

Human Rights Violations and Mental Illness: Implications for Engagement and Adherence

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Abstract

The literature review identifies and examines human rights violations experienced by individuals with mental illness on a global level. In addition, the intent is to explore how current legislation either reinforces or supports these violations. The authors conducted an extensive review of the existing literature on mental health and human rights violations. Keywords were used to exhaust databases on this subject matter and to collect data, interpretations, and government publications on mental health and human rights. Individuals with mental illness are experiencing human rights violations on a global scale both within and outside of psychiatric institutions. These violations include denial of employment, marriage, procreation, and education; malnutrition; physical abuse; and negligence. This information was reviewed and compiled into the following article, along with interpretations of current implications and suggestions for future research. It is evident that more supports need to be instilled, especially within the context of low- and middle-income countries lacking adequate staffing and accessible services. Furthermore, legislation needs to be modified, updated, or created with relevant systems in place to make these laws enforceable.

Keywords

psychiatry, behavioral sciences, rights, criminology, social sciences, sociology of health and illness, sociology, sociology of mental health, social work

Introduction

It is estimated that approximately 500 million individuals globally are affected by mental illness (International Labour Organisation, 2000). The World Health Organization (WHO; 2012) speculates that depression alone will rank second highest in the global burden of disease by 2020. In Canada, it is believed that mental illness will affect approximately 20% of the population in their lifetime (Regehr & Glancy, 2010). According to recent figures, the direct and indirect economic cost of mental illness is estimated to range from 48 to 50 billion dollars (Lim, Jacobs, Ohinwaa, Schopflower, & Dewa, 2008). This significant expense is not expected to decrease, but rather increase over time and moreover affect the labor force while straining the world economy (International Labour Organisation, 2000). Given the inherent vulnerability of those with mental health issues and the stigma of being a burden on society, it is essential that human rights are acknowledged for this population and also that human rights violations are globally recognized and curtailed. Reports show that individuals with mental health issues are maltreated and marginalized due to the nature of their illness. This trend is attributed to a number of factors including culture, ethnicity, religion, language, and poverty.

Although there are ongoing discourses over the treatment of individuals diagnosed with mental illness and those exhibiting mental health symptoms around the world, it is important to note that the severity of abuse varies from one culture to another based on inherent beliefs. For instance, just as in certain cultures, women are not accorded equal rights and are relegated to the background, some cultures perceive the mentally ill as not being part of normal society; therefore, those with mental illness are subjected to varying forms of abuse. The maltreatment and abuse of the mentally ill have been widely captured in literature (Awad & Voruganti, 2008).

The focus of this study was to explore the literature on how mental health issues affect the rights of individuals with mental illness. The rationale for this literature review is to examine globally the human rights abuses of mental health issues and shed light on its impact on economies worldwide. Furthermore, this review intends to explore

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options to enhance the treatment adherence to practices that will improve the conditions of individuals marginalized due to their mental health condition.

Simply put, the question to be explored will be to “examine how human right abuses/violations affect the mentally ill globally.” The study will review the literature as a foundation to our findings and then give recommendations.

Literature Review

Mental health embodies the integration of psychological, emotional, and social harmony. It encompasses ones quality of life and general well-being. Culture, language, ethnicity, and religion play a significant role in the interpretation of mental health causes. Studies show that being diagnosed with or exhibiting symptoms of mental health issues exposes a person or community to labeling. Such people are branded as socially inadequate and are associated with resulting shame, humiliation, and loss of face. In most cultures, groups with low positions in hierarchical social structure experience high rates of mental health problems (Rosenfield, 2012). In modern society, connection with mental illness exposes a person to levels of medicalization and marginalization.

In certain cultures, mental illness is perceived as a sign of weakness or curse. This negative connotation results in family members distancing themselves from or mistreating those who are ill. Furthermore, those with mental illness are deemed unproductive and perceived as not contributing to the upkeep of the family. It is also argued that the lack of resources in African countries as well as in other developing countries makes it difficult for governments to enhance the treatment or improve the conditions of the mentally ill, which inevitably exposes many to abuses.

Over the years, research has shown that stigma plays a significantly debilitating role in the treatment of the mentally ill (Barke, Nyarko, & Klecha, 2011; Link et al., 2001). The literature on stigma describes how individuals with disabilities, including mental illness, often find themselves on the periphery of society. This circumstance is deemed “an attribute that is deeply discrediting” (Goffman, 1963, p. 3). Such individuals are marginalized, mistreated, and often stigmatized in society. Individuals with mental illness are often viewed as “strangers” where this characteristic of “strangeness” frequently results in social distancing (Baumann, 2007). Unfortunately, as this treatment is prevalent in both the industrial and developing countries, the argument could be made that governments are failing to put in place measures or systems to enhance the treatment of the mentally ill. Thus, very limited progress has been made to improve the lot of the mentally ill who are ostracized in society.

Method

The intent of the study was to review the global literature on the subject and examine how different cultures respond to this

topic. The search criteria included papers on the treatment of the mentally ill in various countries throughout the world. The major databases used to identify the articles were PubMed, PubMed Central Canada, SAGE Journals, African Journals Online, Scholars Portal, EBSCOHost, ProQuest, PsycINFO, and Google Scholar. The WHO database was also examined for the purpose of this venture. Only papers published in English were allowed for consideration in this review. The review examined peer-reviewed published articles, policy papers, as well as government publications since 2000. Keywords or statements of combinations of these terms were included in the search along with librarian assistance. Keywords (and a combination of these words) included mental health*, mental illness*, rights, human rights*, psychiatry*, human rights violations and mental illness, colonial psychiatry, and deprivation of liberty. This method yielded numerous articles related to mental illness and human rights.

In the process of searching the literature, keywords (rather than titles and abstracts) were used to examine the documents for matches. All of the references were recorded and stored electronically using refworks. Tracking was conducted after reading the papers and bibliographies were reviewed for further documents. The criteria for inclusion included both qualitative and quantitative articles on human rights and mental illness. For the purpose of this study, literature reviews and meta-analyses were not included. In the event that the same data were reported by two different papers, only the first report has been included. Papers published in peer-reviewed journals and gray literature were included.

Given this study’s objective on mental health and human rights violations, certain articles were excluded from review, in cases where it was determined that the study, article topic, or demographic lay outside of the purview of this article. Information was recorded down in the form of notes, entered into a literature table (see Appendix), and categorized by themes which are represented in the following “Results” section.

