Behind Closed Doors: The Human Rights Conditions of Persons with Mental Disabilities in Ethiopian Psychiatric Facilities

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Abstract

The Mental Disability Advocacy Center (MDAC) headquartered at Central European University has been carrying out a series of studies in Eastern and Central European Countries on the condition of persons with mental disabilities, (hereinafter, PWMDs), in psychiatric facilities titled as "*behind closed doors*". So far, neither the Ethiopian Human Rights Commission nor any other international human rights organization has aired any report from Ethiopian psychiatric facilities. This article is an attempt to unveil the human rights conditions of PWMDs "behind closed doors" in Ethiopia. As a signatory to the Convention on the Rights of Persons with Disabilities (hereinafter, CRPD), Ethiopia has undertaken to take all appropriate measures for the full inclusion and participation of persons with disabilities in the life of the mainstream society. However, the Country has failed to meet its obligations. Among other things, the absence of a special mental health law for the protection of the rights of PWMDs, nor a body that safeguards their condition in psychiatric facilities, the irregularities with the implementation of existing schemes and lack of coordination among responsible government bodies leave many PWMDs without much-needed support. These people are suffering from various forms of human rights violations behind closed doors in addition to lack of access to mental health services. This article has thus an objective of assessing the human rights conditions of PWMDs at the psychiatric settings in two selected facilities: the Amanuel Hospital and the Gefersa Mental Health Rehabilitation Center, which are the only major mental health hospital and a rehabilitation center in the country, respectively. The author believes that the assessment of the two institutions would represent the countrywide perspective.

1. Introduction

Ethiopia has ratified the CRPD in June 2010, which imposes a host of obligations on states towards the realization of the rights of persons with

disabilities on an equal basis with other persons. PWMDs are under the category of these vulnerable groups who require a special consideration by states so that they can be included in the society

However, like any other low-income country, the mental health services of Ethiopia have been proven evidently inadequate to the need.[1] In fact, the WHO described mental health in Ethiopia as "one of the most disadvantaged health programs, both in terms of facilities and trained manpower . . . with estimates of the average prevalence of mental disorders in Ethiopia at 15% for adults and 11% for children."[2] The government has not met its obligations in ensuring a highest standard of health for PWMDs[3] as its access is limited economically, geographically

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[1]. Atalay Alem., 'Human Rights and Psychiatric Care in Africa in Particular in Ethiopia', *Acta Psychiatrica, Scandinavica* ISSN 0902-4441, Munksgaard , (2000), pp 93-96; WHO-AIMS Report on The Mental Health System of Ethiopia, (2005); (2012); Welansa Ayele., Interview with Tadias Magazine, August 20, 2012; Yeshashwork Kibour, 'Mind the Gap', Personal Reflections on the Mental Health Infrastructure of Ethiopia, Psychology International, April 2010

[2]. WHO, Regional Office for Africa, Ethiopia, Department of Mental Health and Substance Abuse, available at http://www.afro.who.int/en/ethiopia/country-programmes/mental-health-and-substance-abuse.html, accessed on April 12, 2012; See also in general WHO-AIMS Report on The Mental Health System of Ethiopia, 2005, *supra at note 1*

[3]. There is no rigid definition for mental disabilities due to the general evolving nature of disability as the CRPD has also refrained from defining disability. The CRPD under Article 1 gives a definition for persons with disabilities as 'persons who have long-term physical, mental, intellectual or sensory impairments that, in the face of various negative attitudes or physical obstacles, may prevent those persons from participating fully in society.' But for the purpose of this study, the definition forwarded by Special Rapporteur Erica, I. in the 'Principles, guidelines and guarantees for the protection of persons detained on grounds of mental ill health or suffering from mental disorder', who defined a PWMDs as 'one who in the course of his/her disability is unable to care for his/her own person or affairs, and requires care, treatment or control for his/her own protection or that of others or of the community' will be availed of. This may include disabilities arising from major mental illness and psychiatric disorders, e.g., schizophrenia and bipolar disorder; more minor mental ill health and disorders, often called psychosocial problems, e.g., mild anxiety disorders; Down's syndrome and other

and owing to lack of information. While the paradigm for the care of PWMDs has been shifting from institutional care to community one, it is disheartening in Ethiopia that there are only few institutions to give the necessary care. Hence, it would be an extravagant and untimely claim to advocate deinstitutionalization in the absence of community settings that fit for treatment of mental illness at this point of time.

Be that as it may, having institutions to admit PWMDs and giving the necessary treatment is not a system to be left out of serious scrutiny; there must be protection, respect and fulfillment of the human rights of the inmates all the way through admission, treatment and discharge. The provision of services in a segregated setting that cuts people off from society often for life is one of the concerns that need scrutiny. The arbitrary internment of people to institutions without due process and with no guarantees of a legal counsel to represent them is another practice that requires looking behind the closed doors. Moreover, the denial of appropriate rehabilitation services in psychiatric facilities, the practice of subjecting to unjustified medications without consent and adequate standards and the lack of human rights oversight and enforcement mechanisms to protect them against the broad range of abuses in institutions are all concerns that put the right of PWMDs at stake in psychiatric facilities. This has been attracting the conscious of a number of human rights bodies and advocacy groups as the clamor behind closed doors is increasing.[4]

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chromosomal abnormalities, brain damage before, during or after birth and malnutrition during early childhood.

[4]. Open Society Institute, Mental Health and Human Rights: A Resource Guide, 4th ed., (2009), available at **www.equalpartners.info,** accessed on July 1, 2012, pp 32; Theo

Though there is no specific undertaking adopted for the protection of the rights of PWMDs in psychiatric facilities, the Principles for the Protection of Persons with Mental Illness (hereinafter, MI Principles) approved by the UN can serve to complement the interpretation of other international human rights agreements as they apply to PWMDs.[5] In doing so, it is tried to see whether these standards are being met in the way these people live in the institutions and the human rights conditions in their admission, treatment and discharge.

