Potential of Human Rights Standards for Deinstitutionalization of Mental Health Services in Russia: a Comparative Legal Analysis

Dmitri Bartenev, M.D., International Policy Fellow 2004-2005, Center for Policy Studies, Open Society Institute, Budapest (Hungary)

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1. Introduction: research context

Russia is undergoing a significant reform of its mental healthcare system in consistency with building the rule of law and democracy. Mental health legislation provided for the background of this reform[1], but enforcement mechanisms are very weak[2]. The provisions of the 1992 law on psychiatric care requiring mental health care facilities to establish services for protection of the rights of the mentally disabled have not been implemented to date in any hospital or other facility[3]. Hence the

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[1] Psychiatric care and rehabilitation in Russia is based on two major acts: "The law on psychiatric care and guarantees of the citizens' rights in its provision" (1992) and Federal Program of Reorganization of Mental Health Care in the Russian Federation in 2003-2008 approved by the Ministry of Health Order No. 98 of 27 March 2002. See also: Poloshij, B. & Saposhnikova, I. Psychiatric reform in Russia. Acta Psyciatr Scand 2001: 104 (Suppl. 410): 56-52; Polubisnkaya S.V., Law and Psychiatry in Russia: Looking backward and forward. In: The evolution of mental health law. Ed. by Lynda E. Frost. Washington, D.C. 2001. P. 113-125.

[2] This situation is common for former socialist countries: "The lack of state legal aid systems, the problems of access-to-justice by those under guardianship housed in remote institutions, the few lawyers willing to represent people with mental disabilities, coupled with the unwillingness of domestic courts to hear ECHR points and the grinding slowness of the Strasbourg Court all combine to produce a pessimistic situation in which the realization of human rights seems a long way off." Oliver Lewis, "Mental disability law in central and eastern Europe: paper, practice, promise", (2002) 8 Journal of Mental Health Law, pp. 293-303.

[3] The 1992 Law requires the State to set up «a service independent of health agency for the protection of the rights of psychiatric patients» (article 38). The Law however does not specify the exact role and

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Russian Ombudsman admitted that enacting of these acts had not resulted in positive changes in the state policies affecting people with mental disabilities[4].

Although the situation in mental health care in Russia has changed considerably since the collapse of the Soviet Union[5] advocacy for the rights of the mentally disabled still remains quite a new issue and does not receive the required amount of attention either from health authorities or from the local NGOs.

People with mental disabilities still remain invisible and excluded from the society[6]. Mental disability is still considered to be almost entirely medical problem and social, cultural and other interrelated implications are not taken seriously[7]. The Russian mental health policymakers place no emphasis on community-based care initiatives and fiercely rely on institutionalized mental health care: in 2003 the number of mental hospitals in Russia increased compared to previous years[8]. Consequently there are no alternatives to the existing system of psychiatric hospitalization or segregated social care in "internats" (specialized social care homes for people with mental disabilities)[9]. The experience of other countries has proven that there are strong medical and economic incentives encouraging the movement of persons with mental disabilities out of large residential facilities into smaller home-like settings.[10]

At the same time there are virtually no mental disability advocacy NGOs in Russia[11], nor there significant public discussion about relevant governmental policies or strategies for deinstitutionalization of mental health care and strengthening equal participation of people with mental disabilities in society[12].

There is an increasing number of non-governmental organizations in other post-communist countries in Europe providing services to the mentally disabled based on the principle of inclusion and offering alternatives to institutionalized care. Their experience does not receive sufficient attention in Russia and the policies behind this movement have not been studied yet. It is indicative that the Russian Ombudsman failed to recognize that segregation of the mentally disabled is a rights issue: the detailed report on the rights of the mentally disabled does not address the issues of deinstitutionalization, mental disability advocacy and the most important demand of the advocacy group: transition from segregative care to community-based services[13].

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functions of such services. In our opinion the wording implies advocacy services similar to ombudsman office in other countries.

[4] The report on the rights of the mentally disabled prepared in 1999 by the Russian ombudsman. Available at www.ombudsman.gov.ru.

[5] It should be admitted that during the last years the conditions of Russian psychiatric inpatient hospitals have been improved and in many of them patients no longer suffer from malnutrition, they are provided with the essential medicines and treatment.

[6] For more information see: Human Rights and Psychiatry in the Russian Federation. Monitoring report. Moscow Helsinki Group. Moscow. 2004.

[7] See: Social Psychiatry; The Korsakov Journal of Neurology and Psychiatry.

[8] According to Russian Academy of Medical Sciences it sees "no ways of adopting the ideas of integration and deinstitutionalization under current circumstances in Russia". See mental health statistics in Russia (appendix 1).

[9] For example, according to the head of one mental hospital in Russia about 40% of patients live there for no therapeutic reason but because their families do not want them. (Personal communication).

[10] See: World Bank (2000), Moving from Residential Institutions to Community-Based Social Services in Central and Eastern Europe and the Former Soviet Union.

[11] Gushanskii E. Is there a need for human rights advocates in psychiatry? (in Russian).

[12] Becker, T., Vazquez-Barquero, J.L. The European perspective of psychiatric reform. Acta Psyciatr Scand 2001: 104 (Suppl. 410): 8-14; The report on the rights of the mentally disabled prepared in 1999 by the Russian ombudsman. Supra at 4.

[13] The report on the rights of the mentally disabled prepared in 1999 by the Russian ombudsman. Supra at 4.

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Over the last ten years, international organizations, such as Mental Disability Advocacy Center (MDAC), OSI Mental Health Initiative (MHI) and Mental Disability Rights International (MDRI), Moscow Helsinki Group (MHG) have identified the particular vulnerabilities of people with mental disabilities who are detained in institutions for people with intellectual disabilities, psychiatric hospitals, orphanages, social care homes, prisons and jails[14]. However, these issues are not addressed by Russian human rights NGOs either.

Understanding legislation and policies fostering participation of the mentally disabled and their integration into society can become an important first step in designing the system of health and social care based on universal human rights values. The process of deinstitutionalization which can be examined from the perspective of mental health professionals, social workers, sociologists and historians, in this study is analyzed from the perspective of human rights advocates. Although legislation is not an alternative to mental health policies it offers an important mechanism to ensure adequate and appropriate care and treatment, protection of human right of people with mental disabilities and promotion of mental health of population.

Thus, the overall goal of the present study is to review the legal background of the recent reforms which are aimed at moving away from institutionalized mental health care in selected Western countries and Central and Eastern European countries in transition in order to formulate policy recommendations for the Russian mental health stakeholders.

2. Research objectives

1. Review international and foreign legal instruments designed to strengthen the individual's position in mental health care by promoting its delivery in the least restrictive settings.
2. Give an overview of mental health care reforms aimed at bringing national policies in conformity with international human rights standards in terms of fostering social inclusion of the mentally disabled through deinstitutionalization.
3. Identify possible benefits and applicability of the gained results to reforming Russian legislation in the field of mental health within the framework of providing mental health treatment in the most integrated setting appropriate (provide policy recommendations).

3. Definitions

Institutionalized mental health care refers to segregated long-stay residential facilities, such as psychiatric hospitals, social care homes ("*internats*" in the Russian terminology), designed specifically for patients (residents) with mental health problems.