In total, approximately 1,000 articles, book chapters, and dissertations were found. Of these, 200 papers were reviewed because they either focused or had some discussions on mental health and human rights abuses. Articles were excluded for numerous reasons including the following: reported the same data as other papers, did not explore issues being looked at, literature reviews and meta-analysis. Nevertheless, the most significant were those that focused on mental health and human rights or articles that reflected research conducted internationally. Of the resulting articles, book chapters, and theses elicited from the search, 37 articles were deemed appropriate and utilized for the purpose of adequately addressing human rights and mental illness. Thus, from the 200 papers reviewed, a preliminary review narrowed the findings to 37 articles and government publications—31 articles and 6 government documents. Articles that did not specifically focus on human rights and mental illness were excluded. Theses and book chapters that did not directly address the issues of human rights and mental illness were excluded as well.

Results

Illiteracy and Mental Health

The findings emphasized the importance of taking note of the co-morbidity of illiteracy and mental illness. This has been linked to an increased likelihood of experiencing human rights violations, as illiteracy can adversely affect the ability to reach out for formal supports. In India, illiteracy has a greater influence on women than men, where despite free education, women are less likely to be encouraged to attend school (Vijayalakshmi, Ramachandra, Reddemma, & Math, 2012).

Stigmatization may also play a role in the educational opportunities for those with mental health issues as reflected by the high incidence of dropouts. Students with mental illness can face teasing, harassment, and prejudice from their peers, and arguably, their teachers (WHO, 2010).

Development Programs and Mental Health

Despite the creation of development programs intended to improve the lives of the world's most vulnerable populations, such programs exclude, often intentionally, the mentally ill as part of their recipients. A striking example is the Bangladesh Vulnerable Group Development Program, which stipulates that service users needed to be "mentally and physically sound" to access the program (WHO, 2010, p. 3). UN Secretary-General Ban Ki-moon clarifies the implications of this exclusion:

The rate of mental disorders and the need for care is highest among disadvantaged people—yet these are precisely the groups with the lowest access to appropriate services. At the same time, fear of stigma leads many to avoid seeking care. The consequences are enormous in terms of disability, human suffering and economic loss. We have a pressing obligation to scale up care and services for mental disorders, especially among the disadvantaged, while stepping up efforts to protect the human rights of those affected. (WHO, 2010, p. 7)

This inequality even extends to emergency and disaster situations. After Hurricane Katrina in the United States, Federal Emergency Management Agency (FEMA) allegedly discriminated against those with mental health issues based on the belief that these individuals were dangerous (WHO, 2010).

Furthermore, the unemployment rate for mentally ill individuals is approximately 70% to 90%; yet, development programs that create job opportunities often omit these individuals in their planning and enactment of projects (WHO, 2010).

Prison Settings and Mental Health Court

In fact, individuals with mental illness who are receiving care in psychiatric institutions suffer greater human rights

violations than individuals who are in correctional facilities. While those in psychiatric care may not have committed a crime, they are subjected to a similar removal of rights and liberties as with a criminal offender. Comparable with their criminal counterparts, individuals with mental illness are perceived as "more dangerous [and] less competent"; two qualities that are not welcome within general society (Diseth & Hoglend, 2011, p. 393).

An additional area of concern regards individuals determined to be not criminally responsible and therefore detained either in the psychiatric section within a prison or in a designated wing within a hospital setting. According to Fellner (2006), the majority of incarcerated individuals in the United States of America are struggling with mental health issues:

Indeed, one of the primary roles of prisons in the United States today is to house the mentally ill. Prisoners have rates of mental illness that are two to four times greater than the rates of members of the general public. (p. 1)

Housing of the mentally ill in prisons can be partially attributed to the lack of community-based services that were to be developed as a result of hospital closures (Fellner, 2006).

Regardless of the environment, the intent is to provide psychiatric treatment to accommodate the unique needs of the prison population. However, issues arise, such as the cohabitation of varying degrees of mental health severities, lack of appropriate professional training for staff members (Naudts et al., 2005), disciplining individuals instead of providing psychiatric support, verbal abuse and neglect from staff, and the exacerbation of mental illness due to confinement (Fellner, 2006). As symptoms of mental illness may be viewed by untrained prison staff as behavioral issues, these prisoners can build lengthy disciplinary records, which could potentially negatively affect their release time (Fellner, 2006; Matejkowski, Caplan, & Cullen, 2010). Reintegration into society and the opportunity for parole are often contingent upon program participation; yet, these classes infrequently consider the additional support that individuals with mental illness may require. In addition, programs may not address certain life skills that are unique to those with mental illness such as compliance with medication (Matejkowski et al., 2010).

Szasz (as cited in Breeding, 2006) suggests that those with mental illness who have been involuntarily admitted may be treated worse than their criminal counterparts:

A prisoner will be released after he completes his sentence, and possibly before. A mental patient may be required to undergo a change in his "inner personality"—a change that may be induced by measures far more intrusive than anything permitted in a jail—before the psychiatric authorities let him go. And they may never let him go. Commitment, unlike a sentence, is for an indefinite period. (p. 252)

Breeding (2006) further highlights the contradiction of justice: Individuals in mental health court are guilty until proven innocent. The added danger is that an individual's refutation of a diagnosis can be interpreted as a symptom of their mental illness.

Physical Health and Mental Health

The gap in service provision for those with mental illness transfers into the health care system as well. Those with mental illness are at a higher risk of acquiring considerable physical health problems, which potentially shortens their lifespan (WHO, 2010). Human rights violations occur frequently within health care settings, if these services are available to those with mental health issues at all (P. Hunt & Mesquita, 2006). An example of this neglect can be found in a shelter in Indonesia that houses individuals with mental illness. During a 7-month time period, 181 of the 644 individuals died of diarrhea or lack of nourishment (WHO, 2010).

Tarantola (2007) points out a cyclical relationship between physical and mental health. Those who experience human rights violations are at an increased risk of experiencing physical health concerns. Poor health, in turn, increases individuals' susceptibility to human rights violations (Tarantola, 2007).

Decision-Making Ability and Mental Illness

Callaghan and Ryan (2012) review the practices of compulsory treatment in Australia and stated that this form of treatment should only concern individuals who are unable to make independent decisions. While this could equally result in a human rights violation, the authors suggest the following criteria for an individual who is able to make decisions: ability to comprehend, recall, repeat, and utilize the information presented to them (Boyle, 2011; Callaghan & Ryan, 2012). In 2004, the European Court of Human Rights emphasized that temporarily detaining an individual who does not offer consent, nor has the capacity to do so, could be considered a deprivation of liberty. In response, the Deprivation of Liberty Safeguards was implemented to ensure the rights of individuals in this position (Boyle, 2011).

