

The interpretation of the right to mental health in the Africa and American systems

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ABSTRACT: The right to health is now justiciable in both the African and Inter-American human rights systems. In Africa, the right to mental health however is still not given priority, leaving persons with mental disabilities marginalised and discriminated against in the allocation of resources. The Lunatics Detention Act of The Gambia has not been amended to comply with the recommendations of the Commission on Human and Peoples' Rights and this reflects how the state views the right to mental health and the weight it attaches to the Commission's recommendations in the *Purohit* case. By comparison, when the *Ximenes-Lopes* case to the American system was still ongoing, the state had already started reforms and has since complied with all the recommendations. The African Commission held that mental health patients had a right to decide their treatment and viewed involuntary detention under mental health legislation as a violation of the right to liberty and security of the person and the prohibition against arbitrary detention. The Inter-American system held that the right to personal liberty established in article 7 of the American Convention on Human Rights also protects people with mental disabilities from institutionalisation. Based on the analysis of the two cases, the article concludes that there is a need for policy change and resource allocation for mental health patients by African states to ensure that they enjoy their right to health.

TITRE ET RÉSUMÉ EN FRANCAIS:

L'interprétation du droit à la santé mentale dans les systèmes africain et américain de droits de l'homme

RÉSUMÉ: Le droit à la santé est désormais justiciable dans les systèmes africain et interaméricain des droits de l'homme. Cependant, ce droit n'est toujours pas une priorité en Afrique, laissant les personnes handicapées mentales marginalisées et discriminées dans l'allocation des ressources. La loi gambienne sur la détention des personnes handicapées mentales n'a pas été modifiée pour se conformer aux recommandations de la Commission africaine des droits de l'homme et des peuples. Cette absence de conformité aux recommandations reflète la manière dont l'État considère le droit à la santé mentale et la valeur qu'il accorde aux recommandations de la Commission africaine dans l'affaire *Purohit*. Comparativement à l'affaire *Purohit*, l'Etat, alors que l'affaire *Ximenes-Lopes* dans le système américain était toujours pendante, avait déjà entamé des réformes et s'était depuis lors conformé à toutes les recommandations. Dans sa décision, la Commission africaine avait estimé que les patients souffrant de troubles mentaux avaient le droit de décider de leur traitement et considérait la détention involontaire au sens de la législation relative à la santé mentale comme une violation du droit à la liberté et à la sécurité de la

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personne et de l'interdiction de la détention arbitraire. Le système interaméricain a estimé que le droit à la liberté individuelle énoncé à l'article 7 de la Convention américaine relative aux droits de l'homme protège également les personnes handicapées mentales du placement en établissement. Sur la base de l'analyse des deux cas, l'article conclut qu'il est nécessaire que les États africains modifient leurs politiques et affectent des ressources aux patients atteints de maladies mentales, afin de leur assurer la jouissance de leur droit à la santé.

KEY WORDS: right to health, mental health, African Commission, Inter-American Court

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1 INTRODUCTION

The rights of persons with mental illness¹ are frequently violated during their treatment despite legal protection of the right to mental health.² The right to mental health is mostly seen as encompassed within the right to health, as captured by Dainius Pūras, the Special Rapporteur on Right to Health: 'Firstly, there is no health without mental health. Secondly, good mental health means much more than absence of a mental impairment.'³ Mental health patients are faced with a myriad of challenges stemming from inadequate resources to facilitating their treatment to society stigmatisation and segregation. The call on the society and all duty bearers is, in words of Brundtland, 'to ensure that ours will be the last generation that allows shame and stigma to rule

1 According to the World Health Organisation (WHO), people with mental disabilities have mental disorders that 'comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, mental retardation and disorders due to drug abuse'. WHO 'Health topics – mental disorders' 2 November 2017 http://www.who.int/mental_health/management/en/ (accessed 21 January 2019).

2 UN General Assembly 'Standard rules on the equalisation of opportunities for persons with disabilities' UNGA Res 48/96 20 December 1993 A/RES/48/96 para 17 provides that 'the term 'disability' summarises a great number of different functional limitations ... [p]eople may be disabled by physical, intellectual or sensory impairment, medical conditions or mental illness ...' <http://www.un.org/esa/socdev/enable/dissre01.htm> (accessed 21 January 2019).

3 D Pūras 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' A/HRC/29/33 para 76 <http://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx> (accessed 21 January 2019).

over science and reason'.⁴ Marginalisation and stigmatisation are fuelled by the historical divide, both in policies and practices, between mental and physical health, a fact that resulted in the political, professional and geographical isolation of mental health care.⁵ People with mental disability rarely get a chance to participate in decisions on their treatment.⁶ States have also allocated minimal resources to mental health treatment and have not updated their policies despite the widespread mental illness being experienced.⁷ Persons with mental health issues are often seen as not being capable of making decisions and are sometimes institutionalised without their consent.⁸ They are frequently forced to take medication and at times they are treated inhumanely, often being chained to soiled beds for long periods of time, subjected to violence and torture, the administration of treatment without informed consent, unmodified use of electro-convulsive therapy (ECT),⁹ grossly inadequate sanitation, and inadequate nutrition.¹⁰ Persons with mental disability are prone to systematic abuse especially in institutions since there is no monitoring and accountability structures.¹¹

This paper examines and compares how the right to mental health has been interpreted in the African and Inter-American systems to protect and enforce the rights of people with mental disability by comparing the decisions in the case of *Purohit and Moore v Gambia*,¹² decided by the African Commission on Human and Peoples' Rights (African Commission) in 2013, and the case of *Ximenes-Lopes v Brazil*,¹³ decided by the Inter-American Court of Human Rights (Inter-American Court) in 2016. The article focuses on the provisions of the right to health rather than disability rights as they relate to mental health. It examines the aspects of policy and resources for mental health, dignity of mentally disabled persons, and their participation and consent in treatment and institutionalisation. The first part of the paper analyses the right to mental health and how its expression in international law. The paper then turns to the African system where it

4 WHO 'World Health Report 2001 - Mental health: New understanding, new hope' October 2001 www.who.int/whr/2001/ (accessed 13 November 2017).

5 Pūras (n 3) para 76.

6 *Purohit and Moore v The Gambia* (2003) AHRLR 96 (ACHPR 2003) (*Gambian Mental Health case*) para 83.