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[14] MDAC shadow report to the Human Rights Committee. 2003. www.mdac.info; Children in Russia's Institutions: Human Rights and Opportunities for Reform. Findings and Recommendations of a UNICEF Sponsored Fact-finding Mission to the Russian Federation 20th October through 6th November 1998. MDRI report 1999; Places of Detention in the Russian Federation. Report from the visit of the delegation of human rights NGOs to places of detention in the Russian Federation on 19 and 20 February 2004. International Helsinki Federation for Human Rights. 2004. Available at http://www.ihf-hr.org.

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Deinstitutionalization in a broad sense refers to the transition from institutional care to community based care: the practice of caring for individuals in the community[15], rather than in an institutional environment with resultant effects on the individual, the individual's family, the community, and the health care system.

"People with mental disabilities" refers to people who have been diagnosed with developmental disabilities, intellectual disabilities, or mental illness, or who are perceived as having such mental disabilities[16].

"People with mental health problems"[17] is used to distinguish between people with intellectual disabilities and mental illness. Many mental health problems are treatable with medication and other therapies.

Inclusion of people with disabilities (social integration) means the ability to participate in society to the largest extent possible.

Participation of people with disabilities means that they must be consulted and participate in the process of making decisions that affect their lives.

4. The debate over deinstitutionalization

This section provides an overview of major arguments in favor and against deinstitutionalization. It is based on the review of published data and the author's interviews with mental health professionals and authorities in Russia.

Since the early 1960's there has been a clear international trend in Western Europe to change policies concerning the care, treatment and accommodation of the mentally ill. Those individuals who until this time had been accommodated within an institutional setting were transferred from hospital environments and returned to the family unit, or placed in residential group homes scattered throughout the general community. The process of returning the mentally disabled to the community, commonly referred to as "deinstitutionalization", is now considered by most mental health professionals to be a more satisfactory means of treatment for the mentally ill and the developmentally disabled[18].

Deinstitutionalization of the mentally disabled has been a trend in western countries for almost three decades now. As early as in 1976 Bachrach wrote that the direction in mental health care in the United States has been undeniably in the pursuit of a community mental health care strategy - the provision of services to patients in their home communities[19]. This has led to the devolution of a number of psychiatric hospitals in that country, with over two-thirds of the residents being returned to live

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[15] Or in more independent living environments compared to large institutions.

[16] It should be noted that "disability" in the Russian law applies to those who have been officially recognized as disabled ("invalids") and issued a special certificate. The English-language term "people with mental disabilities" is broader in its scope and corresponds to the Russian term "people, suffering from psychiatric disorders".

[17] Other terms used (the mentally ill, the mentally handicapped) are considered by many to be pejorative.

[18] Mental Health Declaration for Europe. Facing the Challenges, Building Solutions. 14 January 2005. WHO Doc. EUR/04/5047810/6.

[19] Bachrach, LL. A note on some recent studies of released mental hospital patients in the community. Am J Psychiatry 1976 133: 73-75.

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within the general community environment[20]. The advent of anti-psychotic drugs, which allowed many patients that could not previously function well in society, could, with the use of newer drugs, live independently in society, together with the criticisms directed at the effectiveness and cost of traditional institutional care, have helped to promote the success of deinstitutionalization programs in many Western countries. This transition was also aided by a number of court decisions. The principle which has become known as the "least restrictive alternative" allows involuntary admission to psychiatric hospitals only if there are no other feasible means of treatment that would allow more freedom to patients[21].

Thus, factors contributing to hospital closures and deinstitutionalization can be summarized as follows[22]:

- introduction of new psychotic drugs;
- economic incentives (high costs of long-term inpatient care in Western Countries);
- a shift from treating primarily chronic patients to treating acute ones;
- a shift in psychiatric discourse (development of psychologically-oriented practice);
- integration of human rights paradigm into mental health care.

Another major factor which influenced deinstitutionalization process was a general shift in disability paradigm: traditional models of disability tend to start with the basic premise that the individual experiencing disability is the sole locus of any problems encountered by that person, whereas a contemporary approach tends to move away from a purely medical model: "Disability, under the new model, is seen as a social construction according to which *society* requires adaptation, *not* the person with a disability"[23].

However, these same programs have also been the subject of some fierce criticism in relation to issues such as high recidivism rates, a totally inadequate delivery of programs, supervision and support services to the consumer, and a struggling cost-effectiveness strategy. Concerns have been made that under the banner of deinstitutionalization, patients have often merely been discharged from mental hospitals without the provision of the alternative health care structure required to meet their social and health needs within the community. As Krieg put it

Deinstitutionalization was instituted with the best of intentions. However, there have been unintended consequences accruing to many in society, due to an absence of sufficient planning for alternative care with adequate resources. While most consumers of care benefit from the increased freedom associated with deinstitutionalization, many of the more severely ill have been neglected. In addition,

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[20] See below, section 6.3.

[21] For example, the case of *O'Connor v. Donaldson*, 422 U.S. 563 (1975). The concept, which has also emerged from the ECHR case law, means that non-dangerous mental patients, who are institutionalized against their will, have the right to be treated or discharged. See also *Winterwerp v. Netherlands*. 6301/73 [1979] ECHR 4 (24 October 1979).

[22] Rogers, A. & Pilgrim, D. Mental Health Policy in Britain. 2nd ed. 2001. P. 72.

[23] Understanding the Role of an International Convention on the Human Rights of People with Disabilities. NCD report. 2002. www.ncd.gov, at 35. Unfortunately the said medical model of mental disability still dominates Russian mental health system.

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other members of society have been adversely affected by deinstitutionalization[24]. *…Costs to consumers of independent living include high suicide rates, accidents, and untreated illness, homelessness*[25].

The conceptual bases of psychiatric reforms in most western democracies which incorporated the postulates of community mental health care can be summarized as follows:

- to guarantee the civil rights of persons with mental disabilities;
- to guarantee attention to mentally disabled patients within the general network of health care and specifically in primary care services;
- to redefine the therapeutic meaning of psychiatric hospitalization, which lost its central role in psychiatric care, and was located in general hospitals;
- to provide adequate community services and social support to make it possible to rehabilitate and resettle psychiatric patients in society;
- to bring about changes in the community to prevent the marginalization of these patients.

In the light of these ideas closure of mental hospitals was not the main aim of the reform, but rather was viewed as the consequence of the changes advocated in psychiatric care.

4.1. Major arguments pro and contra deinstitutionalization

When deinstitutionalization began in the 1950-60's skeptical voices declared that most patients would be unable to live outside hospitals[26]. Similar statements are made by Russian mental health authorities today who fiercely rely on medical rationale for protecting the existing system of large mental health institutions[27]. However, deinstitutionalization has been in effect for many years and in several countries there have been attempts to document its consequences[28].