Social/Cultural Stigmatization of Mental Illness

While medical conditions typically have tests, lists of symptoms, and clear treatment methods, mental illness are not as "tangible" and can therefore be viewed as less credible, which only furthers stigmatization (Loo, Trollor, Alonzo, Rendina, & Kavess, 2010, p. 423). This lack of understanding of mental illness conducted through a biomedical lens rather than from the perspective of "social justice, quality of life, human rights and human security" (Giacaman et al., 2011, p. 547). This also raises the concern

of applying Western standards and mental health techniques in countries where there are alternative understanding of mental illness, descriptive language, and treatment techniques. Some countries continue to rely on traditional and/or faith healers, family, and community to remedy their mental health issues (Giacaman et al., 2011; Vijayalakshmi et al., 2013). Davar (2008) suggests that the West's insistence that medication is more effective than counseling in low-income countries may be influenced by underlying tones of colonialism or even as a means to create further profit for the pharmaceutical industry.

Further to not knowing their rights, individuals with mental health concerns are often stigmatized by societal and cultural views. From "not . . . a human being at all" to being seen as "facing punishment for their past actions," individuals struggle to find support within their community, not to mention on a higher systemic level (Drew et al., 2011, p. 1669). The occurrence of stigmatization is exacerbated with the viewpoint that the cause of mental illness is internal and not something that can be addressed from a social or systemic shift (Kogstad, 2009). In India, the principle of karma can impede those with mental illness from reaching out for support due to its implied culpability (Vijayalakshmi et al., 2013). Society also stereotypes those with mental illness as feeble, aggressive, of lower intelligence, or even victim to paranormal influences (WHO, 2010).

As evident throughout this review, it is important to consider culture when studying the types of treatments offered in different communities. For example, out of the 25 nations reviewed by the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS), Korea ranked third in terms of involuntary admissions to hospital. This has created concern regarding forcible admission; however, it is suggested that these numbers must be viewed through a cultural lens. Bola, Park, and Kim (2011) indicate that these numbers can be attributed to the fact that stigma prevents individuals from voluntarily accessing treatment; also, these services may not be adequately supported financially for individuals.

Addressing Stigma

Given the scope of individuals who are affected and how this relates to national levels of success and accountability, implementing education and awareness programs is essential to decreasing stigmatization (Mwanza et al., 2011). However, it should also be noted that stigmatization is a primary cause of human rights violations and that labeling individuals can in fact cause further harm to this population. This gap seems to have been addressed on a grassroots level by nongovernmental organizations (NGOs) and community efforts through support groups and implementation of traditional healing practices (Dhanda & Narayan, 2007).

The concept of spreading awareness is imperative to normalizing a stigmatized population, as lack of infrastructure and monitoring in psychiatric institutions leaves the public unaware of the aforementioned human rights violations (P. Hunt & Mesquita, 2006). However, the notion of education surrounding mental health standards faces a financial barrier, as this agenda is much more accessible to countries that are recognized as high income. Through their research, Drew et al. (2011) identify that the majority of low-income and middle-income countries were not adequately equipped to support those needing to access mental health services.

Violations

Violations of individuals diagnosed with mental health disorders vary from one culture/country to another. These violations may be dependent on the cultures of the country in question or the resources available to those countries. For instance, more resources are allotted to the treatment of mental illness in high-income countries than in low-income countries. In high-income countries, it is ensured that trained professionals are available to treat individuals diagnosed with mental illness. To be specific, the income level of the world based on its Gross Domestic Product (GDP) is divided in categories. According to the World Bank, economies are measured by their gross national income (GNI). According to the 2011 GNI, a lower income country was considered USD \$1,025 or less; a lower middle-income country was \$1,026 to \$4,035; an upper middle-income country was \$4,036 to \$12,475; and a high-income country was \$12,476 or more (World Bank Data, 2013). High-income countries are often developed countries; middle-income countries as well as some developing countries contain emerging markets; and low-income countries mostly consist of developing countries.

The violation and stigmatization of individuals diagnosed with mental illness include discrimination surrounding employment, marriage, parenting, and family planning; access to health services; sexual violence; access to housing; entitlement to vote; and access to basic education (Drew et al., 2011; Vijayalakshmi et al., 2013; WHO, 2010). While it may be presumed that these violations are specific to underdeveloped countries, the inability to marry exists in Bulgaria, Russia, Thailand, and India. In Switzerland, though known for its neutrality, applications of nationality can be declined if an individual struggles with intellectual disabilities. In addition, only Canada, Ireland, Italy, and Sweden (out of 63 countries assessed) do not place legal limitations on voting for individuals with mental illness (WHO, 2010).

The violation of the mentally ill has been reported as occurring in a variety of settings ranging from home life to schools, prisons, work environments, and social services (Drew et al., 2011). The traits of the mental health care system are regularly identified as inadequate and

emotionally or physically abusive (Cooper, Ssebunnya, Kigozi, Lund, & Flisher, 2010). Individuals are often institutionalized for long periods of time without appropriate cause and are then subjected to conditions that include violence, substandard nutrition and cleanliness, torment, unconsented treatment as extensive as electroconvulsive therapy (ECT; P. Hunt & Mesquita, 2006), loss of dignity (Kogstad, 2009), and sedation as a control method (Mayers, Keet, Winkler, & Flisher, 2010). Violations in Zambia have included denial of food, restriction of movement, poverty due to cost of treatment, and being brought to hospital in chains or in the company of armed officials (Mwanza et al., 2011). Treatment can also fail to involve basic social communication, as some believe that this would not be helpful to an individual with mental health concerns (Kogstad, 2009).

While the Cochrane Review highlights the lack of empirical evidence for the effectiveness of isolation and use of restraint, these practices, along with sedation, are frequently implemented within institutions. The review also references that within the literature, certain qualitative studies have in fact pointed to negative outcomes. Another concern that is equal to the use of possibly nonbeneficial practices is the intent behind the use, as sedation can be implemented for purposes of control rather than as a means of support for the individual (Mayers et al., 2010).

Further violations can be witnessed in a number of different countries. As described by Yamin and Rosenthal (2005), in Accra, Ghana, 300 mentally ill men were housed in a space that was built for 50 individuals and were not provided with treatment. In Hungary, individuals were administered obsolete medication and kept in beds that were caged, thereby limiting their movement. In Turkey, Peru, and Bulgaria, institutions engage in the dangerous practice of unmodified ECT, which does not utilize anesthesia.