7 WHO (n 4) figure 4.2 85.

8 United Nations (UN) *From exclusion to equality. Realizing the rights of persons with disabilities* (2007) 5 www.ohchr.org/Documents/Publications/training14_en.pdf (accessed 21 January 2019).

9 See eg American Psychiatric Association *Report of the Task Force on Electroconvulsive Therapy of the American Psychiatric Association* (1978) https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/task-force-reports/tfr1978_ECT.pdf 14.

10 *Ximenes-Lopes v Brazil* (*Ximenes-Lopes case*) IACHR (4 July 2006) Ser C No 149 para 120.

11 P Hunt & J Mesquita 'Mental disabilities and the human right to the highest attainable standard of health' (2006) 28 *Human Rights Quarterly* 332, 333.

12 *Gambian Mental Health case* (n 6).

13 *Ximenes Lopes case* (n 10).

examines the case two cases cited above, and concludes with a comparison of the two systems.

2 RIGHT TO MENTAL HEALTH IN INTERNATIONAL LAW

The right to mental health cannot be discussed separately from the right to health. Since the adoption of the Constitution of the World Health Organisation in 1946, health has been understood as the object of the human right to the enjoy the highest attainable standard of health by the international community.¹⁴ The preamble of the Constitution of the World Health Organisation (WHO) describes the right to health as 'a state of complete physical, mental and social well-being and not merely as the absence of disease or infirmity'. This definition was broadened by the 1978 Declaration of Alma-Ata on Primary Health Care, which calls it 'a fundamental human right' and adds that 'the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector'.¹⁵ In Article 25 of the Universal Declaration of Human Rights (Universal Declaration), the right to health represents 'a standard of living adequate for the health and well-being of [an individual] and his family including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control'. The right to health falls under economic, social and cultural rights (ESCR),¹⁶ and is provided for by International Covenant on Economic, Social and Cultural Rights (ICESCR). It imposes positive obligations on the state¹⁷ that include implementation programmes with budgetary implications.¹⁸ Article 12 of the ICESCR defines the right to health as 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. It obligates states to take all appropriate measures with respect to underlying preconditions of health including water, sanitation and nutrition, and occupational and environmental hygiene, as well as the 'conditions which would assure to all medical service and medical attention in the event of sickness'. In 2000, the Committee on Economic, Social and Cultural Rights (CESCR) – which monitors

14 Constitution of the World Health Organisation www.who.int/governance/eb/who_constitution_en.pdf (accessed 21 January 2019).

15 Declaration 1 of the Declaration of Alma-Ata, adopted at the International Conference on Primary Health Care, Alma-Ata, USSR from 6-12 September 1978 www.who.int/publications/almaata_declaration_en.pdf (accessed 21 January 2019).

16 The International Covenant on Economic, Social and Cultural Rights www.un-documents.net/a21r2200.htm (accessed 21 January 2019).

17 CESCR Committee 'General Comment 3: The nature of states parties obligations' 14 December 1990 UN Doc E/C.12/1990/8 (1990) <http://www.refworld.org/docid/4538838e10.html> (accessed 14 November 2017).

18 M S Giorgi (2012) *The human rights to equal access to health care 2*.

implementation of the ICESCR – published General Comment 14,¹⁹ an extensive and authoritative interpretation of article 12 of the ICESCR. It states that detailed and regular monitoring is essential in the implementation of health rights. It requires that states adopt and implement a national health strategy addressing the needs of the whole population with regard to health care provision and the underlying determinants of health. In 2008, the UN General Assembly adopted an optional protocol to the CESCSC allowing individuals and groups to bring complainants against states on the right to health.²⁰ So far, one complaint has been filed under the Optional Protocol on the right to health but the Committee ruled it was inadmissible because the basis of the complaint concerned events that had happened before the Optional Protocol came into force.²¹ The most recent instrument dealing with people with disabilities is the United Nations Convention on the Rights of Persons with Disabilities (CRPD).²² While the CRPD does not set out any ‘new’ rights, it clarifies the obligations of states parties to promote and ensure the rights of persons with disabilities and sets out the steps that should be taken to ensure equality of treatment. There are other non-binding instruments that provide for the rights of mentally disabled people. The UN in 1991 published the UN Principles for the protection of persons with mental illness and the improvement of mental illnesses and the improvement of mental health care (UN Principles).²³ The 25 UN Principles include wide-ranging commitments relating to standards of care and treatment, including the consent to treatment, right to the least restrictive environment; the right to medication; the review of involuntary admissions; access to information; as well as complaints, monitoring, and remedies. Further in 1993, the General Assembly adopted the Standard rules on the equalisation of opportunities for persons with disabilities containing a broad range of commitments to ensure equal opportunities are available to persons with disabilities in all fields. The rules contain principles regarding responsibility, action, and cooperation with respect to: healthcare, policymaking, rehabilitation, support services,

- 19 CESCSC Committee ‘General Comment 14: The right to the highest attainable standard of health (article 12 of the Covenant)’ 11 August 2000 UN Doc E/C.12/2000/4 <http://www.refworld.org/docid/4538838do.html> (accessed 21 January 2019).
- 20 The Optional Protocol to the International Covenant on Economic, Social and Cultural Rights <http://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCESCR.aspx> (accessed 15 November 2017).
- 21 *Merino Sierra and Others v Spain*, Communication 4/2014, CESCSC Committee (29 September 2016), UN Doc E/C.12/59/D/4/2014 para 6.7, the event complained of happened in 2008/2009 and the optional protocol came into force on 5 May 2013.
- 22 The Convention on the rights of persons with disabilities and its optional protocol <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html> (accessed 16 November 2017).
- 23 UN General Assembly ‘Principles for the protection of persons with mental illnesses and the improvement of mental health care’ UNGA Res 46/119 17 December 1991 A/46/49 <http://hrlibrary.umn.edu/instree/t2pppmii.htm> (accessed 21 January 2019).

raising awareness, employment, family life, education and legislation.²⁴

The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body and the right to be free from interference. Entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.²⁵ To achieve the right to health a just health system is needed. It has become clear that economic and social rights, including the right to health, can be and are increasingly being treated as justiciable under both international law²⁶ and national constitutional frameworks.²⁷ Interpreting the content of this right, the CESCR Committee in General Comment 14 on the right to health, the CESCR Committee identifies four elements: 'availability, accessibility, acceptability and quality', and imposes three types of obligations on states - to respect, fulfil and protect the right.²⁸ In terms of the duty to protect, the state must ensure that third parties (non-state actors) do not infringe on the enjoyment of the right to health. We now look into the aspects that affect provision of mental health before we compare the two systems.