Consequently a range of different arguments has been presented by supporters and opponents of the idea of moving away from large institutional mental health facilities. The present chapter will review major arguments against deinstitutionalization discussed among social and health care professionals to show

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[24] Krieg, R.G. An interdisciplinary look at the deinstitutionalization of the mentally ill. Social Science Journal 38 (2001) 367–380. P. 368.
[25] Ibid, at 371.
[26] Rothbard, A.B. & Kuno, E. The Success of Deinstitutionalization. Empirical Findings from Case Studies on State Hospital Closures. International Journal of Law and Psychiatry, Vol. 23, No. 3–4, pp. 329–344, 2000.
[27] St. Petersburg mental health authorities, personal interview.
[28] Among others: Korkeila, J.A.,Lehtinen, V., Tuori, T. & Helenius, H. Patterns of psychiatric hospital service use in Finland: a national register study of hospital discharges in the early 1990s. Soc Psychiatry Psychiatr Epidemiol (1998) 33: 218-223; Nordentoft , M., H.C. Knudsen, B. Jessen-Petersen, A. Krasnik, P. Treufeldt & B. Wetcher. CCPP-Copenhagen Community Psychiatric Project Implementation of community mental health centres in Copenhagen: effects of service utilization, social integration, quality of life and positive and negative symptoms. Soc Psychiatry Psychiatr Epidemiol (1996) 31:336-344. Chase, K. & Hendryx, M. A continuum of care from hospital to community. Administration and Policy in Mental Health. Vol. 16, No. 4, Summer 1989. Sörgaard, K.W. at al. Predictors of social relations in persons with schizophrenia living in the community: a Nordic multicentre study. Soc Psychiatry Psychiatr Epidemiol (2001) 36: 13-19;

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their invalidity. It will proceed then with a rationale from a human rights perspective – which the author considers the major argument – to support the idea of deinstitutionalization.

Different approaches have been adopted and the effects of deinstitutionalization have been assessed from medical (mental health status of deinstitutionalized patients), social (quality of life) and economic (cost-effectiveness) perspectives[29]. Studies that have evaluated the development from a system with the main emphasis on in-patient treatment to a system mainly based on out-patient treatment and community-based services have focused on readmission rates, psychopathology, user satisfaction, social network and the level of psychosocial functioning[30]. Other indicators of the performance of deinstitutionalized mental health care systems included "life satisfaction"[31].

Analysis of the statements of Russian mental health administrators and psychiatrists has proven an overall negative attitude towards deinstitutionalization which is partially explained by the lack of knowledge of community-based alternatives, but primarily based on a paternalistic Soviet mentality: people with mental disabilities are viewed as patients only and patients cannot be left without (hospital) health care[32]. General skepticism about deinstitutionalization in Russia is supported by some Western studies[33] which give the following major arguments against it:

- **Inadequate planning**: Deinstitutionalization is a movement which has been implemented with little forethought, inadequate planning, and no advance scientific study so it has failed to live up to its promise[34].
- **Inadequate treatment programs:** As a result of poor implementation strategies, some serious problems have developed in the care and treatment of the mentally disabled. Opponents of the deinstitutionalization process believe that the community care model has not lessened the incidence of mental illness or the number of mentally ill:

  "Deinstitutionalization has not reduced the mistreatment and suffering of the mentally ill. Instead of reducing chronic illness, deinstitutionalization all too

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[29] Poitras, S. & Bertolote, J.M. Mental Health Legislation: International Trends. In: Contemporary Psychiatry/ F. Henn et al. (Eds.). New York 2001. P. 270-286; Chih-Yuan, L. Ethical Exploration of the Least Restrictive Alternative. Psychiatric Services. June 2003 Vol. 54 No. 6

[30] Pijl, Y. J., Sytema S. The effect of deinstitutionalization on the longitudinal continuity of mental health care in the Netherlands Soc Psychiatry Psychiatr Epidemiol (2004) 39: 244–248; Povl, Munk-Jørgensen. Has deinstitutionalization gone too far? Eur Arch Psychiatry Clin Neurosci (1999) 249 :136–143

[31] Rothbard, A.B. Op. cit.

[32] This position finds its strong basis in the Russian law: Article 29 of Law on Psychiatric Care states that a mentally disturbed individual may be hospitalised in a psychiatric hospital against his will, if the individual's examination or treatment can only be carried out by in-patient care, and the mental disorder is severe enough to give rise to a significant impairment in health as a result of a deteriorating mental condition, if the affected person were to be left without psychiatric care. According to St. Petersburg State Medical University, this criterion is the most often used to justify civil psychiatric confinement. See: Neznankov N.G. et al. www.pryazhka.ru/sbornik2002_13.php

[33] Personal interviews: Ministry of Health (Psychiatry Group), Bekhterev Research Center (St. Petersburg), Chief Psychiatrist at the St. Petersburg Health Care Committee.

[34] Goodwin S (1997). Comparative mental health policy: from institutional to community care. London: Sage Publications.

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often has resulted in too-short, ineffective care that leads to repeated episodes of illness and chronicity"[35].

- **Increasing number of readmissions to psychiatric hospitals[36].** No statistically proven data have been presented to support this statement.
- **Increase in suicide rates.** Again no statistically proven data are available; no scientific researches have been conducted.
- **Increases in the homeless population:** A study of homeless men in New York reports that there has been a large increase in the number of mentally ill who frequent accommodation facilities for homeless men - the majority of whom are no longer the older alcoholic and black, but instead 'the younger, mentally ill and white'. As a result of these and many other studies, it is suggested that in Australia, as in the United States, deinstitutionalization has produced a real increase in the number of destitute, homeless mentally ill persons[37]. This is also one of the major arguments of the opponents of deinstitutionalization of the mentally ill in Russia: it is true that in many cases people with mental health problems have nowhere to go once they have been discharged from the hospitals[38]. According to some estimates up to 40% of the entire hospital population in Russia does not require any medical mental health care and these patients stay in hospitals for various social reasons[39].
- **Cost-effectiveness**: Community services are more expensive[40]. Given the fact that inpatient mental health services are clearly underfinanced in Russia (appalling living conditions, low salaries of mental health professionals, lack of food have been reported by several monitoring teams)[41], and taking into account insufficient data on cost-effectiveness of community-based services versus mental care in large institutions this seems to be a very weak argument[42]. Moreover, a recent comparative study of community-based services in 25 European countries concluded that such services "tend to cost approximately the same as institutional care. However, the quality of life offered by community-based services tends to be much better. Furthermore, when the structural costs linked to the management of institutions are taken

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[35] Gralnick, A. (1985). Build a Better State Hospital: Deinstitutionalization Has Failed. Hospital and Community Psychiatry, 36(7), 738-739. Although this statement is 20 years old these arguments are still discussed. See: Arvidsson, H. Met and unmet needs of severely mentally ill persons. The psychiatric care reform in Sweden. Soc Psychiatry Psychiatr Epidemiol (2003) 38: 373-379.

[36] Breakey WR (1996). Inpatient services. In: Breakey WR, ed. Integrated mental health services. New York: Oxford University Press Inc. P. 264-75.

[37] Povl, Munk-Jørgensen. Has deinstitutionalization gone too far? Eur Arch Psychiatry Clin Neurosci (1999) 249: 136–143

[38] Bartenev, Dmitri and Smorgunova, Anna. Problems in discharge of incapacitated inpatients from mental hospitals. In: *Glavnyi Vrach*. 2005. V. 3. P. 35-38.