Certain countries perpetuate human rights violations due to the lack of appropriate and accessible staffing. Less than 50% of hospitals in Bangalore, India, have psychologists available to their patients. Some of these violations occur due to a long-standing history of cultural or faith-based practice regarding treatment of the mentally ill (WHO, 2010). For example, in Somalia, an individual may be placed in a hollow with hyenas. The intent is to scare the "dijinns, or evil spirits" from the person, and therefore the symptoms of mental illness (WHO, 2010, p. 12). Other faith-based or traditional practices can involve restriction of movement through chains or attempts to remove spirits by whipping the mentally ill person (Doku et al., 2011).

These violations extend to accessing of justice, civil, and political rights. In England and Wales, a report by Mind discovered that 60% of individuals with mental illness who approached police regarding a crime felt that the authorities did not treat the report with severity. In certain instances, reports are not documented due to the

belief that individuals with mental illness are unreliable (WHO, 2010).

Within the population of individuals with mental disorders, there are subgroups who are at an increased risk of violation. For example, those of varying ethnicities and race are more likely to experience prejudice and women are more likely to be sexually abused and even sterilized without consent (P. Hunt & Mesquita, 2006). Kastrup (2011) notes the disparity between mental health support for those within marginalized populations, as well as the lack of human rights fulfillment.

In 1993, the slogan “Human Rights Are Women’s Rights” became a prominent message. During the World Conference on Human Rights in Vienna (Jansen, 2006), it was agreed that violence against women was considered a human rights issue. This practice is most notably seen during times of war, when sexual violence against women can increase and be used as a tool of war. This violence can lead to fear or mental health issues that deter women from being active community members, which further exacerbates the issue of human rights (Jansen, 2006). Violations can also be seen within the very institutions that are meant to support women with mental health issues, such as in Kosovo, where incidents were reported in which women were raped in psychiatric institutions while the violence was witnessed by staff and humanitarian workers (Yamin & Rosenthal, 2005).

Legislation

Despite the issues of mental health violations documented in the literature, it has also been observed that significant legislations are documented pertaining to the treatment of individuals with disability including those with mental disorders. *The Universal Declaration of Human Rights* (UDHR) encompasses 30 articles; however, no articles identify the need for rights around mental health concerns, and only one article (Article 25) alludes to the importance of social service access (The United Nations, n.d.). Instead, information about mental health can be found in the *United Nations Convention on the Rights of Persons with Disabilities*. As defined here, disabilities include “long term . . . mental . . . impairments . . . which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (The United Nations, 2006, Article 1).

To ensure that human rights are honored in relation to mental health, WHO developed the *Mental Health and Human Rights Project*, which focuses on mental health legislation within a global context (WHO, 2006). This project was supplementary to the *United Nations Principles for the Protection of Persons With Mental Illness and the Improvement of Mental Health Care*, which was established in 1991 and created a minimum level of human rights required in mental health practice (WHO, 2005). However, the principles (known as the Mental Illness [MI] Principles)

have been critiqued as being ineffective and contrary to the UDHR. It is noted that the MI Principles are not legally binding and fail to institute any form of international supervision (Weissbecker, 2009). The UN Secretary-General stated that they “offer in some cases a lesser degree of protection than that offered by existing human rights treaties, for example, with regard to the requirement for prior informed consent to treatment” (WHO, 2005, p. 14). P. Hunt and Mesquita (2006) indicate that “several international human rights instruments allow for exceptional circumstances in which persons with psychiatric disabilities can be involuntarily admitted to a hospital or other designated institution” (p. 344). However, such vague terms protect the regular occurrence of human rights violations (Kogstad, 2009). The case of *Harry v. Mental Health Review Board* in Australia illustrates an example of improper use of mental health law to alleviate embarrassment from family or communities (Freckelton & McGregor, 2010).

These statements call into question the voice of the service user and whether human rights in regard to mental health are indeed being honored. This concern is exacerbated by the fact that individual countries are able to enact their own regulations, definitions of mental health disorders, and principles. As a result, more than 40% of countries lack a mental health policy and more than 30% of countries lack a mental health program (P. Hunt & Mesquita, 2006). In some countries such as Zambia, policies exist but are antiquated, offensive, and based on colonial eras (Mwanza et al., 2011). The lack of legislation can also be attributed to the use of traditional and faith-based practices, which often go unregulated (Doku et al., 2011).

In addition, legislation may be put in place to manipulate social participation. According to WHO (2005), “In many countries a diagnosis of personality disorder has been used against vulnerable groups, especially young women, whenever they do not conform with the dominant social, cultural, moral and religious standards” (p. 21). This method of mental health diagnoses is also used for political purposes to attribute personality disorders to those who may be viewed as a nonconformist (WHO, 2005). In addition, in India, women viewed as oppositional can be branded as insane (Davar, 2008). To create uniformity among the concept of mental health, Tarantola (2007) suggests a more holistic understanding, which would include emotional, social, and cultural influence and welfare.

While the intention of establishing universal guidelines such as UDHR, UNCRPD (UN Convention on the Rights of Persons with Disabilities), and MI Principles is important for those within the government and legislative context, this does little to provide information to those who are directly affected. A survey participant from Jordan stated that “the most important right is my right to have the knowledge of all of my rights and to be empowered to [confront] violations against my rights” (Drew et al., 2011, p. 1666). This right to knowledge relies heavily, however, on the assumption that the legislation in fact supports those with

mental health issues. Uganda's mental health system is an example of a legislation that is in accordance with international policy; yet, it is criticized for its perpetuation of stigmatization and violation of human rights for those with mental health concerns (Cooper et al., 2010). These guidelines additionally rely heavily on agreement, commitment, compliance, and mutual understanding of the issues of mental health and human rights.

Discussion

Human rights violations not only affect the physical, psychological, emotional, and spiritual well-being of service and nonservice recipients with mental disorders but also significantly influence potential service recipients' access to mental health services, thereby creating a dynamic where not receiving any form of treatment or support may become more desirable (Loo et al., 2010).

Furthermore, culture, religion, and traditional practices play a role regarding which type of mental health treatment is sought out by individuals. Some individuals do not believe that mental illness exists or that only the physical symptoms need to be addressed (McDaid, Knapp, & Raja, 2008). This view can be partially attributed to lack of professional and public knowledge, resulting in the stigmatization of this population.

