GUEST EDITORIAL

The rights of persons with mental disabilities: is the UN Convention the answer? An Arab perspective

Nasser Loza[1] and Mostafa Hussein Omar[2]

[1]The Behman Hospital, Cairo, Egypt, email n.loza@behman.com

[2]The Behman Hospital, Cairo, Egypt, email m.omar@behman.com

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The existence of mental health legislation reflects the potential and willingness of a country to provide better mental health services and to move towards realising better human rights standards. We review the availability of mental health legislation in the Arab world in light of the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

The Convention on the Rights of Persons with Disabilities

The CRPD is the first human rights treaty of its kind in the 21st century. It aims to transform attitudes towards persons with disabilities whereby they are viewed, rather than as objects of charity, as individuals with equal rights, capable of making informed decisions and being active members of society. The CRPD came into force in 2008 as a human rights document with a social developmental mandate. It covers the human rights of people with all kinds of disabilities, including mental and intellectual.

The CRPD does not explicitly define 'disability' but characterises persons with disabilities as those who have 'long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.

The CRPD set up the UN Committee on the Rights of Persons with Disabilities and requires state parties to report regularly on their application of the Convention (UN General Assembly, 2007).

Articles 12 and 14 of the CRPD and the Arab Group

Article 12(2) of the CRPD declares that state parties 'shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life', while Article 12(3) compels state parties to provide the support that persons with disabilities may require in exercising their legal capacity. Article 14 states that persons with disabilities should 'enjoy the right to liberty' and that 'if persons with disabilities are deprived of their liberty through any process, they are on an equal basis with others'. The General Comment on Article 12 states that persons with disabilities will have capacity at all times and dismisses all kinds of substituted decision-making, including involuntary admission and treatment under any circumstances.

In the context of Arab culture, the family often participates in decision-making on matters related to health and social welfare, forming a doctor–patient–family relationship as opposed to a doctor–patient relationship (El-Islam, 2005). As mentioned above, Article 12(3) says that people with disabilities should be provided with 'the support they may require in exercising their legal capacity', and the family can be interpreted as being one form of such support. Indeed, various mental health acts across the Arab world involve family members in the application for involuntary hospitalisation. During the drafting of the CRPD, 20 Arab countries included a reservation to Article 12 stating that, for those states, the concept of capacity pertains to holding this right and not to exercising it (Pearl, 2013).

Mental health legislation in the Arab world

The main source of information on the status of mental health legislation in the Arab world is the World Health Organization's *Mental Health Atlas*. First developed in 2001, it provides comprehensive estimates of global mental health resources and policies. The latest edition was developed in 2014. The data are collected through a survey sent to key mental health focal points in every member state of the World Health Organization (WHO).

Out of the 22 countries in the Arab League, 15 countries are included in the WHO *Mental Health Atlas 2014* (Table 1). Of those, seven have a stand-alone mental health law and the other eight countries have not. Four have updated their law in the past 5 years. One country reported full implementation of its mental health legislation and four countries have partially implemented their stand-alone legislation. Only four countries have reported that their laws endorse all domains necessary to comply with the guidelines as suggested in the CRPD.

As of 2014, countries in the region did not involve persons with mental disorders or their family members in mental health legislation, policy and service development (WHO, 2015).

The majority of the countries in the region are classified as middle- or low-income countries (World Bank Group, 2012). Some countries have suffered from violent dictatorships, civil wars or foreign military intervention, which have had deleterious consequences on the health services and the mental health of their people. Despite this, even politically stable high-income countries in the

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Table 1
Mental health legislation in the Arab world

Country	Stand-alone mental health legislation	Legislation updated in the past 5 years	Implementation	Alignment with human rights instruments*
Algeria	Yes	No	Partial	5
Djibouti	No	N/A	Partial	3
Egypt	Yes	No	Full	4
Iraq	Yes	Yes	Partial	4
Jordan	No	N/A	Partial	Not reported
Kuwait	No	N/A	Partial	3
Morocco	Yes	Yes	Partial	5
Oman	No	N/A	Not implemented	Not reported
Qatar	No	N/A	Not implemented	Not reported
Saudi Arabia	Yes	Yes	Not implemented	4
Somalia	No	N/A	Not implemented	Not reported
Sudan	Yes	Yes	Not implemented	5
Syria	No	N/A	Not implemented	Not reported
UAE	Yes	N/A	Partial	Not reported
Yemen	No	N/A	Not implemented	5

*Self-rated score, 5 = fully in line.
Source: Summary of data from the WHO *Mental Health Atlas 2014* (WHO, 2015).

region, such as the United Arab Emirates (UAE), have laws that lack safeguards when it comes to involuntary admission and compulsory treatment, or do not apply their laws consistently (Alhassani & Osman, 2015).

In Egypt, an assessment of the Abbasseya Mental Health Hospital, one of the largest psychiatric hospitals in Cairo, using the WHO Quality Rights Assessment Tool – which uses the CRPD as a framework – showed that the majority of human rights violations concerned: the right to an adequate standard of living (Article 28 of the CRPD); the right to enjoy the highest attainable standard of physical and mental health (Article 25); freedom from torture or cruel, inhumane and degrading treatment or punishment, as well as from physical violence and abuse (Articles 15 and 16); and the right to exercise legal capacity and personal liberty (Articles 12 and 14) (Fawzy, 2015). Even if the Mental Health Act of 2009 – which brought forward many positive changes for ensuring the rights of patients (Loza & El Nawawi, 2012) – were to be firmly implemented as imagined by the General Comment, CRPD Articles 12 and 14 would remain unfulfilled.