2.1 Policy and resources for mental health

'Mental health is grossly neglected within health systems around the world. Where mental health systems exist, they are segregated from other healthcare and based on outdated practices that violate human rights.'²⁹ In some regions, resources allocated to mental health care are used ineffectively and predominantly for maintaining large segregated psychiatric long-term care institutions and separate psychiatric hospitals. In such institutions, psychotropic medications are too often overprescribed, including as a measure of chemical restraint or even as a punishment.³⁰ The WHO recommendations are very clear about the five obligatory components of community-based care for persons with severe psychosocial disabilities, which comprise access to psychotropic medications, psychotherapy, psychosocial rehabilitation, vocational

24 UN General Assembly (n 2).

25 CESCR Committee (n 19).

26 UN General Assembly (n 23).

27 *Soobramoney v the Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC) (Constitutional Court of South Africa), <http://www.saflii.org/za/cases/ZACC/1997/17.html> (accessed 12 December 2017), also see J Heymann et al 'Constitutional rights to health, public health and medical care: The status of health protections in 191 countries' (2013) 8 *Global Public Health* 639–653.

28 CESCR Committee (n 19 above) para 12.

29 Statement by Mr Dainius Pūras, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health before the UN Human Rights Council at its 35th Session held in Geneva, Switzerland 6-23 June 2017 UN Doc A/HRC/35/21 socialprotection-humanrights.org/wp-content/uploads/2017/06/Special-Rapporteur-report-on-mental-health-and-human-rights.pdf (accessed 21 January 2019).

30 B McSherry 'Protecting the integrity of the person: developing limitations on involuntary treatment' (2008) 26 *Law Context: A Socio-Legal Journal* 111, 119.

rehabilitation and employment and supported housing. However, in many countries, a number of those components are not being implemented.³¹ In mixed systems, a person using one institution should have equal access to the same care to which they are legally entitled, as a person using another provider, whether public or private. Courts in Argentina³² and India,³³ have found obligations of private institutions to provide uninterrupted care and to refrain from unilaterally terminating care. In these cases courts have reasoned that when private institutions act as instruments of the state in providing services, the state must nevertheless protect the right to health (and life) by ensuring they do so in a way that ensures fair access to entitlements that are guaranteed under law.³⁴

Seemingly, the African Charter on Human and Peoples' Rights (African Charter)³⁵ does not provide for qualification of progressive realisation and maximum available resources for the realisation of ESC rights.³⁶ As a result, some authors argue that the ESC rights in the African Charter have to be realized immediately.³⁷ However, given Africa's economic realities, these argument would have far-reaching implications for the very nature of ESC rights. In the African human rights system, ESC rights including the right to health are just as justiciable as civil and political rights. This follows from the fact that the main human rights instruments have incorporated the ESC rights alongside the civil and political rights into one document.³⁸ The Commission confirmed the justiciability of ESC rights' in the

- 31 WHO (n 4). Also see WHO *Comprehensive mental health action plan 2013–2020* (2013) http://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf;jsessionid=1746DD27C1912C19A82341A6D91CF9C1?sequence=1 (accessed 21 January 2019).
- 32 *Campodónico de Beviacqua, AC v Ministerio de Salud y Acción Social* (Supreme Court of Argentina) 24 October 2000 (Argentina) (requiring a private entity that unilaterally sought to stop providing a specialized medication whose treatment could not be terminated without causing imminent danger of harm to continue to provide the medication, with the state the primary guarantor of the rights to health and life).
- 33 *All India Lawyers Union v Govt of Delhi and Others* (2009) WP(C) No. 5410/1997 (Delhi High Court), 30 (India) (after contracts with the state obliging it to provide free care, a corporation, Indraprastha Medical Corporation Limited 'had taken onto itself the mantle of a state instrumentality' and was required to provide free care).
- 34 *Campodónico de Beviacqua* (n 32); *All India Lawyers Union* (n 33).
- 35 African Charter on Human and Peoples' Rights <http://www.achpr.org/instruments/achpr/> (accessed 21 January 2019).
- 36 Compare with article 2(1) of the ICESCR. See also CESCR Committee (n 17).
- 37 CA Odinkalu 'Analysis of paralysis or paralysis by analysis? Implementing economic, social, and cultural rights under the African Charter on Human and Peoples' Rights' (2001) 23 *Human Rights Quarterly* 349; F Ougoungou *The African Charter on Human and Peoples' Rights: a comparative agenda for human dignity and sustainable democracy in Africa* (2003) 201.
- 38 See generally the African Charter on the Rights and Welfare of the Child and Protocol to the African Charter on the Rights of Women (which provide civil and political rights and ESC rights on equal footing). The Preamble of the Protocol to the African Charter on the Rights of Women in particular provides that 'civil and political rights cannot be dissociated from economic, social and cultural rights in their conception'.

Ogoniland case where it held that ‘there is no right in the African Charter that cannot be made effective’.³⁹

2.2 Dignity of mental health patients

Principle 1(2) of the UN Principles requires that ‘all persons with mental illness, or who are being treated as such, shall be treated with humanity and respect for the inherent dignity of the human person’.⁴⁰ Further, article 17 of the CRPD, which is entitled ‘Protecting the Integrity of the Person’, states that ‘[e]very person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others’. Article 5 of the African Charter provides that ‘[e]very individual shall have the right to the respect of dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man, particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.’ Human dignity is an inherent basic right to which all human beings, regardless of their mental capabilities or disabilities as the case may be, are entitled to without discrimination. It is therefore an inherent right which every human being is obliged to respect by all means possible and on the other hand it confers a duty on every human being to respect this right. To ensure that the dignity of mentally disabled people who are institutionalised is protected the state should have policies that provide for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.⁴¹

2.3 Participation and consent of mental health patients in their treatment and institutionalisation

People with mental disability are said to lack legal capacity to make decisions and hence they are often put through treatment and placed in institutions without their consent. This results in violation of their human rights. Their right to liberty is curtailed and they do not have effective access to courts to review decisions made on their behalf by their guardians or health providers. Article 14 of CRPD provides that ‘states shall ensure that persons with mental disabilities, on an equal basis with others enjoy the right to liberty and security of person.’ The right to liberty allows a person to choose where and how they live. Mandatory institutionalization of mental disabled people without their

39 Communication 155/196, *Social and Economic Rights Action Center and Another v Nigeria (Ogoniland case)* (2001) AHRLR 60 (ACHPR 2001) para 52.