[39] Personal communication.

[40] Luxembourg is a good example of the fact that economical factors are not the only aspects influencing development in psychiatric care. Psychiatric care is not community based, centralized, separated from medical care, and the supply system concerning complementary outpatients institutions is underrepresented. Thus, in all the countries the process of deinstitutionalization has still not come to a satisfying level. This is not only due to the economically difficult situation in the recent past. A change can only be expected when the opinions about modern principles of psychiatric care receive more weight in general society and with their political representatives.

[41] See: Human Rights and Psychiatry in the Russian Federation. Moscow Helsinki Group, 2004.

[42] For a sample controlled study see: Eggink, E. & Blank, J.L.T. Efficiency of Homes for the Mentally Disabled in the Netherlands. The Hague, 2001.

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into account, it appears that in some cases, institutions actually cost more than community-based services"[43].

- **Distribution of mental health funding:** For example although in Australia hospital in-patient numbers have been reduced by over 80% since 1963 to resume community living, there remains a constant inference that hospitals have continued to receive a far larger proportion of the mental health budget[44].

It is beyond the scope of this paper to discuss in detail all policy implications of moving away from institutionalized mental health care. However, even a very brief analysis of the arguments against deinstitutionalization suggests that most of them are not aimed at its concept but rather refer to the shortcomings in its implementation. Consequently it is wrong to equate deinstitutionalization and psychiatric reform with closure of psychiatric hospitals, without admitting that this process is far more complex.

Forty years after the beginning of the deinstitutionalization process accumulated evidence has shown a range of benefits of community services developments over long-term institutionalization for most users[45]. No controlled trial showed hospital care to be better on any variable. Although it is difficult to synthesize the data because of the lack of a common (internationally accepted) conceptual framework several conclusions can be made. Various researchers showed that 1-3 years after patients were discharged from long-term hospital care to community houses, they had more people to rely on, they significantly improved community skills and their self-perception of quality of life greatly increased[46]. A detailed justification of deinstitutionalized mental health care has been given by the World Health Organization[47].

- **Quality of life.** The findings of most studies suggest that long-stay patients can benefit from discharge into the community, particularly with respect to their quality of life. Positive changes in the process of deinstitutionalization seem not dependent on the specific national context[48]. It should be noted that there have been no such studies in the Russian Federation or CIS countries so far.

- **Reduction of stigma** associated with segregated mental hospitals. Most people are unwilling to use hospital services because of negative social attitudes which can result in delays in mental health care and worse clinical outcomes. Improvement of social attitudes towards people with mental disabilities.

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[43] Included in Society (2004). Results and Recommendations of the European Research Initiative on Community-Based Residential Alternatives for Disabled People. P. 16.

[44] Hobbs, C., Newton, L., Tennant C., Rosen, A., Tribe, K. Deinstitutionalization for long-term mental illness: a 6-year evaluation. Australian and New Zealand Journal of Psychiatry 2002; 36:60-66.

[45] Rothbard, A.B. & Kuno, E. The Success of Deinstitutionalization. Empirical Findings from Case Studies on State Hospital Closures. International Journal of Law and Psychiatry, Vol. 23, No. 3–4, pp. 329–344, 2000.

[46] Home care & people with psychiatric disabilities needs and issues. http://www2.itssti.hc-sc.gc.ca/B_Pcb/HTF/Projectc.nsf/ExecSum/NA0149/$File/NA0149.pdf

[47] See: Mental Health Organization. In: Mental Health Policy and Service Guidance Project. WHO, 2003.

[48] Priebe, S., Hoffmann, K. et al. Do long-term hospitalised patients benefit from discharge into the community? Soc Psychiatry Psychiatr Epidemiol (2002) 37: 387–392.

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- **Socio-medical criteria**. There are clear medical justifications for down-sizing mental hospitals as time spent in psychiatric hospitals may also result in dependency or a pathological adaptation to a hospital environment. It has been also shown that deinstitutionalization and transferring patients to community services results in a reduction in medication which side-effects along are sometimes horrible[49]. WHO refers to several controlled studies which compared the effects of community-based treatment with those of standard inpatient care. The latter indicated significantly better outcomes in many cases[50]. As deinstitutionalization involves a shift in emphasis from custodial accommodation to rehabilitation programs in community settings it is therefore more humane in that it avoids the detrimental psychological effects of long-term hospitalization (so called "hospitalism") and focuses on patients becoming reintegrated into community settings[51].
- **Human rights violations** in mental health institutions have been widely reported in many CEE countries including Russia[52]. A recent report Included in Society summarizes the situation in the 25 EU member states[53]. This argument along can give enough justification for deinstitutionalization of mental health care.
- **Community Based Care.** The rationale for treating all but the most severely mentally disabled people in a community setting, has as its main premise the proposal that the mentally disabled are optimally treated in an environment that permits contact with the rest of society, and readily available access to mainstream social institutions to achieve a continuity of treatment. Community living demands independent functioning, is relatively non-coercive, and encourages contact with family, friends and significant others. Such services are also better accessible as compared to mental hospitals which are usually located at some distance from urban areas and have poor transport links (which is the case in many regions in Russia)[54].
- **Human Resources:** In many countries mental hospitals consume most of the available specialist mental health resources. There are high rates of staff burnout and demotivation and there is a gradual decline in skills of mental health professionals.

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[49] Mor, V., Sherwood, S., & Gutkin, C. E. (1984). Past psychiatric history as a barrier to residential care. Hospital and Community Psychiatry, 34(4), 373-379.

[50] Mental Health Organization. Mental Health Policy and Service Guidance Project. WHO, 2003. P. 46.The criteria used to assess outcomes included global symptomatology, psychosocial adjustment, admission/readmission rates, length of stay in hospital, patient satisfaction, less medication, employment, family burden.

[51] Thornicroft G., Tansella M (1999). The mental health matrix: a manual to improve services. Cambridge: Cambridge University Press.

[52] MDAC report Cage Beds, MDRI. Moscow Helsinki Group.

[53] Included in Society (2004). Results and Recommendations of the European Research Initiative on Community-Based Residential Alternatives for Disabled People. www.community-living.info

[54] Organization of services for mental health (Mental health policy and service guidance package). WHO. 2003. P. 20-21.

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- **Financial costs:** Mental hospitals are expensive and, in many developing countries, consume a significant portion of the budget meant for mental health services[55].
- **Access:** Many mental hospitals in Russia are based at a significant distance from urban areas and have poor transport links.

WHO World Health Report 2001 – Mental Health: New Understanding, New Hope – states:

> *Recommendation 3:* ***Give care in the community***
>
> *Community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders. Shifting patients from mental hospitals to care in the community is also cost-effective and respects human rights. Mental health services should therefore be provided in the community, with the use of all available resources. Community-based services can lead to early intervention and limit the stigma of taking treatment. Large custodial mental hospitals should be replaced by community care facilities, backed by general hospital psychiatric beds and home care support, which meet all the needs of the ill that were the responsibility of those hospitals. This shift towards community care requires health workers and rehabilitation services to be available at community level, along with the provision of crisis support, protected housing, and sheltered employment.*

According to the WHO 2005 Mental Health Declaration for Europe (signed by the Russian Government)[56] governments must take concrete steps to move from institutionalized mental care towards community-based forms of care and to develop community-based services to replace care in large institutions even for those with severe mental health problems.