Accordingly, the article unveils the human rights conditions of PWMDs in psychiatric settings, emphasizing the common civil and political rights that are susceptible to violation at psychiatric institutions including the right to liberty, the right to privacy, freedom from torture and all forms of ill treatment, right to legal counsel and the right to rehabilitation and community integration. The choice of these rights is not however arbitrary. The right to liberty is selected because the nature of the

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B., Special Rapporteur of the Commission on Human Rights on the question of torture and other cruel, inhuman or degrading treatment or punishment, 3 July 2003, pp 12-16; Tina, M., 'The CRPD and the right to be free from nonconsensual psychiatric interventions', Syracuse Journal of International law, Vol. 34, pp 405-428; Mental Disability Advocacy Center (MDAC), 'Human rights in psychiatric hospitals and social care institutions in Croatia', October 2011

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

admission and treatment in psychiatric facilities is usually assimilated to *de facto* detention, in limiting the right to liberty.[6] This has made the right to liberty at the forefront in the study of the human rights of PWMDs in psychiatric facilities. Moreover, the rights to privacy and freedom from torture and all forms of inhumane treatment are routinely violated as their life behind closed doors and their health conditions readily lends them. The rights to legal counsel, rehabilitation and community integration have also a special importance for PWMDs for the respect and protection of all other rights. The cases presented are not however intended to be exhaustive; they are used as illustrative examples of the most common practices in the facilities.

The virtual absence of a special mental health legislation as a standard on admission of PWMDs and treatment benchmark has obviously made this study difficult. Therefore, the study is conducted based on semi-structured interviews with several stakeholders including the directors and psychiatrists at the respective institutions, patients and their care givers coupled with first-hand accounts by the author and secondary data based on the lens of international and national human right standards. The study has intentionally refrained from highly relying on the information obtained from the patients as it has appeared difficult to get the most reliable information from persons who do not recover from their severe mental illness.

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

2. The Right to Liberty

The right to liberty is recognized under numerous international and regional human rights instruments as well as in the Constitution of the Federal Democratic Republic of Ethiopia (hereinafter, FDRE).[7] Such incorporation is a guarantee that no one shall be denied of his liberty without due process. All restrictions on the liberty of a person shall be justified and based on fair hearing of the detainee. In psychiatric facilities, the liberty of a patient may be infringed in two cases: through involuntary admission and measures of seclusion and restraint. The history that the disability discourse came from clearly evidence that mental disability was a legitimate ground to deprive the liberty of those persons.[8] In reaction to this legacy, the CRPD emerged totally against the deprivation of liberty based on disability and, disability and legal capacity are totally de-linked.[9] Even though involuntary admissions and measures of restraint and seclusion are not supposed to be wholly excluded, they should be carefully monitored taking into account the due

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

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

[9] CRPD, United Nations Convention on the Rights of Persons with Disabilities(CRPD), adopted by General Assembly resolution 61/106 of 13 December 2006, article12; Tina M. Supra at note 4

process rights of inmates. These circumstances and their implementation at the selected institutions will be discussed in their order in the following sub-sections.

2.1.Involuntary Admission

As pointed out above, admission to a psychiatric facility is equated with *de facto* detention for all practical purposes as it causes restriction on the liberty of a person. Unless one is released based on the decision of a psychiatrist, an inmate is not allowed to leave at any time. In this regard, the Human Rights Committee recalls that the protection of liberty and security under Article 9 of the ICCPR is applicable to all deprivations of liberty, whether in criminal cases or in other cases such as mental illness.[10] This imports an obligation up on States Parties to ensure that measures depriving an individual of his/her liberty, including for mental health reasons, should comply with Article 9 of the ICCPR. This engenders another important guarantee, i.e., the guarantee of control by a court of the legality of detention to be applicable to all persons deprived of their liberty by arrest or detention.[11] The Committee has submitted its Concluding Observation on the report of Estonia in this respect as:

> '*the State Party should ensure that measures depriving an individual of his or her liberty, including for mental health reasons, comply with Article 9 of the Covenant. The Committee recalls the obligation of the State Party to enable a person detained for mental health reasons to initiate proceedings to review the lawfulness of his/her detention.*'[12]

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

[11]. Ibid. Para 4

[12]. Human Rights Committee, Concluding Observations on the Report of Estonia on article 9 of the ICCPR, 77th session, (2003), Para. 10

This is a reminder to make sure that due process is complied with before a person is committed to a psychiatric facility involuntarily.[13]

In the absence of any normative standards on admission in Ethiopia, Amanuel Hospital admits patients without any regard to their consent. The Gefersa Rehabilitation Center on the other hand has been serving simply as a "dumping ground" for long time since its establishment during the Derg regime for all of persons with disabilities. It is absurd to see persons with different kinds of disabilities living together for long time without any distinction on their treatment and residence facilities. Recently, after the "Brother Charities" took over the Center, it has developed a standard for admission that lists down the conditions to be complied with upon admission complemented with a contract form to be signed by the patient and his/her respective family member with the Center.[14] Despite this, the Center is more concerned if there is a family member to consent on behalf of the patient. What is really required in both facilities is the consent of the family member or any escort coupled with the severity of the condition. This is true especially for persons with

[13] Due process rights traditionally termed as 'fair trial rights', are guaranteed under ICCPR, article 14; The FDRE Constitution under articles 19-23 has guaranteed these fair trial rights.
The African Commission in the case between *Moore and Purhoit vs. The Gambia*, decided that the State should create an expert body to review the cases of all persons detained under the Lunatics Detention Act(LDA) and make appropriate recommendations for their treatment or release.

[14] This standard is a recent development after the Rehabilitation Center is given to a faith-based organization, 'Brothers' Charity'. Before that, the Center has been used simply as a 'dumping zone' for persons with disabilities. It is ironic that persons with physical and mental disabilities are living together in the Center. But, this new standard is not yet tested in practice as the Center does not admit new patients.

psychosis as most of them come to treatment against their will.[15] Families, friends, neighbours, work-mates and the police bring persons with psychosis to the Amanuel Hospital.[16] Especially, the will of this category of persons is usually not taken into consideration because in most cases they are not thought to have insight into their conditions.[17]

This arbitrary and involuntary admission to a psychiatric facility involves a serious deprivation of a person's liberty and a potential source of violation of other human rights, including the right to be free from torture and other forms of ill treatment and the rights to privacy, among others. Indeed, Amanuel Hospital has an in-patient admission procedure based on objectively accepted psychiatric criteria *inter alia*, existence of a severe mental illness, threat of imminent harm or deterioration and necessity of institutional treatment.[18] Nevertheless, these procedures are alien to any legal guarantees for involuntary admission as solely psychiatric professionals make decisions without leaving a room for the patient's view or his/her right to be represented by a legal counsel. There is no indication in the record of the patients whether they are voluntarily or involuntarily admitted. This creates another lacuna on possible review by external bodies about the extent to which coercion is committed at admission and in effect the respect of the fundamental right to liberty of PWMDs is respected.