Absence of resources may be symptomatic of an overlying cause of lower socioeconomic status. While dedication to mental health and humane treatment of these individuals is a noble cause, this may not be feasible in certain countries. Ethiopia is home to 77 million people but only 18 psychiatrists, who are all employed in one hospital, located in the capital city (Alem, Jacobson, & Hanlon, 2008). Even if legislation were put into place, what would be enforced in the rural areas where individuals are not receiving formal care? Bruckner et al. (2011) estimate that 239,000 full-time employees would be required in low- and middle-income countries just to have adequate staffing. A proposed solution is to increase staff presence and emphasize community-based care, which would increase access and honor the human rights of individuals. According to Yamin and Rosenthal (2005),

From a human rights perspective, people are entitled to live in and receive care in the community not because it is more efficient, but because all human beings develop their identities within social contexts, and have rights to work and study, as well as be with friends and family. (p. 297)

Research into *why* human rights violations occur may be beneficial in creating a comprehensive plan to better ensure human rights of those with mental health issues. A psychiatrist in Ghana presents the following dilemma:

. . . people are trying to do their best to help people with mental illness, but when there is inadequacy and all those things set in, we don't intentionally try to violate people's

rights. But when you keep someone in the mental hospital and you can't provide for the person, you then of course, you are violating that person's rights. (Doku et al., 2011, p. 18)

Furthermore, it is evident that legislation needs to be created which honors human rights, as there is a clear disparity between experiences of those with mental health concerns and the intent of human rights (Kogstad, 2009). However, it is also clear that these movements be considered within the contextual framework of culture and religion. P. Hunt and Mesquita (2006) suggest that legislation should consider the following when making decisions surrounding human rights and mental health: "participation, autonomy, dignity, inclusion, monitoring, and accountability" (p. 332). In response to this need for individual voice, the *International Diploma on Mental Health Law* was conceived, it comprised of an interdisciplinary team including service users and aiming to provide education, awareness, and reform on a country-wide basis (Drew et al., 2011). The Mental Health and Poverty Project (MHaPP) is an initiative focusing on the cyclical nature of poverty and mental health in Ghana, Zambia, South Africa, and Uganda (Mwanza et al., 2011). While more integrated, this initiative solely focuses on African countries, which possibly negates the presence of human rights violations in more "developed" countries and creates further stigmatization for a continent that is already branded by poor global opinion.

Clearly, the prevalent issue of human rights violations in the context of mental health can no longer be ignored. However, given the additional factors and barriers of income status, accessibility, culture, religion, and traditional practices, it will be a challenge to create an understanding and enforcement of universal human rights. To completely dismiss cultural tradition would only contradict another set of human rights, thereby exchanging one form of violation for another. Thus, discussion is necessary regarding how one can balance the rights of traditional or faith-based practice with the UN's view of human rights.

This therefore creates the need for both advocates and researchers to continue challenging and embarking on studies that will improve the lot of the mentally ill. For progress to enhance mental health treatment in numerous countries, serious intervention and engagement from governmental bodies are necessary.

Despite these arguments, one should not lose sight of the fact that programs have been introduced in the Western world to improve the treatment of the mentally ill. For example, the work of Winick and others on therapeutic jurisprudence has been designed to shift the treatment of the mentally ill from the medical model to a more collaborative approach. This shift in direction commenced in the 1980s as an interdisciplinary scholarly approach to enhance the treatment of the mentally ill (Winick, 2002, 2006). Since then, a number of interventions have been introduced in the treatment of the seriously mentally ill in the Western world,

including Community Treatment Orders (CTOs) or Mandated Outpatient Treatment which legally compels individuals diagnosed with mental illness to follow through with a proposed treatment or else risk being hospitalized (A. M. Hunt, da Silva, Lurie, & Goldbloom, 2007; Kisely, Campbell, Scott, Preston, & Xiao, 2007; Mfofo-M'Carthy & Williams, 2010).

In addition, it should be noted that the study adds to the literature on issues of human rights abuses of the mentally ill and contributes to the discourse. Also, it continues to bring attention to the stigmatization of the mentally ill and the need for more education and understanding of the needs of this marginalized community.

Limitation

This review may not be considered exhaustive due to the fact that the literature reviewed were only English language articles, this eliminates the cross-cultural perception of the study as articles in other languages were excluded. Also, all the articles reviewed focused solely on Westernized perception or definition of mental illness, which does not enhance the diversity of the discourse.

Appendix

Summary Table for Literature Review

Author	Article	Type of Publication	Key points	Findings
Alem, Jacobson, and Hanlon (2008)	Community-based mental health care in Africa: Mental health workers' views		<ul style="list-style-type: none"> Shift from hospital-based care to community-based care in West 	<ul style="list-style-type: none"> This strategy is less easily implemented in low-income countries in Africa due to shortage of mental health professionals with adequate training, lack of social service, role of traditional and faith healers
Bola, Park, and Kim (2011)	Reassessing the High Proportion of Involuntary Psychiatric Hospital Admission in South Korea	Study— Comparison, estimation, data analysis	<ul style="list-style-type: none"> Article addresses the concern around the large number of involuntary hospital admission in South Korea; the statistics have caused concern that it is “an excessively coercive system” (p. 603) 	<ul style="list-style-type: none"> Article suggests that involuntary admission needs to be considered within the cultural context of a collectivist society
Boyle (2011)	Early Implementation of the Mental Capacity Act 2005 in Health and Social Care	Journal article	<ul style="list-style-type: none"> Reviews Mental Capacity Act 2005—Who has capacity, who makes decisions, criteria for capacity 	<ul style="list-style-type: none"> The Act states that those individuals who do not have the ability to make decisions be given support to do so. Capacity testing for this decision-making ability is twofold: Diagnostic test and functional test. Criteria needed to be deemed able to make decisions: “understand, and retain, the relevant information, use or weight up the information as part of the decision-making process and communicate the decision” (p. 366).

Conclusion

Based on the findings of this review, the literature clearly articulates the importance of creating a system that will curtail the marginalization and stigmatization of individuals diagnosed with mental disorders. The review identified legislations intended to limit the human rights violations of individuals with mental health issues, yet not much has been achieved. Even in the Western world, programs including the work of Winick on therapeutic jurisprudence and other treatment options such as CTOs aimed at enhancing treatment to limit mental health violations have not made a significant impact. A major factor to improving the conditions of the marginalized is to curb violations against the mentally ill through meaningful engagement and political will on the part of governments. The observation is that, despite laws governing the treatment of those with mental health issues, much has not been done to address stigmatization of individuals diagnosed with serious mental illness. In developing countries and other parts of the world, family members with mental health issues continue to be marginalized, medicalized, and ostracized, hence exposing them to human right abuses.