5. Rights-based approach to deinstitutionalization

The purpose of this section is to analyze human rights implications of deinstitutionalization to show that it has found a strong basis in international and domestic human rights law. Therefore this part of the research seeks to highlight the most relevant binding and non-binding international documents in comparison with the Russian laws relevant to establishing a claim for community integration and against unnecessary institutionalization as discrimination under international law.

Institutionalization of people with mental disabilities, as defined in the introductory part of this paper, refers to the provision of mental care in long-stay residential facilities, such as psychiatric hospitals, social care homes ("*internats*"), designed specifically for patients (residents) with mental health problems. Institutionalized mental health care raises a number of human rights issues, especially

[55] 80% in Russia. See: State Report on Health Status of the Population of the Russian Federation in 2003. Ministry of Health Care and Social Development. Russian Academy of Medical Sciences, 2004.
[56] Mental Health Declaration for Europe. Facing the Challenges, Building Solutions. 14 January 2005. WHO Doc. EUR/04/5047810/6, par. 10, section xi.

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in Russia and other post-soviet countries where living and material conditions in such institutions are in general extremely poor[57].

The current increase in attention to the human rights of people with disabilities has naturally derived from the civil rights tradition, and has emerged to challenge existing notions of human rights that have frequently ignored the lives of people with disabilities[58]. A human rights approach transformed the "needs" models of people with disabilities into the "rights" model. Grounded in basic concepts of justice and human dignity, human rights enable people to reconceive their basic needs as a matter of rights to claim, rather than charity to receive. Having changed the focus from needs to rights, people with disabilities may be recognized as active rights-bearing individuals who are participants in their own development and who should be consulted accordingly in development decision-making.

As *Krieg* put it, the debate over deinstitutionalization and the development of community based services has been associated with three types of rights. They are: (1) the right of the individual to receive treatment, (2) the right to treatment in the least restrictive setting, and (3) the right to freedom from harm[59]. Indeed, although there is no explicit recognition of the right to be free from (indeterminate) institutionalization international law may provide important protections for institutionalized people with mental disabilities. However, as noted by *Rosenthal*:

While these general arguments about the application of international human rights law are intuitively powerful, human rights covenants have not been used historically to protect against human rights abuses in psychiatric institutions. The major limitation on the use of existing covenants to enforce the rights of institutionalized people with disabilities is their failure to include specific provisions regarding people with disabilities[60].

While it is true that the right to be free from institutionalized mental health care as a human right has yet to be recognized explicitly under general international human rights covenants, this right has gained some recognition over the past 20 years in various human rights documents. The «right to deinstitutionalization» can be claimed by referring to a number of universally accepted and interrelated fundamental human rights[61]:

- The right to liberty and personal security
- The right to be free from inhuman and degrading treatment
- The right to private and family life
- The right to health
- Equality of rights and prohibition of discrimination

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[57] Human Rights and Psychiatry in the Russian Federation. Moscow Helsinki Group, 2004. http://www.mhg.ru.

[58] Rosenthal, E. & Sundram, C.J. Recognizing Existing Rights and Crafting New Ones: Tools for Drafting Human Rights Instruments for People with Mental Disabilities P. 467-501.

[59] Krieg, R.G. An interdisciplinary look at the deinstitutionalization of the mentally ill. Social Science Journal 38 (2001) 367–380.

[60] Rosenthal, E. & Sundram, C.J. The Role of International Human Rights in Domestic Mental Health Legislation. Submitted to the WHO. 2002.

[61] See: Gostin, L. Human Rights of Persons With Mental Disabilities. Int'l J Law Psychiatry. Vol. 23, No. 2, pp. 125-159, 2000; Included in Society (2004). Results and Recommendations of the European Research Initiative on Community-Based Residential Alternatives for Disabled People. www.community-living.info.

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Moreover, this section will make an attempt to conclude that there is an emerging positive right to community integration understood as the right of a mentally disable person to be able to participate in the community life to the maximum extent possible, equally with other citizens which naturally implies living in the community.

5.1. The right to liberty and personal security[62]

Being one of the core values of a democratic society and based on the principle of rule of law the concept of liberty provides a strong basis for challenging institutionalized mental health care. The right to liberty and personal security has been recognized in a number of binding[63] international human rights instruments and in the Russian Constitution[64].

The jurisprudence of the European Court of Human Rights created a number of important requirements under Article 5 in the context of mental health[65]: an individual must reliably be shown to be of "unsound mind"; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder[66]. Article 29 of the Russian Law on Psychiatric Care lists similar requirements for lawful detention of the mentally disabled:

A mentally disturbed individual may be hospitalised in a psychiatric hospital against his will or the will of his legal representative and without a court decision having been taken, if the individual's examination or treatment can only be carried out by in-patient care, and the mental disorder is severe enough to give rise to: a) a direct danger to the person or to others, or b) the individual's helplessness, i.e. an inability to take care of himself, or c) a significant impairment in health as a result of a deteriorating mental condition, if the affected person were to be left without psychiatric care[67].

These requirements apply to both substantial and procedural aspects of the right to liberty and personal security. It is therefore clear that all these guarantees apply to the situations of involuntary civil confinement of people with mental health problems in institutions in accordance with Article 5(1)(e) of the European Convention.

[62] The following analysis is based primarily on the ECHR provisions and the European Court of Human Rights jurisprudence. The Russian Federation is a party to the ECHR as of 5 May 1998, in 2003 the Supreme Court reaffirmed that the jurisprudence of the European Court applies in full to interpreting the provisions of the Convention.

[63] International Covenant on civil and Political Rights (1966), Article 9; ECHR (1950), Article 5.

[64] Article 22 of the Constitution of the Russian Federation, of 12 December 1993.

[65] For a detailed analysis see: Mental Disability Advocacy Center. The European Convention on Human Rights and the rights of people with mental health problems and/or intellectual disabilities.2003. Available at www.mdac.info; The Standards of the European Court of Human Rights and the Russian Law-Enforcement Practice. M.Voskobitova (ed.). Moscow, 2005. pp. 196-247.

[66] *Winterwerp v. Netherlands*, 2 EHRR 387 (1978), § 39; *Luberti v. Italy* judgment of 23 February 1984, Series A no. 75, § 27, *Johnson v. the United Kingdom*, judgment of 24 October 1997, *Reports* 1997-VII, § 60 and *Hutchison Reid v. the United Kingdom*, no. 50272/99, § 47, ECHR 2003-IV).]

[67] Article 29 of the Law. Articles 32-35 of the Law specify the procedure for the examination of patients compulsorily confined in a hospital and set out in detail the procedure for judicial review of applications for the compulsory treatment of mentally ill persons.