An assessment using the same tool showed similar results in Tunisia (WHO & Ministry of Health, 2008; Rekhis, 2015) and Somalia (WHO, 2010; Currie, 2012). Somalia's prolonged conflict has contributed to the neglect of the mental health system and a high prevalence of mental health disorders, even compared with other low-income countries. The CRPD framework places different countries with very different resources and situations on the same level.

The General Comment on Article 12

General perspective

A General Comment is an official statement that can include a comprehensive interpretation of the fundamental rights in a human rights treaty. The General Comment on Article 12 claims that mental capacity is an unscientific concept yet offers no alternatives in cases where patients are unable to give informed consent, for example those with a severe psychotic condition. Additionally, it dismisses all substituted decision-making and involuntary treatment under any circumstances. In our opinion, this undermines the chances that treatment may lead to recovery. Additionally, the absolute rule of not admitting persons with mental disability involuntarily may lead to loss of life in cases of suicidal ideation or, in other cases, to long-term imprisonment.

Freeman *et al* (2015) argue that the impact of the General Comment may be paradoxical if implemented fully and it may worsen the human rights of persons with mental disabilities. Thus involuntarily admitting people temporarily for treatment – under certain strict conditions – may prevent the loss of life, may help some people enjoy a higher standard of mental health and may prevent longer-term deprivation of liberty.

Arab perspective

Despite being the most comprehensive source of information, the *Mental Health Atlas* keeps track of the mental health situation of only about two-thirds of the Arab countries. Furthermore, among the few countries that have a modern mental health law that is in line with international human rights standards, implementation is weak. In the Arab world, mental health legislation stands a long way from realising the objectives of the CRPD.

For countries in the region, the propositions of the General Comment on Article 12 may not be practical, as they fail to highlight the role of the family for people with disabilities who are unable to choose 'one or more trusted support persons to assist them'. Furthermore, the reservation of the Arab Group to the concept of capacity, by defining capacity as the ability to hold certain rights but not exercise them, effectively reduces the General Comment to empty rhetoric.

Just as a lack of resources can never justify human rights violations, the existence of human rights abuse, unjustifiable admissions and the politicisation of psychiatric facilities do not justify the complete prohibition of involuntary admission and treatment. The General Comment on Article 12 interprets important human rights provisions from a narrow perspective, distances medical knowledge and alienates families in many cultures.

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GUEST EDITORIAL

Coercion in mental healthcare: different perspectives, similar concerns and a united call for action

Andrew Molodynski

Chair of the World Association of Social Psychiatry Working Group on Coercion; Consultant Psychiatrist, Oxford Health NHS Foundation Trust, UK; Honorary Senior Lecturer, University of Oxford, UK; email andrew.molodynski@oxfordhealth.nhs.uk

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Recently I had a conversation with my daughters about Nelson Mandela. They had been watching television and simply did not believe that he and others were segregated and locked up simply because they were black, and that many were killed for the same reason. They were incredulous that this occurred in my lifetime and was allowed to go on (I found them checking later on the computer!). Our conversation went on to homosexuality and gender identity issues, with the same result. I remember having a similar sense of outrage and incredulity myself visiting the national civil rights museum in Memphis, the site of the murder of Martin Luther King in 1968.

Soon after this discussion I saw the report by Human Rights Watch (HRW, 2016) about the treatment of many people with mental illness in Indonesia and in particular the use of *pasung*. *Pasung* is an overarching term applied to various forms of restriction, such as chaining, tying, shackling and locking in outbuildings, animal sheds or similar. It was outlawed in 1977 but persists to this day. The Indonesian government estimates that 18 000 people are currently subject to such measures.

My charity work has brought me into contact with many such cases. They do not respect geography and represent an affront to human dignity. They are a clear form of discrimination and exclusion. The three thematic papers in this issue approach the use of coercive measures from different perspectives – of people experiencing coercion, their family carers and those who deliver services.

The causes of the use of *pasung* and related 'interventions' are complex and variable. They include lack of resources, absent, ignored or overly coercive legislation and the value different cultures place on the rights of the individual as compared with the rights of the community (Molodynski *et al*, 2016). Shame and stigma are key toxic ingredients in the formula too. Indonesia is an interesting example in these respects, as it is in the G20 and has a vibrant economy on a number of measures. Although the HRW report primarily highlights institutional care (and rightly), the majority of containment happens within families. It is not borne out of anger or hate but out of a combination of desperation, the absence of effective treatments and/or a desire to keep a loved one safe. The issue of coercion resulting from limited care provision is apparent in all continents, especially but not exclusively in low- and middle-income countries (Alem & Manning, 2016).

In the first paper, Rugkåsa & Canvin sensitively explore these issues for families, highlighting the central dilemma of wanting to support a loved one and see them do well while respecting their wishes and autonomy as far as possible. They look at examples and evidence from diverse sources and areas of the world to bring out universal themes.

In the following article, Rose and colleagues examine those same issues from the point of view of

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