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[15] Psychotic persons have a disorder such as schizophrenia or mania that is marked by distorted perception of reality and paranoia. This leads them to believe people around them are conspiring to harm them and they perceive the attempt for treatment by a close person as threat against them.

[16] Interview with Dr Lulu Bekana, Medical Director, Amanuel Hospital, on July 2, 2012, Addis Ababa , Ethiopia

[17] Atalay Alem., Supra at note 1

[18] Interview with Dr Lulu Bekana, Supra at note 16

The CRPD has altogether rejected coercive mental health care when it provides that care should be provided to persons with disabilities on the basis of free and informed consent, on an equal basis with others. It also requires health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care.[19] However, if we have to be realistic, this undertaking may not take us far as coercion-free psychiatric care may not be to the best interest of the patient as the latter may sometimes lack the insight about his/her conditions and the State may have a duty to take care of them from an imminent danger to themselves and the community. A person who has lost his conscious, or who has a suicidal temptation, unless she/he is watched out seriously, may cause something worse which may amount to violation of right to life for not taking proper care.[20] This gap could be rather rectified by a system of complaint or review body on involuntary admissions so that both interests can be maintained.[21]

The decision as to whether the person should be admitted involuntarily, while initially a medical or psychiatric determination should ultimately

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[19] CRPD, Supra at note 9, Article 25

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

[21] Héyer, G., Supra at note 6, pp 66

be subject to judicial review to ensure that the determination is consistent with legal standards.[22] The MI principles demand that:

> '*PWMDs who are involuntarily admitted to a psychiatric facility must have the right to a fair and timely review of their detention by a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law.*'[23]

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

> *'in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account and issue a decision on the involuntary commitment of a person as soon as and shall periodically review the cases of involuntary patients.*'[24]

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

In Ethiopia, where there is no any legislative guarantee on admission proceedings, there are no judicial reviews for involuntarily admitted persons. For what is adding 'an insult to the injury', there is even no review of the decision of a psychiatrist to involuntary admission by another psychiatrist or that of a board of psychiatrists. The decision of a

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[22] MI Principles, Supra at note 5, Principle 16, Para. 2

[23] MI Principles, Principle 17, Para.1

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

psychiatrist to commit a patient serves as a 'rubber stamp' and it is not reviewable. One may wonder here that while there is a clamor about the lack of in-patient facilities, a psychiatrist would not dare to admit a person involuntarily. In fact, it is not news that the availability of in-patient services is seriously inadequate in the country. However, this does not ensure that the human rights of persons to liberty are not endangered. For instance, a psychiatrist does not consider family and professional conflicts with the patient when the latter appear before him involuntarily escorted by a family member or professional associate.[25] This amounts to a violation of the due process that in effect is arbitrarily denying one's liberty against fundamental guarantees.

2.2. Seclusion and Restraint

After being interned to a psychiatric facility, another circumstance that PWMDs would face is solitary confinement and chaining as a form of control and/or medical treatment. These measures are known as seclusion and restraint often practiced in psychiatric facilities based on clinical assumptions. Seclusion and restraint may take different forms including environmental restraints by imposing barriers to free personal movement that confine patients to specific areas in seclusion rooms; physical restraints using appliances, usually chains and cuffs that inhibit free physical movement and cannot be removed by the person to whom they are applied, such as hand restraints and cage beds and finally chemical restraints by pharmaceuticals that are prescribed for the main purpose of

[25] Interview with Dr Lulu Bekana, Supra at note 18.

inhibiting specific behavior, such as aggression.[26] These three kinds of restraints and seclusion may be used either alone or in a combination depending on the clinical objectives aimed to be met. However, although these measures may serve a purpose in the treatment process of the patient and the security of other residents, they have the potential to cause serious violations of the human rights of PWMDs unless they are effectively regulated.

The Special Rapporteur on Torture noted that seclusion and restraint of mental health patients is a method that tends to be avoided by modern psychiatric practice, though this form of restraint is still being used.[27] The Rapporteur recalled that the Basic Principles for the Treatment of Prisoners adopted and proclaimed by General Assembly by Resolution 45/111, in particular Principle seven,[28] shall be applicable to those confined in psychiatric institutions.[29] While it is clear that the restraint of violent and agitated patients may be necessary in some circumstances, the Rapporteur stressed that this should always be conducted in accordance with accepted guiding principles. Therefore, initial attempts to restrain agitated or violent patients should, as far as possible, be non-physical

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[26] Gutheil, T. 'Observations on the Theoretical Bases for Seclusion of the Psychiatric Inpatient', American Journal of Psychiatry, Vol. 135, (1978), pp 325-328; Moosa, J., 'The Use of Restraints in Psychiatric Patients', South African Journal of Psychiatry, Vol. 15, No. 3, (2009).

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

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

[29] Report of the Special Rapporteur on the question of torture and other cruel, inhuman or degrading treatment or punishment, in accordance with Assembly resolution 57/200 of 18 December 2002, Para 50

through verbal instruction and that where physical restraint is necessary, it should in principle be limited to manual control."[30] The MI Principles also corroborates this position when it states that:

> *"physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff."*[31]

Amanuel Hospital does not have any written guidelines in regulating the use of seclusion and restraint on which forms of restraint and seclusion to be used, in regulating when and how to administer restraint and seclusion and the duration of the measure.[32] This lack of standards has a series of implications which directly affects the proper implementation of the measures *per se*. Nor are there registers kept for this purpose which have to be signed and completed by the relevant medical practitioner who follows up the restrained and secluded person. In the absence of any record, it is hardly possible to know if all other means short of seclusion are exhausted and if the less restrictive method is availed of before

[30] Ibid. Para 51

[31] MI Principles, Supra at note 24, Principle 11, Para11

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

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

While the seclusion rooms are closed, the Medical Director of Amanuel Hospital mentioned that restraints are practiced only in some situations as a last resort after therapeutic measures are exhausted.[33] Despite this, handcuffed patients are seen here and there together with others wandering in the Hospital's compound and few patients are seen chained with their beds in the wards. The survivors of restraint accuse that any nurse or a person following up a patient may order to be handcuffed without getting a direction from a psychiatrist.[34]