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The situation becomes less clear when deprivation of liberty takes place without formal confinement under a court decision. Indeed, in most cases institutionalization is not based on a court order and such patients (residents) who spend years of their lives in the hospitals (social care homes) are considered "voluntary" in law. In fact in most cases such patients (those who have mental capacity to consent) signed a "voluntary informed consent" form. It is also true that there are many of non-objecting patients who do not have capacity to consent. However should any such "voluntary" patient decide to leave the hospital in Russia that would be not only physically impossible (as the doors are always locked) but in many cases would result in a formal procedure of civil confinement[68]. These are the examples of *de facto* detention.

Thus, a number of issues can arise under Article 5 in applying it to the situations of detention of the mentally disabled in psychiatric (social care) institutions.

1. What constitutes detention?

According to the doctrine detention means that a person "reasonably feels that his liberty is constrained"[69], in other words he perceives the situation as preventing him from leaving certain place. This might seem self-evident but there are certainly situations where someone has been deprived of his or her liberty but this might still not be appreciated by the persons responsible, particularly if no physical restraint has been imposed[70]. For instance, in *Ashingdane v. the United Kingdom* the Court found that Article 5 was applicable to the situation where a person who, although being kept compulsory in a mental hospital, was placed in a ward which was not locked and was allowed to leave the hospital grounds during the day and over the weekend without being accompanied[71].

Detention is such a restriction of a person's liberty which is against his or her will. The question arises whether detention implies taking into account any person's will or only the one of legally capable persons. In other words is institutional placement of incapacitated persons shall be regarded as detention to which the above mentioned guarantees must apply? Under the Russian law those declared legal incapable[72] are not entitled to make a valid decision regarding institutional placement, it is either a guardian or guardianship authorities who make such a decision on behalf of such individuals[73]. Consequently if an incapable person is found to be in need of supported living the guardianship authorities can make the decision to place this person to a social care home (*internat*) for an indefinite period without taking into account the view of the person concerned and without judicial order[74]. Moreover even these guarantees are abandoned if a guardian decides to place an incapable person in a

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[68] Given the fact that court orders are granted in almost all cases of civil confinement this is not a mere speculation. For example, according to St. Petersburg Chief Psychiatrist during 10 years of her office there was only one case when the court refused to issue an order. There are about 1000 of civil confinement cases in St. Petersburg each year.

[69] Gostin L. *Human Rights of Persons With Mental Disabilities*. Int'l J Law Psy, Vol. 23 No. 2 (2000), pp. 125-159, at p. 138.

[70] *The right to liberty and security of the person. A guide to implementation of Article 5 of the ECHR*. By Monica Macovei. Human Rights handbooks, No. 5. Council of Europe, 2002. P. 17.

[71] Judgment of 28 May 1985.

[72] It should be noted that the Russian legislation does not allow for *partial* incapacity because of the presence of a mental disorder unlike in other countries. There is no requirement for periodic review of the incapacity status. An incapable person lacks any standing under the Russian law.

[73] Article 4(2) of the Law on Psychiatric Care.

[74] Article 41 of the Law on Psychiatric Care.

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mental hospital or in a social care home: this is a sole discretion of the guardian[75], no court order is required and no judicial remedies are available to the person concerned to review the lawfulness of his hospital stay[76].

Hence, institutional placement of the incapable individuals is not considered "detention" under the Russian law and substantial or procedural guarantees do not apply to it. This problem affects thousands of people in Russia who are sent to social care homes or locked away in geriatric units of mental hospitals for the rest of their lives without being able to review the lawfulness of such a detention. The European Court has not had a chance to test compliance of such form of detention with Article 5 guarantees but the Court is not bound with the meaning of "lawful" under domestic law and can test the quality of a national law in the light of the Convention objectives.

Informal (non-objecting) patients/residents

The Committee of Ministers of the Council of Europe recommends that "member states should ensure that appropriate provisions exist to protect a person with mental disorder who does not have the capacity to consent and who is considered in need of placement and does not object to the placement"[77].

According to the ECHR jurisprudence the involuntary detention guarantees apply to non-protesting individuals held in mental health facility because of their mental condition. The European Court found in *H.L. v. United Kingdom*[78] that

As a result of the lack of procedural regulation and limits, the Court observes that the hospital's health care professionals assumed full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit[79]*. ... The Court therefore finds that this absence of procedural safeguards fails to protect against arbitrary deprivations of liberty on grounds of necessity and, consequently, to comply with the essential purpose of Article 5 § 1 of the Convention. On this basis, the Court finds that there has been a violation of Article 5 § 1 of the Convention.*[80]

2. When detention of people with mental disabilities violates the ECHR standards?

The European Court has not had an opportunity to examine in full detail human rights implications of institutionalization of people with mental disabilities. As a general rule the Court has held that the detention of an individual is such a serious measure that it is only justified where other, less severe measures have been considered and found to be insufficient to safeguard the individual or public interest which might require that the person concerned be detained[81].

In a recent case of *Hutchison Reid v. the United Kingdom* which dealt with the issue of detention of a person whose mental health condition did not benefit from detention in an institution, the Court's approach appeared to be very cautious. The Court held that although the detention under this Article will only be lawful if effected

[75] Articles 4(2) and 29 of the Law on Psychiatric Care.
[76] Given the fact that financing of mental health care is based on a number of beds and circulation of beds, lengthy and unnecessary hospitalization is a common practice in mental hospitals in Russia.
[77] Rec(2004)10, article 26.
[78] Judgment of 5 October 2004. Application no. 45508/99.
[79] Ibid. § 121.
[80] Ibid. § 124.
[81] *Witold Litwa v. Poland*, no. 26629/95, § 78, ECHR 2000-III

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in a “hospital, clinic or other appropriate institution”[82], there is no requirement imposed by Article 5 § 1 (e) of the Convention that detention in a mental hospital needs to be “conditional on the illness or condition being of a nature or degree amenable to medical treatment”[83]. The Court’s case-law refers rather to the applicant being properly established as suffering from a mental disorder of a degree warranting compulsory confinement. Such confinement may be necessary not only where a person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons[84].

It therefore remains unclear whether the Court would find a violation of Article 5 in a case where someone is detained in a mental health institution for various social reasons – the argument frequently used by Russian mental health hospital to justify continued confinement when a patient no longer needs any medical inpatient care (no guardian, no place to go, no adequate care outside hospital settings)[85]. The *Johnson v. the United Kingdom* judgment provides an example of the Court’s cautious approach to interpretation of the right to liberty. In the Court’s view id does not automatically follow from a finding by an expert authority that the mental disorder which justified a patient’s compulsory confinement no longer persists, that the latter must be immediately and unconditionally released into the community[86]. The Court further noted that “whether or not recovery from an episode of mental illness which justified a patient’s confinement is complete and definitive or merely apparent cannot in all cases be measured with absolute certainty. It is the behaviour of the patient in the period spent outside the confines of the psychiatric institution which will be conclusive of this”[87]. By recalling its *Luberti* judgment the Court concludes that some caution in terminating a patient’s confinement is justified as “the termination of the confinement of an individual who has previously been found by a court to be of unsound mind and to present a danger to society is a matter that concerns, as well as that individual, the community in which he will live if released”[88].

