.104

Some examples are, for want of a better word, stupefying. In Hungary, until very recently, convicted prisoners from Budapest Prison were used to “keep an eye on” patients in IMEI (Hungary’s only high security forensic psychiatric institution) “with high suicide risk.”105 In Albania, persons with mental disabilities who have been charged with a criminal offense reside in a prison unit and must comply with prison rules while institutionalized.106 “Although Albanian law stipulates one year of treatment to be followed by a re-evaluation, the average length of stay is five years.”107

In Kyrgyz, there are no statutory provisions to deal with cases of persons who are potentially incompetent to stand trial.108 As a result, persons with severe mental illness who are charged with crime have no opportunity to be treated in an effort to improve their condition so as to become competent to stand trial. In insanity cases, although Kyrgyz

108. Id.
109. KYRGYZ REPORT, supra note 25, § 4.2.1. On the (otherwise) universality of the incompetency to stand trial status, see 4 PERLIN, supra note 10, § 8A-2, at 2-5.
110. See Jackson v. Indiana, 406 U.S. 715 (1972) (unconstitutional to retain untreated defendant indefinitely in maximum security forensic hospital if it is not probable he will regain his competency to stand trial in the foreseeable future). But, on the failure of many
law allows for an independent evaluation of a defendant prior to trial, "legal aid attorneys [said] that they have never retained an independent expert because they have no money to do so." This right thus becomes illusory.112

Although, in Hungary, patients have the right to a retention hearing following a finding of non-responsibility for a criminal act (insanity), such "[p]roceedings are over in less than 5 minutes, and the issues remain untested: similar to detention hearings under civil law, lawyers do not meet their clients or take instructions."113 Such hearings, again, reflect the endemic pretextuality of the Hungarian mental health delivery system.

CONCLUSION

I know that I have painted a bleak picture in this Article. I expect that, were there more NGOs doing the work done by MDRI and MDAC, it would have been even bleaker, as I have no doubt that I would have been able to draw on examples from yet other nations of the world. My research and travels have left me little doubt that the examples I have offered here are neither unique nor exceptional. Rather, I believe they are endemic to institutional mental health care around the world.

This is not an optimistic picture, to be sure. But, there are some rays of light that may lead to at least a measure of optimism in the future – the fact that groups such as Amnesty International have (albeit tardily) entered the fray,114 the publication of the WHO Manual,115 the settlement of the Paraguay case,116 the publication of the U.N. Convention.117 Yet, all in all, the "bankrupt without remedy" descriptor used by the president of the American Psychiatric Association in 1958118 could still be used to describe the state of mental disability law

U.S. jurisdictions to implement Jackson, see Michael L. Perlin, "For the Misdemeanor Outlaw:" The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities, 52 ALA. L. REV. 193, 213 (2000).

111. KYRGYZ REPORT, supra note 25, § 6.2.


113. Lewis, supra note 18, at 297.

114. See supra text accompanying note 75.

115. See WHO MANUAL, supra note 76.

116. See Paraguay Settlement, supra note 102.

117. See U.N. CONVENTION, supra note 7.

118. See Solomon, supra note 11, at 7.
treatment in many countries of the world.

I am heartened by the increased interest in this area. It is important to keep in mind that MDRI’s and MDAC’s excoriating reports, in addition to drawing the attention of scholars and policymakers to these issues, have even intruded into the political process of European Union accession.119 And in the past several years, they have also been covered extensively in the mainstream media.120 Again, the recent publication of the U.N. Convention cannot help but draw political attention to these issues.121 From the perspective of legal education, the publication of the first casebook in this area of the law122 will likely lead to courses about this topic being offered at more law schools, reaching future potential public interest/human rights lawyers.123 I hope and expect that these circumstances and combination of factors will lead to ameliorative changes in the nations discussed here, as well as elsewhere in the world.124

119. In the Czech Republic, researchers – led by officials of the MDAC – found “cases of individuals, including young children, kept in cage beds for practically the entire day - every day - except when they needed to use the toilet.” Press Release, Mental Disability Advocacy Center, supra note 61. These practices were subsequently decried by a member of the European Parliament who demanded abandonment of the use of such beds as a prerequisite for the Czech Republic’s admission to the European Union. Id. (quoting Member of Parliament John Bowls). See also Press Release, Mental Disability Advocacy Center, MDAC Urges EU to Include Human Rights in Mental Health Strategy (June 3, 2006), available at http://www.mdac.info/documents/PR_MDAC_urges_EU_20060603_eng.pdf (last visited Feb. 12, 2007).

120. See, e.g., Craig Smith, Abuse of Mentally Ill Is Reported in Turkey, INT’L HERALD TRIBUNE, Sept. 28, 2005, at 1; Craig Smith, Romania’s Orphans Face Widespread Abuse, Group Says, N.Y. TIMES, May 10, 2006, at A3.


122. See PERLIN ET AL., supra note 21.

123. The casebook was published in the summer of 2006. At this point, courses are being offered at New York Law School and Syracuse University College of Law, and a course was offered using the in-press page proofs at the Institute of Human Rights at Abo Akademi University in Turku, Finland, in the fall of 2005. The course is also scheduled to be offered at Gonzaga University School of Law in the next academic year.

124. On the capacity of Internet instruction to reach law students, professionals and other policymakers elsewhere in the world, see Perlin, supra note 29; Michael L. Perlin, “Ain’t No Goin’ Back”: Teaching Mental Disability Law Courses on Line, 51 N.Y. L. SCH. L. REV. (forthcoming 2007).
Writing in 1993, Eric Rosenthal and Leonard Rubenstein first illuminated how the MI Principles "come from an individualistic, libertarian perspective that emphasizes restrictions on what the state can do to a person with mental illness."\(^{125}\) A presenter at a conference held at New York Law School on the treatment of persons with mental disabilities referred to this article, and then told the audience, "[w]ithout advocates willing to get in the trenches and fight for these ideals, so that they might become a reality for persons with mental disabilities, these treaties and standards remain mere words without action."\(^{126}\) This is a goal to which all of us who takes this area of law and society seriously should aspire.

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