40 UN General Assembly (n 23).

41 UN General Assembly (n 23).

consent and participation violates their right to liberty.⁴² Article 16 of the UN Principles provides that a person may be admitted involuntarily to a mental health facility as a patient if a) because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or b) that, in the case of a person whose mental illness is severe and whose judgment is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative. The Inter-American Commission approved emergency measures to protect the lives and physical integrity of persons detained in a psychiatric hospital in Paraguay.⁴³ The Commission also facilitated a friendly settlement between the applicants and the government of Paraguay that guarantees the rights of patients to live and receive mental healthcare in the community.⁴⁴

3 THE RIGHT TO MENTAL HEALTH IN THE AFRICAN SYSTEM

The right to mental health is guaranteed in different instruments in the African system. Article 16 of African Charter states that '[e]very individual shall have the right to enjoy the best attainable state of physical and mental health and states parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.'⁴⁵ Article 14 of the 1999 African Charter on the Rights and Welfare of the Child provides that 'every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health'. States are obligated to create and maintain an environment where people enjoy the highest standard of both physical and mental health.⁴⁶ The right to mental health also entails the state not do anything to interfere with the

42 Art 19(a) of the Convention on the rights of persons with disabilities and its Optional Protocol.

43 *Enxet-Lamenxay and Kayleyphapopyet Indigenous Communities v Paraguay* (Friendly Settlement) (*Enxet-Lamenxay* case), Inter-American Commission of Human Rights, IAm Comm of HR (29 September 1999), Report 90/99.

44 Art 19(a) of the Convention on the Rights of Persons with Disabilities and its Optional Protocol

45 Art 16(2) of the African Charter on Human and Peoples' Rights.

46 Communications 25/89, 47/90, 56/91, 100/93, *Free Legal Assistance Group, Lawyers' Committee for Human Rights, Union Inter africaine des Droits de l'Homme, Les Témoins de Jehovah v Zaire*, Ninth Activity Report of the African Commission on Human and Peoples' Rights 1995-1996 where the Commission held that article 16 of the African Charter grants every individual the right to enjoy the best attainable state of physical and mental health, and that States Parties should take the necessary measures to protect the health of their people. The failure of the Government to provide basic services such as safe drinking water and electricity and the shortage of medicine as alleged in communication 100/93 constitute a violation of article 16.

health right of its people.⁴⁷ The obligation to protect therefore includes taking concrete and targeted steps towards the full realisation of the right, and adopting legislation or other measures to ensure equal access to health-related services and health care.⁴⁸ In the African system, the African Commission and the African Court on Human and Peoples' Rights (African Court) have not had the opportunity to determine many cases on mental health right. The one outstanding case in the region is the *Gambian Mental Health* case,⁴⁹ which illustrates how the African Commission interprets and applied the right to mental health.

Purohit and Moore v The Gambia was brought to the African Commission by mental health advocates, submitting the communication on behalf of patients detained at Campama, a Psychiatric Unit of the Royal Victoria Hospital, and existing and 'future' mental health patients detained under the Mental Health Acts of the The Gambia. The complaint was filed on 7 March 2001. The complainants alleged several violations including (i) that legislation governing mental health in The Gambia is outdated; (ii) that within the Lunatics Detention Act (LDA) there is no definition of who a 'lunatic' is; and (iii) that there are no provisions and requirements establishing safeguards during the diagnosis, certification and detention of the patient. The complainants further alleged that there was overcrowding in the psychiatric unit, that there is no requirement of consent to treatment or subsequent review of continued treatment of patients. The Complainants also stated that there is no independent examination of administration, management and living conditions within the unit itself. The complainants also complain that patients detained in the psychiatric unit are not even allowed to vote, and that there is no provision for legal aid and the Act does not make provision for a patient to seek compensation if his or her rights have been violated.⁵⁰

One of the issues raised in this case is whether mentally ill people enjoy the same protection under the law. The complainants state that 'there are no review or appeal procedures against determination or certification of one's mental state for both involuntary and voluntary mental patients. Thus the legislation does not allow for the correction of an error assuming incorrect certification or diagnosis, which presents a problem in this particular case where the medical

47 Communication 379/09 *Monim Elgak, Osman Hummeida and Amir Suliman (represented by FIDH and OMCT) v Sudan* (AHRLR 2014) ACHPR 2015 paras 90, 132: The complainants submit that the right to health includes the right to be free from torture and a positive obligation to provide access to adequate medical treatment in detention. It is the Complainants' contention that the treatment to which they were subjected, which caused physical and psychological harm, violated their right to enjoy the best attainable standard of physical and mental health. The Commission observes that according to its Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter, the right to health includes the right to control one's health and body and the right to be free from interferences, such as the right to be free from torture and other forms of ill-treatment.

48 *Egyptian Initiative for Personal Rights and Interights v Egypt* (2006) AHRLR 1994 (ACHPR 2006).

49 *Gambian Mental Health* case (n 6).