Breeding (2006)	The Case of Sohrab Hassan: Assault on Liberty in the Texas Mental Health Courts	Journal article	<ul style="list-style-type: none"> • Mental health courts treat mentally ill as criminals. Article argues that this is a misuse of psychiatric authority 	<ul style="list-style-type: none"> • It is important that Deprivation of Liberty Safeguards be in the interest of the individual as detaining individual who is deemed incapable of decision-making can become a human rights violation • "A prisoner will be released after he completes his sentence, and possibly before. A mental patient may be required to undergo a change in his "inner personality"—a change that may be induced by measures far more intrusive than anything permitted in a jail—before the psychiatric authorities let him go. And they may never let him go. Commitment, unlike a sentence, is for an indefinite period" (p. 252).
Bruckner et al. (2011)	The mental health workforce gap in low- and middle-income countries: A needs-based approach	Bulletin of World Health Organization	<ul style="list-style-type: none"> • Utilized WHO-AIMS to assess the lack of professionals in the mental health field in LMICs. • The research utilized 58 LMICs 	<ul style="list-style-type: none"> • Estimated that 239,000 full-time mental health workers needed in these 58 countries
Callaghan and Ryan (2012)	Rising to the Human Rights Challenge in Compulsory Treatment	Review	<ul style="list-style-type: none"> • The Victorian and Tasmanian draft mental health bill addresses mandatory psychiatric care in Australasia. • The draft suggests an "additional harm test" be required before nonconsensual treatment. • It also proposes to replace this test with a "best interests" test (p. 1) 	<ul style="list-style-type: none"> • Evidence suggests that assessing for future harm is ineffective and a potential detriment to individuals with mental illness. • Article suggests that "best interests" test would be more appropriate in deciding the treatment protocol for clients. • Article defines what it means for a client to be unable to make a decision regarding their own mental health care
Cooper, Ssebunnya, Kigozi, Lund, and Flisher (2010)	Viewing Uganda's Mental Health System Through a Human Rights Lens	Reviewed first stage of MHaPP as completed in Uganda; quantitative data were gathered through WHO-AIMS; qualitative data were gathered through interviews and focus groups	<ul style="list-style-type: none"> • "Despite possessing a draft mental health policy that is in line with many international human rights standards, Uganda's mental health system inadequately promotes and protects, and frequently violates the human rights of people with mental disorders" (p. 578) 	<ul style="list-style-type: none"> • Human rights violations include physical and emotional abuse, inadequate care. • Ugandan legislation uses offensive language in describing mentally ill individuals (e.g., "lunatics," of "unsound minds," p. 580)
Davar (2008)	From Mental Illness to Disability: Choices for Women Users/Survivors of Psychiatry in Self and Identity Constructions	Journal article	<ul style="list-style-type: none"> • Reviews the women's movement in mental health in India 	<ul style="list-style-type: none"> • Women who are seen as rebellious can be diagnosed with a mental illness. • Certain individuals argue that the use of psychiatric medication is more effectual in low-income countries than counseling. Author argues that this may be due to the colonialism and the profit attained by the pharmaceutical industry

Dhanda and Narayan (2007)	Mental Health and Human Rights	Comment (journal article)	<ul style="list-style-type: none"> • Suggests that human rights violations of those with mental illness is primarily due to stigmatization and labeling 	<ul style="list-style-type: none"> • Suggest importance of going beyond medical model. Refers to grassroots agencies, NGOs, and community efforts that implement support groups, life skills and traditional healing practices
Diseth and Hoglend (2011)	Potential legal protection problems in the use of compulsory commitment in mental health care in Norway	Journal article	<ul style="list-style-type: none"> • In Norway, involuntary admission is dependent on a medical assessment. However, this process does not have a mandatory legal review 	<ul style="list-style-type: none"> • In Norway, human rights violations occur more often in psychiatric care than in prison facilities. Freedoms are removed from an individual with mental illness, similar to the freedoms lost by criminals. • The public belief still exists that those with mental illness are “dangerous” (p. 393) and are unwelcome in general society. • The authors propose that those with mental illness have the right to legal counsel prior to “involuntary commitment” (p. 399)
Doku et al. (2011)	Stakeholders’ perceptions of the main challenges facing Ghana’s mental health care system: A qualitative analysis	Qualitative analysis	<ul style="list-style-type: none"> • Qualitative results of a situation analysis conducted as part of the MHaPP. • Data gathered through 81 interviews, 7 focus groups, location: 5 regions in Ghana 	<ul style="list-style-type: none"> • Stakeholders indicated the following challenges: <ul style="list-style-type: none"> • “Inadequate implementation of mental health policy • Legislative limbo • Inadequate human and financial resource • Widespread stigma • Dominance of psychiatric hospitals • Insufficient human rights protections for the mentally ill” (p. 8). • Challenge is improving MH policy within budget of a low-income country
Drew et al. (2011)	Human Rights Violations of People with Mental and Psychosocial Disabilities	Survey, report, and review of literature	<ul style="list-style-type: none"> • Names where and how human rights violations occur in regards to mental health. • Discusses stigmatization and impact of religion/culture. • Survey included 51 people with mental/psychosocial disabilities and 18 low- and middle-income countries 	<ul style="list-style-type: none"> • Location of human rights violations includes home, school, prison, work, social services. • Type of violations include marriage, parenting, employment, family planning, health services and accessibility, sexual violence. • Type of stigmatization influenced by views of the society or culture, belief of karma, belief the person is not human, not receiving proper support from the community or systemic level. • Additional challenge exists for countries of low- and middle-income; lack of finances leads to lack of adequate resources to address mental illness and necessary services
Fellner (2006)	Prison Reform: Commission on Safety and Abuse in America’s Prisons: A	Journal article	<ul style="list-style-type: none"> • American prisons greatly comprised of individuals with mental health concerns 	<ul style="list-style-type: none"> • Part of the problem is that hospitals closed down without having services to replace them.