However, it is this reasoning of the Court which strengthens the potential of arguing that a danger to society is different from social disorder of a mentally disabled person which should not be equated with “the mental disorder of a kind or degree warranting compulsory confinement”. Although the State has some interest in protecting the rights of the patients who are unable to take care of themselves outside hospital settings without assistance, a mere confinement is not an adequate measure to protect such interests. It should be noted that the list of exceptions from the right to liberty contained in Article 5(1) is exhaustive[89].

Obviously it is hard to argue that the right to liberty imposes any positive obligations on the State to set up community-based services alternative to institutionalized care but the mere fact of a violation of the Article 5 guarantees may be used for advocating for such services. In *Johnson v. the United Kingdom* the Court

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[82] *Ashingdane v. the United Kingdom,* judgment of 28 May 1985, § 44.
[83] Ibid. § 52.
[84] *Witold Litwa v. Poland*, no. 26629/95, § 60, ECHR 2000-III.
[85] An issue under Article 5 (1) (e) may arise here with regard to lawful detention of “vagrants” (*De Wilde, Ooms and Versyp v. Belgium*).
[86] Application no. 119/1996/738/937. Judgment of 24 October 1997, § 61.
[87] Ibid, § 61.
[88] Ibid, § 62.
[89] *Engel et al.*, § 57, *Witold Litwa*, § 49.

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examined the situation of a patient who was no longer with mental disability but still detained[90] and found that the imposition of the hostel residence condition by the Mental Health Review Tribunal as a prerequisite of the applicant's discharge, which led to the indefinite deferral of the applicant's release from high security mental hospital because of the Government's failure to find an appropriate hostel, did not satisfy the requirements of Article 5 (1) of the Convention[91]. Although the situation in *Johnson* was quite peculiar, the Court's findings still emphasize the requirement for the state parties to guarantee effective and not illusory rights set forth in the Convention.

People with mental disabilities are very often locked away and forgotten in mental health institutions in Russia without being able to review the lawfulness of their detention. It is therefore important that people in institutions have an effective right to periodic reviews of their detention. Frequency of reviews is especially important in the context of unnecessary institutionalization: article 5 § 4 of the Convention provides a fundamental safeguard against arbitrary detention in requiring that an individual who is deprived of his liberty has the right to have the lawfulness of that detention reviewed by a court. The European Court has not yet stated how frequently a patient must be able to exercise this right[92].

5.2. Right to be free from inhuman and degrading treatment

Although some may argue that mental hospitals and specialized social care homes were introduced with the best of intentions, namely to provide specialized mental health treatment and care of a high quality, it is a well known fact that "abuse is particularly rife in large psychiatric hospitals and other residential institutions"[93]. The reasons are manifold. Most importantly, psychiatric institutions are *de facto* closed facilities in Russia (and in most post-soviet countries) and inevitably continue to abuse human rights of the inpatients: most regulations and treatments used are clearly humiliating in their nature[94]. There have been numerous reports on large psychiatric and social care institutions in Russia which detailed unacceptable conditions and gross violations of their residents' human rights and dignity[95].

The lack of effective human rights oversight and enforceable legal protections permits abuses to go on unmonitored: due protections that might prevent arbitrary or

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[90] It should be noted that Mr. Johnson who had a diagnosis of a mental illness was convicted of causing actual bodily harm and imposed a hospital order.

[91] Application no. 119/1996/738/937. Judgment of 24 October 1997, § 67.

[92] Mental Disability Advocacy Center. The European Convention on Human Rights and the rights of people with mental health problems and/or intellectual disabilities.2003. Available at www.mdac.info. P. 34. Some guidelines can be found in the following cases: *Herczegfalvy v. Austria*, 15 EHRR 437 (1992); *E v. Norway*, 17 EHRR 30 (1990); *Musial v. Poland*, 13 EHRR 820 (1991).

[93] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt. 11 Feb 2005. UN Doc. E/CN.4/2005/51, par. 10.

[94] United Nations, Sub-Commission on Prevention of Discrimination and Protection of Minorities, Principles, Guidelines and Guarantees for the Protection of Persons Detained on Grounds of Mental Ill-Health or Suffering from Mental Disorder; Report by the Special Rapporteur: Erica-Irene A. Daes, U.N. Doc. E/CN.4/Sub.2/1983/17/Rev.1, U.N. Sales No. E.85.XIV.9 (1997)

[95] Places of Detention in the Russian Federation. Report from the visit of the delegation of human rights NGOs to places of detention in the Russian Federation on 19 and 20 February 2004. International Helsinki Federation for Human Rights. 2004. Available at http://www.ihf-hr.org; Human Rights and Psychiatry in the Russian Federation. Moscow Helsinki Group, 2004. http://www.mhg.ru; Monitoring psychiatric institutions in Kaliningrad Oblast', Report by MDAC (forthcoming).

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improper institutionalization are almost non-existent in Russia. This segregation is especially intolerable in mental health care.

When arguing violations of Article 3 of the Convention the most important issue is the nature of treatment which is allegedly inhuman or degrading. There have been no Strasbourg cases yet on violations of the Article 3 safeguards by appalling mental hospital conditions although similar cases resulted in positive judgments by the Court[96]. In most cases which the Court (and the former Commission) found inadmissible the facts alleged did not amount to inhuman and degrading treatment[97]. It is therefore unlikely that the Court will find institutionalization per se to be inhuman or degrading to fall within the de minimis rule of Article 3. However Article 3 still has a great potential for advocating against institutionalized mental health care especially in Russia where in many hospitals living conditions are so appalling that taking into account the duration of stay there of some patients such care may rise to the level of a violation of the Convention[98]. This is particularly important because of a growing importance of the CPT (and UN CAT) standards used by the European Court to interpret the provisions of Article 3.

The European Court also recognized in *Herczegfalvy v. Austria* the particular inferiority and powerlessness which is "typical of patients confined in psychiatric hospitals" and therefore "calls for increased vigilance in reviewing whether the Convention has been complied with"[99]. Although the conclusion in *Herczegfalvy* was negative, it is noteworthy that the Convention is a "living instrument" and it is quite possible that today's Court would come to a different conclusion[100]. Although there have been no successful cases brought by people who had allegedly suffered abusive treatment in mental health institutions[101], according to *Lewis* it is interesting to note that the Court has recently hinted in *Selmouni v. France* that acts currently classified as inhuman or degrading treatment "could be classified differently in the future"[102]. The Court stated that "the increasingly high standard being required in the area of the

[96] For example *Dougoz v. Greece*, application 40907/98, judgment of 6 March 2001.

[97] For example, *B. v. United Kingdom.* App. No. 6870/75. 10 Eur. Comm. H.R. Dec. & Rep. 37 (1977).

[98] In the latest CPT report the Committee documented violations of the European Convention against torture in psychiatric facilities in Russia. See: Report to the Russian Government on the visit to the Russian Federation carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 2 to 17 December 2001. CPT/Inf (2003) 30. It is worth noting that in *Peers v. Greece* the Court found violation of Article 3 in the situation where a person was detained in a very small cell in the prison, toilet in the cell was not screened and there was no adequate ventilation and it was very hot. Although there was no evidence to positively humiliate or debase the applicant, the conditions in which he lived amounted to inhuman and degrading treatment as they caused feelings of anguish and inferiority capable of humiliating and debasing him. Application no. 28524/95, judgment of 19 April 2001.