50 *Gambian Mental Health* case (n 6) paras 1-8.

examination was performed by general practitioners and not psychiatrists. Therefore, if an error is made and there is no avenue to appeal or review the medical practitioners' assessment, there is a great likelihood that a person could be wrongfully detained in a mental institution. Furthermore, the LDA does not lay out fixed periods of detention for those persons found to be of unsound mind, which, coupled with the absence of review or appeal procedures could lead into a situation where a mental patient is detained indefinitely'.⁵¹ In other words, are there domestic remedies available to the victims in this instance? In considering this issue, the Commission examined the conditions and place of mental ill persons in society and held that they were vulnerable and without legal aid they could not access justice to defend their rights and hence the state must take all necessary measures to ensure that their decisions made on their behalf go through checks and balances and where they have issues legal aid is availed to them. The Commission found the communication admissible since there was no national avenue for review or appeal of decisions made under LDA and the state admitted to this fact.⁵²

On the policy and resources for mental health, the Commission indicated that 'it is clear that scheme of the LDA is lacking in terms of therapeutic objectives as well as provision of matching resources and programmes of treatment of persons with mental disabilities, a situation that the Respondent state does not deny but which nevertheless falls short of satisfying the requirements laid down in articles 16 and 18(4) of the African Charter'.⁵³ The Commission however noted that many African countries lack sufficient resources therefore, having due regard to 'this depressing but real state of affairs', the Commission held that the obligation under article 16 of the African Charter requires states party to 'take concrete and targeted steps, while taking full advantage of its available resources, to ensure that the right to health is fully realised in all its aspects without discrimination of any kind'.⁵⁴ The Commission recommended that the Gambian government replace the outdated law (Lunatics Detention Act) since it lacked in terms of therapeutic treatment, resource allocation and programmes for the treatment of persons with mental disabilities.

On the dignity and integrity of the mental patients the complainants argued that under the LDA, persons with mental illness have been branded as 'lunatics' and 'idiots'. These are terms that without any doubt dehumanise and deny them any form of dignity in contravention of article 5 of the African Charter. The Commission held: 'Clearly the situation presented above fails to meet the standards of anti-discrimination and equal protection of the law as laid down under the provisions of articles 2 and 3 of the African Charter and Principle 1(4) of the UN Principles. In coming to its conclusion, the African Commission drew inspiration from Principle 1(2) of the UN Principles.

51 *Gambian Mental Health* case (n 6) para 30.

52 *Gambian Mental Health* case (n 6) paras 26 & 27.

53 *Gambian Mental Health* case (n 6) para 83.

54 *Gambian Mental Health* case (n 6) para 84.

Principle 1(2) requires that ‘all persons with mental illness, or who are being treated as such, shall be treated with humanity and respect for the inherent dignity of the human person’.⁵⁵ More so, as a result of their condition and by virtue of their disabilities, mental health patients should be accorded special treatment which would enable them not only attain but also sustain their optimum level of independence and performance in keeping with article 18(4) of the African Charter and the standards applicable to the treatment of mentally ill persons as defined in the UN Principles.⁵⁶ However, the right to integrity was not discussed at all in this regard.

On consent and institutionalisation, the complainants alleged that institutionalisation of detainees under the LDA who are not afforded any opportunity of being heard or represented prior to or after their detention violates articles 7(1)(a) and 7(1)(c) of the African Charter.⁵⁷ Articles 7(1)(a) and 7(1)(c) of the African Charter provides that ‘every individual shall have the right to have his cause heard. This comprises: (a) The right to an appeal to competent national organs against acts of violating his fundamental rights as recognised and guaranteed by conventions, laws, regulations and customs in force; (c) The right to defence, including the right to be defended by counsel of his choice.’ The Commission held that the LDA does not contain any provisions for the review or appeal against an order of detention or any remedy for detention made in error or wrong diagnosis or treatment.⁵⁸ Neither do the patients have the legal right to challenge the two separate medical certificates, which constitute the legal basis of their detention. These omissions in the LDA clearly violate articles 7(1)(a) and 7(1)(c) of the African Charter. Article 7(1) necessitates that in circumstances where persons are to be detained, such persons should at the very least be presented with the opportunity to challenge the matter of their detention before the competent jurisdictions that should have ruled on their detention.⁵⁹ The entitlement of persons with mental illness or persons being treated as such to be heard and to be represented by counsel in determinations affecting their lives, livelihood, liberty, property or status, is particularly recognised in Principles 16, 17 and 18 of the UN Principles. The African Commission dismissed the argument that the ‘automatic’ detention of those considered being mentally ill or disabled violated the prohibition on arbitrary detention in article 6. In the Commission’s view, those who had been institutionalised under mental health legislation did not fall within the protections offered by article 6 which sets out the right to liberty and security of the person. The Commission stated: Article 6 of the Charter was not intended to cater for situations where persons in need of medical assistance or help are institutionalised.⁶⁰ Thus, while there has not been any case directly on the meaning of the right to integrity under the African Charter, it

55 *Gambian Mental Health case* (n 6) para 60.

56 *Gambian Mental Health case* (n 6) para 81.

57 *Gambian Mental Health case* (n 6) para 69.

58 *Gambian Mental Health case* (n 6) para 70.

59 *Gambian Mental Health case* (n 6) para 71.

60 *Gambian Mental Health case* (n 6) para 68.

seems that, at least in relation to medical treatment, there may be an overlap with the right to respect for human dignity. What is revealing, however, is that the African Commission is prepared to view involuntary detention under mental health legislation as an exception to the right to liberty and security of the person and the prohibition against arbitrary detention. Where third parties are involved in medical treatment, and since health is a public interest the protection of which is a duty of the states, these must prevent third parties from unduly interfering with the enjoyment of the rights to life and personal integrity, which are particularly vulnerable when a person is undergoing health treatment. The Commission considers that the states must regulate and supervise all activities related to the health care given to the individuals under the jurisdiction thereof, as a special duty to protect life and personal integrity, regardless of the public or private nature of the entity giving such health care.⁶¹ Further, 'Health is a right due to everyone and the state's duty, which is guaranteed through social and economic policies which have the purpose of reducing health risks and guaranteeing the universal and egalitarian access to health programs and services aimed at ensuring health promotion, protection, and recovery,' as provided for by article 196 of its Constitution. Furthermore, in accordance with article 197 thereof, it is 'the responsibility of the power of the state, according to law, to provide for the regulation, supervision and control of such health programs and services [... and their] implementation must be carried out either directly or through third parties, and by private natural or artificial persons.'⁶²

The Commission made the following recommendations to the respondent state: It must repeal the LDA and replace it with a new legislative regime for mental health in line with the African Charter and international standards and norms for the protection of mentally ill or disabled persons as soon as possible. It must, pending this repeal, create an expert body to review the cases of all persons detained under the LDA and make appropriate recommendations for their treatment or release. Lastly, it must provide adequate medical and material care for persons suffering from mental health problems in the territory of The Gambia. Unfortunately, The Gambia has not implemented these recommendations, although it is in the initial stages of reviewing the LDA.⁶³

4 THE RIGHT TO MENTAL HEALTH IN THE INTER-AMERICAN SYSTEM

In the Inter-American system, the right to health is codified in the Additional Protocol to the American Convention on Human Rights in

61 *Gambian Mental Health* case (n 6) para 82.