Moreover, Amanuel Hospital is situated next to the Ethiopian Commodity Exchange (ECX), the largest grain market in the country, on a slummy area that is highly trafficked with loaded and unloaded Lorries all through the day and the night. This endangers the life and security of

[33] Interview with Dr Lulu Bekana, Supra at note 25
[34] Interview with Abraham Kassahun, an inmate at Amanuel Hospital, interview held on July 19, 2012.

the inmates of the hospital as there are complaints on the hospital that patients are absconding from the compound. In fact, there is construction underway to shift this hospital to around Kotebe in Addis Ababa. However, it is unlikely to see immediate transfer as the construction is taking longer time than initially imagined. Apart from the access to health point of view, the construction and renovation of institutions for PWMDs partly proves that Ethiopia is yet lingering on the medical model of addressing disability than to work on the social model.

At the Gefersa Rehabilitation Center, the manager divulged that restraining patients with big chains was pervasive when they arrived to take over the Center before six months.[35] What they did immediately was to abandon the system of restraint altogether and collect back all the chains in use believing that they could manage the aggressive patients using medication. While this is commendable, it has however opened for underground restraint without the knowledge of any professional caretaker. The representative of the inmates witnessed that when anyone disturbs his/her ward mates at the nighttime, the mates would chain him to his bed using the bed sheets and they would bring to the nurses in the morning.[36] This clandestine and haphazard restraining of the inmates readily lends a room for serious deprivation of their rights. There are even cases that the inmates drag those who are disturbing out forcing them to spend the whole night wandering in the compound that exposes

[35] Interview with Brother Eric, manager of the Gefersa Rehabilitation Center, interview held on July 10, 2012, Gefersa.

[36] Interview with Shibabaw Workie, a representative for inmates at Gefersa Rehabilitation Center, interview held on July 10, 2012, Gefersa

them to more threats to life and security.[37] These situations really constitute a threat to the life and security of the inmates. Therefore, the move towards total abandonment of restraint at the Gefersa Rehabilitation Center may be counter-productive since it does not salvage the residents from infringement of their liberty and security, unless a follow up mechanism is adopted together with the abandonment of the restraint system.

Finally, the arbitrary internment of PWMDs in to psychiatric facilities may have an effect on the rights of children causing an emotional distress. When we send parents to psychiatric facilities, the right of children to live with their parents and to be intact in family relationships would obviously be affected and come under strain.[38] Especially, children may feel despair and deprivation when their parents are interned to psychiatric facilities involuntarily.

3. Freedom from Torture and all forms of Ill Treatment

The prohibition of torture and cruel, inhuman or degrading treatment or punishment is among the most serious obligations reflected in a host of international instruments, including a specialized convention on the subject.[39] The prohibition of torture in fact has attained the status of a

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[37] Ibid.

[38] CRC, adopted by the UN General Assembly in resolution 44/25 of 20 November 1989 at New York, Article 8(1) of the CRC requires States Parties to guarantee children to family relations as one element of recognition and respect of the identity of children be preserved.

[39] The CAT, UDHR, ICCPR, ACHPR have all prescriptions on the prohibition of torture. The FRDE Constitution, too, though it does not indicate torture explicitly, the prohibitions against other forms of ill treatment under article 18 are considered as sufficient guarantees against torture.

peremptory norm under international law that can never be derogated from even in emergency situations. As such, it must be regarded as having attained the status of customary international law and, moreover, there is ample authority for the proposition that the prohibition of torture be assigned *jus cogens* status.[40] While the ICCPR does not contain any definition of torture, the CAT has come up with a definition to be availed of for that Convention only, which is in fact used for further analysis of the concept.[41] There is always an argument over the distinction between torture on the one hand and cruel, inhuman, and degrading treatment or punishment on the other. But the Human Rights Committee has asserted that it does not:

> *"consider it necessary to develop a list of prohibited acts or to establish sharp distinctions between different kinds of punishment or treatment; the distinction depends on the nature, purpose and severity of the treatment applied".*[42]

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[40] The *jus cogens* status of the torture prohibition has been recognized by the Committee against Torture, the treaty body that monitors the Convention against Torture, and provides authoritative interpretations of CAT obligations. See also U.N. Committee Against Torture, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: General Comment No. 2: Implementation of article 2 by States Parties, P 1, U.N. Doc. CAT/C/GC/2 (Jan. 24, 2008); See also Bassiouni, M. & Daniel, D., An Appraisal of Torture in International Law and Practice: The need for an international convention for the prevention and suppression of torture, (1977), p. 67-88; Rosalyn, H., 'Derogations under human rights treaties', British Year Book of International Law, Vol. 48, (1978), pp 282

[41] CAT, adopted by the UN General Assembly in resolution 39/46 of 10 December 1984 at New York, Article 1

[42] Human Rights Committee, Supra at note 12, General Comment No. 20 on article7 of the ICCPR, Para 4, The common elements pertaining to all acts within the torture and ill-treatment prohibition include: (i) meeting a minimum threshold level of severity; (ii) subjective and objective assessment; (iii) physical and or mental suffering fall within the scope of protection; (iv) the protection is not confined to the criminal investigation and judicial process; See generally Gabrielle, M. & Olivia, S. (eds.), Torture and other offenses involving the violation of physical and mental integrity of the human person, in substantive and procedural aspects of international criminal law, (2000), pp 226-27,

The first instrument that prohibits torture and cruel, inhuman, or degrading treatment or punishment in contemporary human rights law is the UDHR, which states: "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."[43] Article 7 of the ICCPR reaffirms this when it clearly sets out that

> "*no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.*"

The ICCPR went on to guarantee that all individuals deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.[44] The CRPD on the other hand reaffirming the above prohibitions requires States to take effective measures to prevent persons with disabilities, on an equal basis with others, from being subjected to such treatment.[45] The prohibition set out in Article 15 of the CRPD is reinforced by Article 17 that simply and decidedly guarantees the physical and mental integrity of persons with disabilities.[46] The protection from degrading treatment is reinforced for persons in psychiatric facilities under the MI Principles which states that

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[43] UDHR, adopted and proclaimed by the UN General Assembly in resolution 217 A (III) of 10 December 1948 at Paris, Article 5.