	Conundrum for Corrections, a Tragedy for Prisoners: Prisons as Facilities for the Mentally Ill		<ul style="list-style-type: none"> • Prisoners with mental illness may face disciplinary action instead of having their psychiatric needs addressed. This can lead to lengthy behavioral histories. Individuals with mental illness face the same punishments as other inmates, even though they have unique needs and are not always able to follow the same requirements as the others. • Issues include maltreatment, seclusion, neglect; mental illness is exacerbated by small living space or solitary; cyclical relationship occurs between deprivation, psychiatric deterioration, psychiatric institutional care, return to prison setting and the cycle repeats itself
Freckelton and McGregor (2010)	Human Rights and Review of the Involuntary Status of Patients with a Mental Illness: Kracke after Momcilovic	Case commentary • <i>Harry v. Mental Health Review Board</i>	<ul style="list-style-type: none"> • In <i>Harry v. Mental Health Review Board</i>, it was noted that mental health law should be utilized to protect those with mental illness; however, it can be used to benefit the family, friends, etc. instead by manipulating the individual's behavior
Giacaman et al. (2011)	Mental health, social distress and political oppression: The case of the occupied Palestinian territory	Discussion and critique • International mental health continues to be primarily based on Western and biomedical models	<ul style="list-style-type: none"> • Concern whether West can "contribute to a realistic understanding of mental health and adequate planning of services in the occupied Palestinian territory, with its specificity of history, cultures, and prevailing socio-economic and political conditions" (p. 548). • Historically, Western-based trauma services were introduced, yet Palestinians continued to utilize their traditional methods of support (family, community). • Colonization emphasized the inadequate native mind instead of addressing oppression that was occurring due to politics and race, and was occurring across generations. • Different approaches include Western models see mental illness as internal, while oPt is collective and has experienced trauma, oppression, and injustice as a society; traditional and cultural healing practices are not considered within Western counseling; within oPt, Western medication and counseling did not appear to be effective in the community.

P. Hunt and Mesquita (2006)	Mental Disabilities and the Human Right to the Highest Attainable Standard of Health. <i>Human Rights Quarterly</i>	Exploratory journal article	<ul style="list-style-type: none"> • Authors suggest that human rights should incorporate the following: participation, autonomy, dignity, inclusion, monitoring, accountability. Violations are not part of public awareness due to poor infrastructure and supervision 	<ul style="list-style-type: none"> • Palestinian researchers indicate that local language depicts a holistic state of health and uses language that is not diagnostic but emphasizes a collective experience. • Suggested approach: “social justice, quality of life, human rights, human security” (p. 556) • There is often poor availability or accessibility to health services. Of the few services that meet these requirements, many include human rights violations. • This is evident in that 40%+ of countries lack mental health policies and 30%+ of countries lack a formal mental health program. • Human rights violations are exacerbated because insurance policies typically do not cover mental health care. • Types of violations include violence, torture, nonconsensual treatment, insufficient hygiene and nutrition, chaining to beds, unmodified use of ECT and inappropriate (and often long term) institutionalization. • Women with mental illness are susceptible to be victims of sexual abuse and involuntary sterilization. • Individuals with MI from an ethnic or racial minority often face discrimination
International Labour Organisation (2000)	Mental Health and Work: Impact, Issues and Good Practices	Government document	<ul style="list-style-type: none"> • Mental illness and addictions affect countries' efficiency 	<ul style="list-style-type: none"> • Globally, 500 million individuals suffer with mental illness and/or addiction. • Mental illness affects labor force and economy
Jansen (2006)	Gender and War: The Effects of Armed Conflict on Women's Health and Mental Health	Journal article	<ul style="list-style-type: none"> • Jansen argues that social workers play a role in advocating for women's human rights 	<ul style="list-style-type: none"> • World Conference on Human Rights slogan: “Human Rights are Women's Rights” (p. 137); stated that violence toward women during times of war constitutes as a human rights violations. • It is important to be aware that sexual violence is used as a type of weapon during war. This sexual abuse can exclude women from taking part in employment, which extends into another form of a rights violation
Kastrup (2011)	Gender, Human rights and cultural diversity: Reflections on a career in transcultural psychiatry	Journal article	<ul style="list-style-type: none"> • Psychiatric care is influenced by a person's gender, culture, and ethnicity; some of these groups may have trauma history 	<ul style="list-style-type: none"> • Kastrup focuses on the fulfillment of human rights for marginalized populations and the need for professionals to be trained in the treatment and ethics of individuals who have survived torture

Kogstad (2009)	Protecting mental health clients' dignity—The importance of legal control	Study: Qualitative Content Analysis	<ul style="list-style-type: none"> Reviews service users' experience of "violation of dignity" (p.383) 	<ul style="list-style-type: none"> Main finding: There is a disparity between the intent of human rights and how clients experience mental health services and whether these rights are honored.
Loo, Trollor, Alonzo, Rendina, and Kavess (2010)	Mental Health Legislation and Psychiatric Treatments in NSW (New South Wales: Electroconvulsive Therapy and Deep Brain Stimulation	Review	<ul style="list-style-type: none"> There is a view that mental illness is not as legitimate as medical illness due to lack of concreteness 	<ul style="list-style-type: none"> Article highlights that human rights violations cause the general population to be suspicious of mental health care. The Mental Health Act 2007 has guidelines around the use of ECT and DBS (Deep Brain Stimulation). However, it does not consider current knowledge of security and effectiveness of these treatments.
Matejkowski, Caplan, and Cullen (2010)	The Impact of Severe Mental Illness on Parole Decisions: Social Integration Within a Prison Setting	Journal article	<ul style="list-style-type: none"> Individuals with mental illness who are in prison either receive limited or no psychiatric treatment 	<ul style="list-style-type: none"> Prison staff are not trained for mental health issues. Inmates with mental illness are more likely to have "disciplinary infractions," which can affect their chances of parole and involvement in programs (p. 1009). Those with MH issues have higher rates of disciplinary infractions, cause problems with parole that is dependent on program participation
Mayers, Keet, Winkler, and Flisher (2010)	Mental Health Service Users' Perceptions and Experiences of Sedation, Seclusion, and Restraint	Focus group with eight service users	<ul style="list-style-type: none"> Authors argue that sedation, seclusion, and restraint can be used inappropriately and become violations of human rights. Provides summary of service users rights 	<ul style="list-style-type: none"> There are no studies that assess the positive qualities of seclusion or restraint when used with individuals with serious mental illness. However, research exists on its harmful outcomes. Focus group identified the following themes: "inadequate communication, a violation of rights, and the experience of distress" (p. 66). Focus group provided the following recommendations: "prevent human rights abuse," "minimize isolation and distress," "privacy should be ensured," "improve communication between service providers and service users," (p. 69) "promote attitudinal changes which reflect respect for the other person's dignity" (p. 70)
McDaid, Knapp, and Raja (2008)	Barriers in the mind: Promoting an economic case for mental health law in low- and middle-income countries	Journal article	<ul style="list-style-type: none"> Article looks at mental illness in low- and middle-income countries as compared with high-income countries 	<ul style="list-style-type: none"> 2020 prediction of mental illness as "global burden of disease": 15% (p. 79). Speculated that a large amount of this will affect low-income countries
Mwanza et al. (2011)	Stakeholders' perceptions of the main challenges facing Zambia's mental health	Qualitative analysis	<ul style="list-style-type: none"> Challenges in Zambia's mental health care system: "marginalization of mental 	<ul style="list-style-type: none"> Mental Health Disorders Act of 1951 is the most recent legislation. It does not address