62 *Gambian Mental Health* case (n 6) para 90.

63 WHO 'Stakeholders in The Gambia review draft mental health legislation' <https://afro.who.int/news/stakeholders-gambia-review-draft-mental-health-legislation> (accessed 21 January 2019).

the Area of Economic, Social, and Cultural Rights (Protocol of San Salvador).⁶⁴ Article 10 of the Protocol of San Salvador provides that everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being. Similar to the CESCR and article 26 of the American Convention, the Protocol – with two exceptions⁶⁵ – merely calls for progressive realisation. The Protocol of San Salvador contains no mechanism for individual complaints under the right to health, and for a long time claims under the Protocol were held to be generally inadmissible, as they were considered by the Inter-American Commission to be beyond both the Commission's and the Inter-American Court's purview. However, in some recent cases, such as *Lluy v Ecuador* in Judge Macgregor's opinion (of 2015),⁶⁶ and *Llagos Del Campo v Peru*, delivered on 13 November 2017,⁶⁷ ESCR have been regarded as justiciable in the Inter-American system.⁶⁸

When it comes to mental health, the Inter-American Commission on Human Rights has analysed the situation of institutionalisation of people with mental disabilities. Unlike the African Commission, it has stated that the right to personal liberty established in article 7 of the American Convention on Human Rights also protects people with mental disabilities from the institutionalisation.⁶⁹ It states that the mere existence of a disability shall in no case justify a deprivation of liberty. Further, it acknowledges that the health systems of the states should apply a view to gradually de-institutionalise people with mental disability and implement community-based health care. Also in *Victor*

64 Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights www.oas.org/juridico/english/treaties/a-52.html (accessed 21 January 2019).

65 Under article 19(6) of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights, the Inter-American Commission and the Court can review alleged violations of article 8(a) (on trade union rights) and article 13 (on education).

66 *Gonzales Lluy and Others v Ecuador (Gonzales Lluy case)* IACHR (1 September 2015) Ser C No 289 http://www.cortelbidh.or.cr/docs/casos/articulos/seriec_298_ing.pdf (accessed 13 December 2017).

67 *Lagos del Campo v Peru* (31 August 2017) Ser C No 340 http://www.corteibidh.or.cr/docs/casos/articulos/seriec_340_esp.pdf (in Spanish). According to the Court, the Peruvian State violated the right to work in relation to guarantees of labor stability and freedom of association of Mr Lagos del Campo due to the lack of protection for the arbitrary dismissal of which he was victim in 1989 as a result of his statements given to a media outlet about his employer, a private company, while acting in his capacity as worker representative. In terms of the rights protected by article 26 of the American Convention, the Inter-American Court stated that such rights are derived from the economic, social, educational, scientific, and cultural norms of the Charter of the Organisation of American States.

68 Organisation of American States (OAS) 'The Special Rapporteurship on Economic, Social, Cultural and Environmental Rights welcomes the historic decision of the Inter-American Court of Human Rights on justiciability in matters of ESCR' http://www.oas.org/en/iachr/media_center/PReleases/2017/181.asp (accessed 21 January 2019).

69 *Rafael Ferrer-Mazorra et al. v United States (Mazorra case)*, Inter-American Commission on Human Rights IAm Comm of HR (4 April 2011) case 9903, report 51/01 para 115.

Rosario Congo v Ecuador, which concerned a mentally ill prisoner at a rehabilitation center who had been denied psychiatric care, struck on the head, denied medical treatment, and left in isolation for forty days; and subsequently died, the Commission held that the victim's right to physical integrity, life, and judicial protection under the American Convention were violated.⁷⁰ To understand the Court's position on mental health, we now analyse the case of *Ximenes-Lopes v Brazil*.

It noteworthy that in the *Ximenes-Lopes* case, the right to mental health was not addressed directly but the Court looked at other rights as they relate to mentally disabled people because until 2017 the Court did not consider economic, social and cultural rights enforceable under article 26 of the American Convention.⁷¹ The Commission filed the application for the Court to determine whether 'the State had violated the rights embodied in articles 4 (right to life), 5 (right to humane treatment), 8 (right to a fair trial) and 25 (right to judicial protection) of the American Convention in relation to the obligation set forth in article 1(1) (obligation to respect rights) of the Convention, to the detriment of Damião Ximenes-Lopes for the alleged inhuman and degrading hospitalisation conditions of Ximenes-Lopes, a person with mental illness; the alleged beating and attack against the personal integrity of the alleged victim as a result of the action of the Officers of Casa de Reposo Guararapes; his death while held under psychiatric treatment; and the alleged lack of investigation and respect for the right to a fair trial that derived in the impunity surrounding such case.'⁷²

Ximenes-Lopes was hospitalized on 1 October 1999 as part of a psychiatric treatment in Casa de Reposo Guararapes, which is a private psychiatric clinic that operated in the public health system of Brazil. On 3 October 1999, Ximenes-Lopes had an aggressive crisis and was disoriented. The alleged victim got into one of the bathrooms of Casa de Reposo Guararapes and refused to come out until he was overpowered and forced out by a nurse's aide, Mr Elías Coimbra, together with two other patients, and in the process he suffered an injury to his face, in the eye brow region. He was immediately subjected to physical restraint and the physician who was at Casa de Reposo Guararapes at the time decided to administer 'intramuscular fèrnagan and haldol' to the patient. In the evening of the same day, the alleged victim had another aggressive episode and was once again placed under physical restraint, to which he was subjected from Sunday night to Monday morning.⁷³ On Monday morning when the mother went to see him, she found him bleeding, with bruises, his clothes torn, dirty and smelling like excrement, with his hands tied backwards, having difficulty breathing, agonizing and shouting and calling out to the police for help. Ximenes-Lopes was still under physical restraint, which had been applied the night before. She requested the clinical director to attend to him, who,

70 *Rosario Congo v Ecuador* (*Rosario Congo* case), Inter-American Commission on Human Rights, IAm Comm of HR (12 March 1997) OEA/ Ser.LJV/II.102 Doc 6 Rev 1.

71 OAS (n 68 above); *Mazorra* case (n 69); *Rosario Congo* case (n 70).

72 *Ximenes-Lopes* case (n 10) para 2-3.