[44] ICCPR, adopted by the UN General Assembly in resolution 2200 A (XXI) of 16 December 1966 at New York, article 10.

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

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

> "every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort".[47]

All the above guarantees on the freedom from torture and all other forms of ill treatment shall therefore be applicable to persons who are interned at psychiatric facilities who are prone to these sorts of treatments as evidenced in many institutions.[48] As it is pointed out somewhere above, the Human Rights Committee has submitted that "it is appropriate to emphasize that article 7 of the ICCPR protects, in particular [...] patients in [...] medical institutions".[49] While treatments of PWMDs after admission are issues to be dealt with independently, involuntary admission and lack of a review body shall be scrutinized if they do amount to the violation of the above undertakings by themselves. In this regard, the Special Rapporteur believes that the internment of mentally sane individuals in a psychiatric institution may amount to a form of ill-treatment and in certain circumstances, to torture.[50] In fact, while a person is healthy, it is degrading to be treated like an insane person and to be subjected to unjustified medications and be cared for together with PWMDs. This illusion and confusing treatment may even expose one to a psychiatric disorder.

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[47] MI Principles, Supra at note 31, Principle 8, Para2

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

[49] The Human Rights Committee, Supra at note 42, General Comment 9 on Article 10 of the ICCPR, Para 4

[50] Ibid. Para 48

Another case of torture that is often perpetrated at psychiatric facilities is 'nonconsensual psychiatric and medical interventions' which have been contemplated as torture or cruel, inhuman or degrading treatment and prohibited by all the instruments which deal with torture.[51] On this point, the Special Rapporteur on Torture emphasized that certain practices such as irreversible treatments, including sterilization or psychosurgery, experimental treatment without informed consent which are expressly forbidden by the MI Principles, shall be prohibited, as they may amount to a form of ill-treatment or even, in certain circumstances, to torture. However, the right to informed consent and the right to refuse treatment may be restricted, but only under limited circumstances specified in international standards.[52] As it is described by the Special Rapporteur on the right to highest attainable standard of health, strict protections are needed to protect the right to informed consent for PWMDs. In the Rapporteur's experience, decisions to administer treatment without consent are often driven by inappropriate considerations, in the context of ignorance or stigma surrounding mental disabilities and expediency on the part of staff.[53] This is inherently incompatible with the right to health,

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

[52] MI principles, Supra at note 47, Principle 11

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

the prohibition of discrimination on the ground of disability, and other provisions in the MI Principles. In such circumstances, the Rapporteur recommends that it is important that the procedural safeguards protecting the right to informed consent are both watertight and strictly applied.[54] Recently, the European Court of Human Rights issued a strong judgment on the rights of PWMDs to be free from arbitrary interference with their rights to liberty and to self-determination.[55] The Court found a violation of Article 5(1) of the European Convention of Human Rights on the right to liberty, which has a similar content with the protections under Article 9 of ICCPR. In doing so, it articulated principles upholding the rights of PWMDs to make choices about their own treatment and of the need for less restrictive alternatives to detention.[56]

Lack of consent and review on the admission of an involuntary patient will continue all through the treatment process since there is no system to get the consent of the patient as treatments are solely administered based on the discretion of the psychiatrist and sometimes with the consent of a

[54] Ibid. Para 90-91

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

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

family member.[57] Therefore, psychiatrists are not required to ask for any form of consent to treatment from patients. The latter are not informed about risks or side effects of treatment or any alternatives for treatment that might have been available. At both Amanuel Hospital and Gefersa Center, there are no systems to get the consent of patients in the treatment process even where the latter are able to share their views over the procedure of the treatment and the type of treatment. The testimony of one inmate at Amanuel Hospital goes like this:

> *"I have been here for two months. It is only on the first day that I was asked by the doctor on my diagnosis and treatment. After that time, I have never been consulted about my treatment plan, alternative treatments and the progress I am showing even though I am able to give opinions about my treatment. I am just a passive recipient of what is given here."*[58]

In most cases, psychiatrists are under the impression that obtaining consent from family members is adequate.[59] Of course, patients may sometimes be unable to consent to their treatment depending on the severity of the illness they are suffering from. In these cases, getting the consent of the caregivers may suffice. But neither is there consulting families nor care givers on the treatment plan and the possible repercussions of the treatments administered on a patient.[60] This means

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

[58] Interview with Abraham Kassahun, Supra at note 34

[59] Interview with Dr Lulu Bekana, Supra at note 33

[60] Mulu Haile and Nakachew Asmare. whom the author interviewed while caring for their respective families confirm that neither patients nor family members have any say

that inmates are at the mercy of whatever plans the psychiatrist or head nurse happened to consider suitable for them. This lack of consultation and securing the consent of the patients and their family members or care givers gives a 'blank cheque' for the persons following up to administer the treatment they think fit. In such cases, there are no guarantees if sterilization and abortion, which are irreversible forms of treatment, are not administered without the consent of the patient.

The other circumstance that exposes PWMDs to torture and degrading treatments is Electro-Convulsive Therapy (hereinafter, ECT) which is practiced in psychiatric facilities. ECT is a form of treatment widely used to treat depressed patients, which is terrifying, especially if administered without anesthesia or muscle relaxants as the body shakes in a convulsion that can cause fractures. However, use of anesthesia and muscle relaxants in "modified electroshock" necessitates the use of more electricity to achieve a seizure, which can cause increased brain damage and might not be as effective as the treatment in its unmodified form.[61] This has been evidenced when some of the persons against whom ECT is administered have suffered from loss of memories long time after it is administered.[62] This may even cause a permanent loss of memory. Abrams R. has observed that:

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over the treatment plan and progress of the patients. Everything is top down that the psychiatrists order and the nurses administer.

[61] Squire, L. and Slater, P., "Electroconvulsive therapy and complaints of memory dysfunction: A prospective three-year follow-up study", British Journal of Psychiatry, Vol.142, (1983), pp1-8; Zielinski, R., *et al.*, "Cardiovascular complications of ECT in depressed patients with cardiac disease", American Journal of Psychiatry, Vol.150, (1993), pp 904-909.