	care system: A qualitative analysis		health; flawed policy development; outdated and harmful legislation; human rights abuses, including stigma; limited mental health services; and inadequate psychiatric professionals” (p. 39)	<ul style="list-style-type: none"> • human rights of those with mental illness; its roots are in colonialism; the language is insulting. • Human rights violations cited as isolation, confined, deprived of food and hygiene, physical abuse, nonconsensual treatment, deficient quality of living, expensive therapeutic care, being brought to hospital in handcuffs as if the individuals with mental illness are criminals. • Human Rights Commission (intended to address human rights) has never attended any mental institution in Zambia. They cite this is due to insufficient funding. • Discrimination cited as including job loss and family rejection. • Stakeholder suggestions for improvement of mental health care system: “community sensitization and public awareness campaigns” (p. 48) and increased education and training of staff; increased number of staffing; increased financial backing for mental health care
Naudts et al. (2005)	Belgium and its internees: A problem for human rights and a stimulus for service change	Journal article	<ul style="list-style-type: none"> • In Belgium, individuals who suffer from mental illness and have been deemed not criminally responsible for a crime are held in prisons. During this time, they do not receive necessary psychiatric support 	<ul style="list-style-type: none"> • Issues include excess individuals in prison, inadequate training for staff around mental illness, and the cohabitation of individuals with a variety of psychiatric disorders
Tarantola (2007)	The Interface of Mental Health and Human Rights in Indigenous Peoples: Triple Jeopardy and Triple Opportunity	Literature review	<ul style="list-style-type: none"> • Policymakers need to understand mental illness in a more comprehensive manner by including consideration of physical, social, emotional and cultural rights and health 	<ul style="list-style-type: none"> • Human rights violations can negatively influence physical health and poor physical health can prevent full achievement of human rights (cyclical)
The United Nations (n.d.)	The Universal Declaration of Human Rights	Government document	<ul style="list-style-type: none"> • None of the 30 articles in the UDHR refer to mental health rights 	<ul style="list-style-type: none"> • Only Article 25 refers to social service access
The United Nations (2006)	Convention of the Rights of Persons with Disabilities	Government document	<ul style="list-style-type: none"> • Mental illness may impede societal involvement 	<ul style="list-style-type: none"> • “. . . disabilities include . . . long-term . . . mental . . . impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (Article 1)
Vijayalakshmi, Ramachandra, Reddemma, and Math (2012)	Perceived human rights violations in persons with mental illness: Role of education	Descriptive study	<ul style="list-style-type: none"> • Individuals who struggle with mental illness and illiteracy are more susceptible to experiencing human rights violations 	<ul style="list-style-type: none"> • Individuals who do not struggle with literacy face less barriers regarding accessibility to mental health care and basic utilities. • Part of Indian culture includes karma, which places the

				culpability for mental illness on the individual with the MH concern. This can lead individuals to not access services or face human rights violations without notifying anyone about their experience.
Weissbecker (2009)	Mental health as a human right in the context of recovery after disaster and conflict	Journal article	<ul style="list-style-type: none"> The experience of natural disasters and armed discord can have an impact on mental health; however, international/national agencies often fail to recognize this as a need 	<ul style="list-style-type: none"> More than one third of adults and children who have survived disasters also experience PTSD. Affects job productivity, employment, education. MI principles: Individual with mental illness "shall have the right to live and work, as far as possible, in the community" (UN General Assembly, 1991, p. 80)
WHO (2005)	Resource Book on Mental Health, Human Rights, and Legislation	Government document	<ul style="list-style-type: none"> MI principles (United Nations Principles for the Protection of Persons With Mental Illness and the Improvement of Mental Health Care): Minimum requirements for human rights for individuals obtaining mental health services 	<ul style="list-style-type: none"> MI principles have been called inadequate and not in line with UDHR. Mental illness diagnoses can be unjustly assigned to limit social or political dissent. Countries are responsible for the development of their own mental health law as well as the definition of what constitutes mental illness and its disorders
WHO (2006)	Mental Health and Human Rights Project	Government document	<ul style="list-style-type: none"> Project focuses on mental health legislation within global context 	<ul style="list-style-type: none"> Project focuses on creation and application of legislation to address mental health rights. Supports countries in this process and provides a checklist for countries to assess their mental health legislation
WHO (2010)	Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group	Government publication	<ul style="list-style-type: none"> Program development often neglects those individuals with mental health concerns 	<ul style="list-style-type: none"> Some development programs are limited to individuals who have a certain level of mental well-being. Publication argues that human rights need to be considered in development programming. Barriers for vulnerable populations: "Stigma and discrimination; Violence and abuse; Restrictions in exercising civil and political rights; Exclusion from participating fully in society; Reduced access to health and social services; Reduced access to emergency relief services; Lack of educational opportunities; Exclusion from income generation and employment opportunities; Increased disability and premature death" (p. 8)
WHO (2012)	Depression	Government publication	<ul style="list-style-type: none"> Estimate of future global incidence of depression 	<ul style="list-style-type: none"> By 2020, depression is estimated to become the second highest global burden of disease.
Yamin and Rosenthal (2005)	Out of the Shadows: Using human rights approaches	Policy forum	<ul style="list-style-type: none"> MDRI: Focus is on human rights of those with mental 	<ul style="list-style-type: none"> In Kosovo, women had been raped in psychiatric institutions,

to secure dignity and well-being for people with mental disabilities

illness

which was witnessed by both staff and humanitarian workers who did not respond.

- In Hungary and Paraguay, people with mental illness are contained in cages.
- In Turkey, Peru, and Bulgaria, ECT is used without the proper safeguards for recipients.
- In Uruguay and Mexico, mental illness diagnosis is enough for involuntary commitment; however, the validity of the diagnosis is arguable. Furthermore, the process violates international law by not providing reassessment or counsel

Note. LMICs = low and middle-income countries; WHO-AIMS = World Health Organization's Assessment Instrument for Mental Health Systems; MHaPP = Mental Health and Poverty Project; oPt = occupied Palestine territory; ECT = electroconvulsive therapy; UDHR = Universal Declaration of Human Rights; MDRI = Mental Disability Rights International; PTSD = posttraumatic stress disorder; MI = mental illness.

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