73 *Ximenes-Lopes* case (n 10) para 112 (7 & 8).

without performing any physical examination of Ximenes-Lopes, prescribed some medications and then left the hospital. No doctor remained in charge of the institution at the time. Ximenes-Lopes died on 4 October 1999.⁷⁴

The clinical director was called and upon examining the body of the alleged victim, declared him dead and included in the record that the body did not show any external injuries and that the cause of death had been a 'cardio respiratory arrest'. The doctor did not order an autopsy of the body of Ximenes-Lopes. The next of kin of Ximenes-Lopes upon learning of his death requested an autopsy which revealed physical bruises and indicated that the cause of death was unknown.⁷⁵ On the request of the Attorney General the Medico-Legal Institute elaborated on its conclusions and informed that 'the injuries described [in the post-mortem examination report] were caused by a blunt instrument (or by multiple bumps or falls) and that it was impossible to identify the precise manner in which they were caused.'⁷⁶ In April 2002, Ximenes-Lopes' body was exhumed and another autopsy done but the cause of death was still unknown.⁷⁷ Criminal investigations were instituted and charges filed in court but proceeded at very slow pace. A civil action was also filed but a decision had not been made by the time of the current judgment.⁷⁸

The state was found to have violated article 2 of the American Convention since it had failed to supervise and regulate the provision of mental health care resulting to violation of right to life and dignity of patients. The state has the obligation to ensure that all people enjoy their rights without individual or state interference.⁷⁹ On the issue of dignity and vulnerability of mental patients the Inter-American Court held that the hospital has an 'atmosphere of violence, aggression, and abuse where many in-patients frequently suffered injuries' at the hands of the facility's employees.⁸⁰ Hospital employees applied chokeholds and physically restrained patients without direction from physicians, and 'physical confrontations between patients were encouraged'. The Court characterized the hospital as 'inhumane and degrading', noting that medicine was lacking and, for a period of time, there was no examination room so that medical procedures had to be administered in the lobby in front of other patients as well as visitors.⁸¹ Other patients had died before Damido Ximenes-Lopes, which 'may have involved blows to the head with a blunt instrument, and where patients were admitted to the hospital in good physical condition and died during hospitalisation'.⁸² The Court went ahead to quote the European

74 *Ximenes-Lopes case* (n 10) para 112 (10-11).

75 *Ximenes-Lopes case* (n 10) para 112 (14).

76 *Ximenes-Lopes case* (n 10) para 112 (15).

77 *Ximenes-Lopes case* (n 10) para 112 (16).

78 *Ximenes-Lopes case* (n 10) para 112.

79 *Ximenes-Lopes case* (n 10) paras 80 & 90.

80 As above.

81 As above.

82 As above.

Court of Human Rights to emphasize the special care needed to guarantee dignity of mental disability patients: '[r]egarding to persons in need of psychiatric treatment in particular, the Court observes that the state is under an obligation to secure to its citizens their right to physical integrity under article 8 of the Convention. For this purpose there are hospitals run by the state which coexist with private hospitals. The state cannot completely absolve itself of its responsibility by delegating its obligations in this sphere to private bodies or individuals. [...] The Court finds that, similarly, in the present case the state remained under a duty to exercise supervision and control over private psychiatric institutions. Such institutions, [...] need not only a license, but also competent supervision on a regular basis of whether the confinement and medical treatment is justified.'⁸³ The state has the obligation to provide special protection to vulnerable persons and must take positive steps to ensure their protection.⁸⁴

The Inter-American Court has indicated that while the right to the recognition of juridical personality implies the capacity to be the holder of rights and obligations, the right to legal capacity is the right to exercise this rights and duties. In that sense, it acknowledged in *Ximenes-Lopes* that when people with mental disabilities cannot give their consent, their legal representatives will give the consent required as regards to the institutionalisation or a medical treatment. However, the Court did not say whether the institutionalisation of the victim in itself was a violation of the right to personal liberty of the victim because of his institutionalisation. As a matter of fact, *Ximenes-Lopes* was placed in a mental institution without his authorisation and only with the consent of his mother.⁸⁵ On institutionalisation and consent to treatment the Court found that the patients were under constant threat of physical attack by officials who were not trained to work with persons with mental illness and that physical containment and control techniques were frequently applied to patients when they were in crisis with the help of other.⁸⁶ Further, the Court found that the use of physical restraint would be in breach of article 5(1) unless it was used as a last resort by qualified staff and 'with the only purpose of protecting the patient, or else the medical staff or third persons.'⁸⁷ The Court criticised the tying of *Ximenes-Lopes*' hands, particularly for an excessively long period of time, and stated that 'health care staff should apply the least restrictive possible restraint techniques and only for such period of time as is absolutely necessary'.⁸⁸ Judge Sergio Garcia-Ramirez in a separate opinion stated that measures taken in relation to those with mental illness should be 'consistent with the characteristics

83 *Ximenes-Lopes* case (n 10) para 102: Also see *Storck v Germany* (2005) ECHR 406.

84 *Ximenes-Lopes* case (n 10), para 103.

85 *Ximenes-Lopes* case (n 10) para 3.

86 *Ximenes-Lopes* case (n 10) para 120.

87 *Ximenes-Lopes* case (n 10) para 134.

88 *Ximenes-Lopes* case (n 10) para 135.

of the suffering and the need for treatment', be 'reasonable and moderate' and 'aim at relieving pain and foster wellbeing.'⁸⁹

5 COMPARISON OF THE AFRICA AND INTER-AMERICAN SYSTEM

The right to health has long been justiciable in the African system, but not until 2017 in Inter-American system. In the African system there are already a number of cases⁹⁰ focusing on the right to health though not mental health, while in the American system the right to health before 2017 had always been litigated under the right to life.⁹¹ The new developments in the Inter-American system mean that all the rights under article 26 of the American Charter are now regarded as justiciable.⁹²

Both the Inter-American Court and the African Commission have indicated that people with mental illness are a vulnerable group because they were historically subject to prejudice with lasting consequences, resulting in their social exclusion. The state is obligated to take positive measures to protect their dignity even as it provides medical treatment. The African Commission held that this class of persons are vulnerable and without legal aid they could not access justice to defend their rights. Hence, the state must take all necessary measures to ensure that decisions made on behalf of the mentally ill go through checks and balances and where issues arise, legal aid is availed to them. Both the right to life as interpreted by the Inter-American Court and the right to health impose positive obligations on states, both require governments to regulate private parties so that the conditions necessary for a dignified life are not denied to any individual. With regard to the relationship of the obligation to ensure rights (article 1(1) to article 5(1)) of the Convention, in a most recent case (*Gonzales Lluy et al*)⁹³ the Court established that 'the right to personal integrity is directly and immediately linked to health care, and that the lack of adequate medical treatment may result in a violation of article 5(1) of the Convention. Thus, the Court has affirmed that the protection of the right to personal integrity supposes the regulation of the health care services in the domestic sphere, as well as the implementation of a series of mechanisms designed to protect the effectiveness of this regulation.'⁹⁴ The Inter-American Court of Human Rights has brought

89 *Ximenes-Lopes* case (n 10) para 25.