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

'... a patient recovering consciousness from ECT might understandably exhibit multiform abnormalities of all aspects of thinking, feeling and behaving, including disturbed memory, impaired comprehension, automatic movements, a dazed facial expression and motor restlessness.'[63]

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

'there is considerable empirical evidence that ECT induces significant and to some extent lasting brain impairment. The studies ... suggest that ECT is potentially a harmful procedure, as indeed are most naturally occurring episodes of brain trauma resulting in concussion, unconsciousness and grand mal-epileptic seizures, Accordingly, the continued use of ECT in psychiatry must be questioned very seriously.' [64]

So, whether it is modified or not, ECT causes a serious pain and should be regarded as a degrading treatment. At Amanuel Hospital, modified ECT is a common way of treatment as it is taken as an effective way of treatment for the seriously depressed patients.[65]

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

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

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

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

> "article 7 expressly prohibits medical or scientific experimentation without the free consent of the person concerned. . . The Committee also observes that special protection in regard to such experiments is necessary in the case of persons not capable of giving valid consent and in particular those under any form of detention or imprisonment. Such persons should not be subjected to any medical or scientific experimentation that may be detrimental to their health."[66]

The Ethical Principles for Medical Research Involving Human Subjects of the World Medical Association Declaration of Helsinki further addresses the limited conditions under which such research may be conducted. Principle 24 provides that research subjects who are legally incompetent or physically or mentally incapable of giving consent should not be included in research unless the research is necessary to promote

[66] Human Rights Committee, Supra at note 49, General Comment 20, para.7; Ethiopia, a signatory to both the ICCPR and CAT has an obligation to protect individuals from these set of practices which tantamount to torture and other forms of ill treatment.

the health of the population represented and this research cannot instead be performed on legally competent persons.[67] If the above allegations are thus true, it is a clear violation of the guarantees under the ICCPR and the CRPD.

The Human Rights Committee has referenced both forced abortion and involuntary sterilization as violations of article 7 of the ICCPR.[68] These practices would obviously trigger violations of article 15 of the CRPD too, for the latter has imposed similar prohibitions against forced medications and medical experiments. The Special Rapporteur on Torture has also noted that:

> "given the particular vulnerability of women with disabilities, forced abortions and sterilizations of these women if they are the result of a lawful process by which decisions are made by their 'legal guardians' against their will, may constitute torture or ill-treatment."[69]

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

[68] Human Rights Committee, Supra at note 66, Concluding observations on the report of Estonia on article 9 of the ICCPR, 77th session, (2003), Para. 10; See also Janet, E., 'Shared Understanding or consensus-masked disagreement? The anti-torture framework in the CRPD', Loyola of Los Angeles International and Comparative Law Review, Vol. 33, No 27, (2010), available at: http://digitalcommons.lmu.edu/ilr/vol33/iss1/3 accessed on ,July 21, 2012

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

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

Moreover, the Committee against Torture pointing to overcrowding, inadequate living conditions, and lengthy confinement in Russian psychiatric hospitals considered it as "tantamount to inhuman or degrading treatment."[70] The Human Rights Committee, too, called for the improvement of hygienic conditions and adequate treatment of the mentally ill in detention facilities in Bosnia and Herzegovina both in prisons and in mental health institutions as a protection from ill treatment.[71] Against this, at Amanuel Hospital and Gefersa Rehabilitation Center, there are at average 20 patients in one ward. Even though patients should be provided with a comfortable environment which ought to be safe, clean and attractive, the bad odor especially at the wards of the Gefersa Rehabilitation Center is horrifying even for a short time visit.

At both the Amanuel Hospital and the Gefersa Rehabilitation Center, the inmates spend their day being closed in the hospital's compound with no means of refreshment, or being provided with a television as the only means of entertainment. Most of them are seen smoking cigarettes and wandering here and there, and sometimes engaging in brawls which may be a threat to the life and security of the patients. While this may not constitute degrading treatment *per se*, the cumulative effect may be

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

[71] The Human Rights Committee, Supra at note 68, Concluding comment on the initial report of Bosnia and Herzegovina on the ICCPR, 88th session (2006), Para. 19.

degrading, as the social and other skills of institutionalized individuals deteriorate on this kind of dulling environment. Indeed, the Human Rights Committee has noted that the duration of a practice will be taken into account when determining if it constitutes degrading treatment.[72]

Last but not least, the practice of continuously dressing patients in pyjamas at both Amanuel Hospital and Gefersa Rehabilitation Center is not conducive to strengthening personal identity and self-esteem as individualization of clothing should form part of the therapeutic process.[73] For these inmates who are accommodated in overcrowded conditions with few activities at their disposal, when they are obliged to wear institutionalized clothing throughout the day, 'the cumulative effect of such conditions is profoundly anti-therapeutic and is degrading.'[74]

4. The Right to Legal Counsel

The right of access to legal counsel is traditionally guaranteed in connection with the right to fair trial in the determination of a criminal

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

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

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

charge against a person.[75] As interpretations make clear, however, a legal counsel should be provided for all detained persons, because access to a legal counsel is an important means of ensuring that the rights of detained persons are respected.[76] The Human Rights Committee has recognized that the right to counsel means the right to an effective counsel and that should be provided immediately up on detention.[77]

Under the section on the right to liberty, it is pointed out that admission to psychiatric facilities amounts to detention for all practical purposes. This therefore imports a duty upon States Parties to provide a legal counsel for these persons who may be involuntarily admitted and treated in mental health facilities.[78] This is because, without the involvement of a legal counsel, it will be hard to prove if the PWMDs have consented for admission, especially where they came escorted by a family member or a police. The role of the counsel is not however limited to representation of the persons at admission proceedings. Even after admission, there is a need to provide with legal counsel, because without the availability of such counsel, it is virtually impossible to imagine the existence of valid consent of the patients towards treatment, right to apply against involuntary admission to a review body, right to accept or to refuse

[75] ICCPR, Supra at note 44, Article 14(3)(d)
[76] The Human Rights Committee, Supra at note 71, General Comment No 13, Para 11, The Committee understands the right to legal assistance to be extended for all detained persons who cannot defend themselves and could not afford a private lawyer. As submitted above, the Committee in its General Comment No 8, on the right to liberty and security of persons, it has subscribed admission to psychiatric facilities to detention that amounts to denial of liberty of a person. Thus, a person admitted to a psychiatric facility is entitled to be represented by a legal counsel of his own choice, if he is not in a position to hire his own lawyer.
[77] Ibid.
[78] Ibid.

treatment, or any aspect of forensic mental disability law. Especially where the persons lack capacity, their wishes and feelings should be given a room through the involvement of a legal counsel. In such cases, appointment of a guardian or a tutor may not be sufficient to represent the persons on their rights in their stay in the facilities. In order to fill such gaps, the CRPD requires States Parties to take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.[79] One of such supports is to provide a legal counsel to help them effectively exercise their other human rights.

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

In Ethiopia, there is no guarantee for legal counsel both at Amanuel Hospital and Gefersa Rehabilitation Center. There is currently no plan to employ a legal counsel at both institutions to ensure that all inmates who wish to be represented at admission, during treatment and release are put in touch with a legal counsel.[80] This left PWMDs at the psychiatric facilities prone to various forms of human rights violations ranging from

[79]CRPD, Supra at note 51, Article 12(3)

[80] Interview with Dr Lulu Bekana, Supra at note 59 and Brother Erick, Supra at note 35

involuntary admission to involuntary treatment and denial of legal capacity.

5. The Right to Rehabilitation

The other right of PWMDs that is usually infringed at psychiatric facilities is the right to rehabilitation guaranteed under the CRPD.[81] The CRPD specifically requires States Parties

> *"to take effective and appropriate measures including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability and full inclusion and participation in all aspects of life".*[82]

This in turn requires states to train professionals who can work in habilitation and rehabilitation services and making available assistive devices and technologies designed for persons with disabilities.[83] The failure to provide persons with disabilities appropriate services to ensure their integration into community life and enhance their independence runs thus against the commitment of States towards the right to rehabilitation, guaranteed under the CRPD. Especially PWMDs who are

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[81] CRPD, Supra at note 79, Article 26; See generally Janardhana, N. & Naidu, D. 'Inclusion of people with mental illness in community based rehabilitation: need of the day'. International Journal of Psychosocial Rehabilitation, Vol. 16 No. 1, (2012), pp 117-124; Corrigan, P. et al, 'Mental illness stigma and the fundamental components of supported employment', Journal of Rehabilitation Psychology, Vol. 52, (2007), pp 451-457.

[82] Ibid. CRPD, Article 26(1)

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

interned in psychiatric facilities are as a matter of fact delineated from the mainstream society and need to be rehabilitated as they lose ties either for short or extended time. This engenders obligations up on states to provide inmates with rehabilitative activities so that they can remain in touch with the community and facilitate easy integration up on discharge from the facilities. This may include providing skill trainings, formal education and leisure time activities in the facilities.

At Amanuel Hospital and Gefersa Rehabilitation Center, a significant number of persons are seen lying in their beds, or on the institution grounds, completely idle. In the absence of any support for rehabilitation, PWMDs lose ties with their families and communities over time and become more dependent on institutions. As a result, the system of indifferent institutionalization diminishes prospects for rehabilitation, contributes to the chronicity of illness and increases disabilities, making it all the more difficult for these individuals to reintegrate into the community. The Gefersa Rehabilitation Center, counter to its name, does not have any leisure time facility for rehabilitation; *inter alia*, with no access to radio, newspapers and any skill trainings. The residents of this Center are often provided with little or no appropriate stimulation, like sporting activities or refreshment services. Moreover, there are no any religious institutions in the compound to help the patients freely practice their religion or belief. Thus, the environment at the facility is dull that it does not help much in rehabilitating PWMDs that were meant to be rehabilitated. While the Center has no proper fencing, the mobility of the inmates is surprisingly *laissez faire* that the inmates do even import *cha*t

in and many of them spend their day chewing *chat*.[84] This is another challenge to rehabilitation since this exposes them to substance abuse. Few of them are seen at the immediate highway wandering and begging for money and food. These persons may abscond altogether and may not come back to the Center in the absence of any organized follow up on their movements outside of the compound. This may ultimately lead them to remain on the streets in the absence of any viable communication between the families and the Center to follow up their whereabouts.

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

Both at Amanuel Hospital and Gefersa Rehabilitation Center, with family visitors being rare, communication with the outside world must be maintained through letters and phone calls. The author did not find any means of phone communications and postal service at Gefersa Rehabilitation Center.[85] Many of the patients at Amanuel Hospital request any passerby a favor to get a phone call to families. All inmates

[84] Interview with Shibabaw Workie, Supra at note 37.

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

are permitted to use public-payphones although there is only one to cater for more than 360 residents,[86] and to use mobile phones although this is only feasible for those who can afford to buy a phone and pay the bill. This limitation on the inmates to keep contact with families would obviously affect their rehabilitation process and easy integration in to the community up on release from the institutions.

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

6. The Right to Privacy

Privacy is a broad concept ranging from informational and physical to proprietary and decisional circles of a person's life.[87] Apart from the traditional investigative intrusion in crime suspects, it is common in the conduct of clinical research and administrative practices to intrude in one's privacy. There is however wide consensus about the importance of medical confidentiality, modesty and bodily integrity in all health settings; though there is a substantial philosophical disagreement about

[86] A personal observation by the author, July 19, 2012

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

the limits of personal autonomy or individual choice in fields relating to human reproduction and genetics.[88] Be this as it may, privacy is protected as a right under a host of international, regional and national human rights instruments.[89] The relatively detailed standards on the content of the right are forwarded by the Human Rights Committee commenting on article 17 of the ICCPR.[90] The Committee recognized that the protection of privacy is necessarily relative as all persons live in society but any intrusion to any one's private life should be essential in the interests of society as understood under the Covenant.[91] The Committee therefore requires states to take effective measures:

> *"to ensure that information concerning a person's private life does not reach the hands of persons who are not authorized by law to receive process and use it, and is never used for purposes incompatible with the Covenant."*[92]

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[88] Ibid.

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

[90] Human Rights Committee, Supra at note 76, General Comment 16, The right to respect of privacy, family, home and correspondence, and protection of honour and reputation, (article 17), 32nd session, 1988, Para 7

[91] Ibid.

[92] Ibid.