90 The African Commission has dealt with 16 cases relating to the right to health <http://www.achpr.org/communications/decisions/?a=872> (accessed 13 December 2017).

91 *Mazorra* case (n 69); *Rosario Congo* case (n 70).

92 OAS (n 68); *Mazorra* case (n 69 above); *Rosario Congo* case (n 70 above).

93 *Mazorra* case (n 69).

94 *Ximenes-Lopes* case (n 10) para 171.

civil and political rights together with economic and social rights in a way that was always intuitive.⁹⁵

On institutionalisation, the African Commission in *Purohit and Moore* dismissed the argument that the ‘automatic’ detention of those considered being mentally ill or disabled violated the prohibition on arbitrary detention in Article 6. In the Commission’s view, those who had been institutionalised under mental health legislation did not fall within the protections offered by article 6 which sets out the right to liberty and security of the person. The Commission stated that ‘[a]rticle 6 of the Charter was not intended to cater for situations where persons in need of medical assistance or help are institutionalised’.⁹⁶ While as in *Ximenes-Lopes*’ case the Court seem to suggest that the right to respect for physical and mental integrity operates to limit certain practices once a person with a serious mental illness has been detained. While not a central issue, it seems to have been assumed that the deprivation of liberty may be justified for the purpose of treatment by the Africa Commission. The African Commission viewed involuntary detention under mental health legislation as an exception to the right to liberty and security of the person and the prohibition against arbitrary detention.⁹⁷

Both the African Commission and the Inter-American court upheld the right of mental health patients and implore upon states to formulate policies that protect the rights of mentally ill persons, focus on deinstitutionalisation, and monitor facilities offering mental health services. The African Commission recommended that the Lunatics Detention Act be amended to be aligned to international law and standards.

The recommendations that were made in the African case have never been acted upon and according to the WHO’s Country Report on Mental Health the situation has not improved: ‘The Campama Psychiatric Unit (Banjul), the only inpatient facility in the country, is isolated and difficult to access, custodial in nature and has poor living conditions.’⁹⁸ The WHO is however currently assisting the Gambia to review the LDA.⁹⁹ A mental health policy and strategic action plan were drafted in 2006,¹⁰⁰ outlining how to narrow the gap in mental health services but it lacks implementation. The African Commission should follow up with the state of Gambia to ensure that mentally disabled persons enjoy their right to mental health as per the Commission’s latest Resolution on the Rights to Dignity and Freedom from Torture or

95 SR Keenern & J Vasquez ‘A life worth living: Enforcement of the right to health through the right to life in the Inter-American Court of Human Rights’ (2009) 40 *Columbia Human Rights Law Review* 595 624.

96 *Enxet-Lamenxay* case (n 43) para 68.

97 *Enxet-Lamenxay* case (n 43) para 25.

98 http://www.who.int/mental_health/policy/country/thegambia/en/ (accessed 21 January 2018).

99 *Gonzales Lluy* case (n 66).

100 http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/gambia/gambia_mental_health_strategic_plan_2007-2012.pdf (accessed on 20 December 2018).

Ill-Treatment of Persons with Psychosocial Disabilities in Africa.¹⁰¹ The state of Gambia still lacks a budget for mental health patients and relies on grants from donors.¹⁰² While the recommendation in the Inter-American system made to Brazil enjoyed strong support in ‘efforts by domestic stakeholders including patients’ relatives, health professionals, and local and national health Commissions [triggering] an on-going shift from an internment model of mental healthcare to a system focused on outpatient care and respect for patients’ rights.’¹⁰³

6 CONCLUSION

The rights to health is now justiciable in both the African and Inter-American systems, thereby opening up possibilities for more strategic litigation to improve the general health services. While many elements of the right to physical and mental health are subject to progressive realisation and resource availability, there is a great deal that countries can do, even within their limited resources. For example, even a country with limited resources can for example: include the recognition, care, and treatment (where appropriate) of mental disabilities in training curricula of all health personnel; promote public campaigns against stigma and discrimination of persons with mental disabilities; support the formation of civil society groups that are representative of mental healthcare users and their families; formulate modern policies and programmes on mental disabilities; downsize psychiatric hospitals and, as far as possible, extend community care; actively seek assistance and cooperation that benefits persons with mental disabilities from donors and international organisations. It is essential that persons with mental disabilities and their representative organisations are involved at all stages of the development, implementation, and monitoring of legislation, policies, programmes, and services relating to mental health and social support and to broader policies and programs, such as poverty reduction strategies, that affect them. States should affirmatively solicit their input. Litigation of the right to health in both systems has brought social changes, albeit quite slowly in the African system. As they fully take root, these changes will go a long way in improving the dignity, treatment and care of mental health patients.

101 Resolution 343: Resolution on the right to dignity and freedom from torture or ill-treatment of persons with psychosocial disabilities in Africa, adopted by the African Commission on Human and Peoples’ Rights at its 58th Ordinary Session held in Banjul, the Gambia, from 6 to 20 April 2016 <http://www.achpr.org/sessions/58th/resolutions/343/> (accessed 20 December 2018).

102 WHO ‘Country profile’ https://www.who.int/mental_health/policy/country/thegambia/en/

103 JL Cavallaro & SE Brewer ‘The virtue of following: The role of Inter-American litigation in campaigns for social justice’ (2008) 8 *SUR – International Journal on Human Rights* 85 at 92.