Under article 22 of the CRPD, too, there is a guarantee that "no person with disabilities, regardless of place of residence or living arrangements, should be subjected to arbitrary or unlawful interference with his or her privacy". The Convention recognizes that person with disabilities have the right to the protection of the law against such interference or attacks. PWMDs interned in psychiatric facilities whose liberty is limited as a matter of course are prone to intrusion with their privacy. Therefore, the other most pervasive violation of human rights in psychiatric facilities is the violation of the right to privacy. The inmates may be forced to live for years in common wards where their privacy may be compromised and may not find a moment of a little privacy. They may have no secure place to put their personal possessions and have no privacy when bathing and using toilet. Intimate meetings with friends, family, or even a spouse may be restricted. The MI Principles taking this in to account has set standards of respect of their privacy.[93] The WHO's Guidelines designed to assess the application of the MI Principles recognizes the indicators for respect of the right to privacy in psychiatric facilities *inter alia*, whether toilets and bathrooms can be locked from the inside, whether body inspection and urine screening respect the full privacy of the person.[94] The importance of providing patients with lockable space in which they can keep their belongings should be underlined as the failure to provide such a facility can impinge upon a patient's sense of security and autonomy. All personal data relating to an inmate should be considered confidential. Such data may only be collected, processed and communicated according

[93] MI principles, Supra at note 52, Principle13 (1) protects the right to privacy, freedom of communication, and private visits.

[94] Guidelines for the promotion of the rights of persons with mental disorder , WHO/MNH/MND/95.4, Geneva, (1996) available at www.who.int/mental_health/media/en/74.pdf , accessed on July 6, 2012

to the rules relating to professional confidentiality and personal data collection.

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

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

7. The Right to Community Integration

The other guarantee for PWMDs is the right to live and be treated in the community.[95] This includes the right to participation in political and public life. In the case of PWMDs in psychiatric facilities, this is to mean, at least that they should not live for life in institutions and they should be integrated to the community when they have recovered and promoted to coexist and live independently in the community. This requires creating a concerted effort towards reunion with families and former employers so that they can come back to their previous life. Families and employers due to the deep prejudice and stereotype hardly accept that these persons have recovered and can maintain their normal life.[96] Some families even hesitate to recognize that the person belonged to their family.[97] The recent efforts of the Gefersa Rehabilitation Center to reunite the relatively recovered persons to families have been less successful for the consistent denial and rejection by the families and the

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[95] CRPD, Supra at note 83, under article 19 as part of a guarantee to live independently, States Parties have undertaken to 'take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that;
a. Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
b. Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
c. Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs'.
The MI principles, Supra at note 93, Principle 3 states that: 'Every person with a mental illness shall have the right to live and work, to the extent possible, in the community.'

[96] Bruce, G. et al, 'The social rejection of former mental patients: Understanding why labels matter', American Journal of Sociology, (1987), Vol. 92, No. 6, pp1461-1500.

[97] Interview with Brother Eric, Supra at note 80

employers.[98] As a result, many inmates in this Center have lived for about 20-30 years with no hope of going back to their families. The recently admitted inmate at the Center has at least lived for two years. Those first inmates interned in the Center at its establishment are found there in not few numbers with about thirty years with no prospect of leaving the Center as they have nobody to welcome them outside. These people are surely fit to live in the community as they personally witness.[99] They tell the stories of their former mates who left the Centre who are now living in the streets completely insane as they have no families to take care of them. This is an alarm for them not to leave the Center. A testimony of one of the inmates goes as follow:

> *"I have stayed for 22 years in this Center. Before ten years, after I recovered somewhat, I left this Center and tried to join with my families at Addis Ababa. I found my father and mother dead. I became a refugee with my aunt, albeit short lived. She finally pushed me out of her home and I returned to this Center. Now, I have adapted myself to this Center as my home, and I have no any hope to leave."*[100]

These persons are still subjected to long-term and even permanent institutionalization in this Center in an isolated environment set apart from established communities. This has placed a formidable obstacle against the right to integration of PWMDs interned in psychiatric facilities in to the community, and the right to be treated in a least

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[98] Ibid.

[99] Interview with Zegeye, Haile., an inmate at Gefersa Rehabilitation Center, interviewed on July 9, 2012, Gefersa.
The interviewee believed that he is healthy enough to live in the community but he is living in the Center for he has nobody to welcome him as a family or employer. This is a manifest lack of a system for community integration for persons with mental disabilities. The greater challenge that has frustrated the manager of the Center is this lack of a system for community integration in which even after the persons have recovered and fit to live and be treated in the community

[100] A personal testimony of a 35 years old inmate at the Center, interviewed on July 9, 2012, Gefersa.

restrictive environment. The newly developed admission standard by the Center sets out that a person will be admitted only if there is a family that pledges that it will take the person back after three months. This limits the access to other persons who cannot afford this family pledge. Moreover, in a center which is understaffed, it does not seem realistic that a person shall be rehabilitated and discharged in three months.[101]

8. Conclusion

The human rights conditions in the psychiatric facilities in Ethiopia under study divulged that, behind the closed doors, PWMDs are languishing under severe human rights conditions. These violations of human rights are committed at the state established institutions which admit persons for treatment. The lack of guarantees against involuntary admission amounts to denial of the liberty and security of persons. This is against the guarantees of due process of law under the host of instruments that Ethiopia has ratified, inter alia, the ICCPR, ACHPR and the CRPD. It is also against the FDRE Constitution. The non-consensual treatments and the continued use of ECT are considered ill treatments or the worst torture. The degrading conditions and ill treatments in the institutions are thus against the prohibition of torture and all other forms of ill treatments. The arbitrary deprivation of privacy coupled with denial of the legal capacity of the inmates is a failure of the State in protecting and respecting the human rights of PWMDs. The lack of rehabilitative services and a system for community integration has destined the life of

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

these persons at institutions with little or no hope of joining the mainstream society and engage in an independent life. This, too, contravenes the obligations Ethiopia has undertaken towards PWMDs under the CRPD.

And for what is worse, there is a complete lack of any type of human rights oversight and monitoring body in terms of overseeing and reporting these human rights violations in the country. This is an insult to the injury for PWMDs in psychiatric facilities as there is little prospect of airing their sufferings to the international community and the human rights bodies of the UN and the AU. This gives leverage for the institutions to keep on working without considering the human rights of PWMDs they are violating. Most of these violations are committed due to ignorance of the persons on duty.