[99] Judgment of 24 September 1992, 244 Eur. Ct. H.R. (Ser. A), par. 82; 15 EHRR 437, 484 (1993).

[100] See: Mental Disability Advocacy Center. The European Convention on Human Rights and the rights of people with mental health problems and/or intellectual disabilities.2003. Available at www.mdac.info. P. 18.

[101] In *Price v. the United Kingdom* (application 33394/96, judgment of 10 July 2001) the Court found a violation of Article 3 because the police and prison authorities were unable adequately to cope with the applicant's special needs who suffered from four-limb deficiency. Although the Court found no evidence of any positive intention to humiliate or debase the applicant it considered that the fact that the applicant – a severely disabled person – was detained in conditions where she was dangerously cold, risked developing sores because her bed was too hard or unreachable, and was unable to go to the toilet or keep clean without the greatest of difficulty, constituted degrading treatment contrary to Article 3.

[102] *Selmouni v. France* (2000) 29 EHRR 403. As cited in: Mental Disability Advocacy Center. Ibid., P. 19.

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protection of human rights and fundamental liberties correspondingly and inevitably requires greater firmness in assessing breaches of the fundamental values of democratic societies”[103].

5.3. The right to respect for private and family life

The European Court has not had a chance yet to analyze applicability of Article 8 to the issue of institutionalization of the (mentally) disabled. However, the Court at numerous occasions remarked that the concept of “private life” is a broad term not susceptible to exhaustive definition. It covers the physical and psychological integrity of a person[104]. It can sometimes embrace aspects of an individual's physical and social identity[105]. Article 8 also protects a right to personal development, and the right to establish and develop relationships with other human beings and the outside world[106]. It is not necessary and most likely impossible to give an exhaustive definition of private (family) life and the Court itself has refrained from doing so[107]. Although no case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considered that the notion of personal autonomy to be an important principle underlying the interpretation of its guarantees[108].

Therefore it can be argued that certain aspects of institutionalized mental health care fall within the scope of Article 8, for example, right to live in one’s home (protected by the right to respect for family life and respect for one’s home), right to live with one’s family, etc.

Following the analysis of an alleged violation of Article 8 adopted by the Court several questions raise in discussing institutionalized care:

1. Does institutionalized care constitute an interference with the Article 8 right? Although conditions in mental health institutions in Russia are quite different some generalization is permissible and it would not be an overemphasis to say that institutionalized care interferes with several aspects of the Article 8 right: private life, family life, respect for home, and (sometimes) correspondence[109].

Institutionalization of mental health care promotes human rights violations as such institutions are *de facto* closed facilities, especially in the absence of effective monitoring mechanisms in Russia which allows serious and systemic human rights abuses to go on unchecked. There have been numerous reports over the past years which demonstrated serious human rights abuses within institutions in Russia[110]. As noted by Paul Hunt, mental health care users are vulnerable to violations of their human rights particularly in “segregated service systems and residential institutions,

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[103] Ibid.
[104] *X and Y v. the Netherlands*, judgment of 26 March 1985, Series A no. 91, p. 11, § 22
[105] *Mikulić v. Croatia*, no. 53176/99, § 53, ECHR 2002-I
[106] *Pretty v. the UK*, Application No. 2346/02, judgment of 29 April 2002, § 61.
[107] *Costello-Roberts v. the UK*, judgment of 25 March 1993, § 36.
[108] Ibid.
[109] For recent examples see: Places of Detention in the Russian Federation. Report from the visit of the delegation of human rights NGOs to places of detention in the Russian Federation on 19 and 20 February 2004. International Helsinki Federation for Human Rights. 2004. Available at http://www.ihf-hr.org; Human Rights and Psychiatry in the Russian Federation. Moscow Helsinki Group, 2004. http://www.mhg.ru.
[110] Ibid.

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such as psychiatric hospitals, institutions for people with intellectual disabilities, nursing homes, social care facilities, orphanages, and prisons" [111].

> *The Special Rapporteur has received numerous accounts of the long-term, inappropriate institutionalization of persons with mental disabilities in psychiatric hospitals and other institutions where they have been subjected to human rights abuses, including: rape and sexual abuse by other users or staff; forced sterilizations*[112]*; being chained to soiled beds for long periods time, and, in some cases, being held inside cages; violence and torture; the administration of treatment without informed consent; unmodified use (i.e. without anaesthesia or muscle relaxants) of electro-convulsive therapy (ECT); grossly inadequate sanitation; and a lack of food.*

2. If there has been an interference, is it in accordance with law? Although the law does permit mental health care in institutions it contains some explicit restrictions on hospital care: hospital care shall be voluntary unless criteria for involuntary placement are met and it is permitted only for the period required for treatment of a mental disorder[113]. In practice these clear requirements are interpreted to allow prolonged hospital care in the absence of medical grounds and without giving due respect of a patient's right to live in the community. The law also provides for clear requirements for the conditions in mental health institutions and many of such requirements guarantee compliance with the Article 8 standards, including sanitary conditions, rights to meet other people, privacy rights etc[114]. These requirements are not observed in many of the institutions due to fiscal problems, poor management and lack of human rights awareness among personnel.
3. Does this interference pursue a legitimate aim? Institutionalized mental health care pursues a legitimate aim in some cases, namely to prevent "disorder and crime", to secure "public safety", to protect "the rights and freedoms of others" (Article 8(2) of the Convention).
4. The main question to be answered is whether such interference necessary in a democratic society. In our view the interference which institutionalized mental health constitutes care fails to pass the tests under Article 8, mostly because its necessity in a democratic society (pressing social need) cannot be shown in many cases. Given the detrimental consequences for an individual's life and conditions in the institutions discussed above, proportionality of institutionalization can be challenged using European case-law on the right to privacy.

A separate issue under Article 8 of the European Convention which placement of the mentally disabled people into institutions may also arise is whether it constitutes a discriminatory – as compared to health care to people with somatic disorders – action contrary to Article 8 taken in conjunction with Article 14 (prohibition of discrimination with regard to the Convention rights)[115].

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[111] UN Doc. E/CN.4/2005/51, par. 8 and 9.
[112] Forced sterilization has been also reported in some Russian institutions. See video report at: http://www.atv.ru/video3/0705/1207-2.asf
[113] Article 5 of the Law on Psychiatric Care.
[114] Article 37 of the Law on Psychiatric Care
[115] Clements, L. and Read, J. *Disabled People and European Human Rights*. Bristol, 2003, P. 50.

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It is also important to note that Article 8 sometimes requires positive steps to be taken by the State in order to comply with its standards.

Although the object of Article 8 is essentially that of protecting the individual against arbitrary interference by the public authorities, it does not merely compel the State to abstain from such interference: in addition to this primarily negative undertaking, there may be positive obligations inherent in effective respect for private or family life. In determining whether or not such a positive obligation exists, the Court will have regard to the fair balance that has to be struck between the general interest of the community and the competing interests of the individual, or individuals, concerned[116].

Finally, it is worth noting that certain practices that do not amount to inhuman and degrading treatment (Article 3) can still be considered under Article 8 (for example, unnecessary seclusion and misuse of restraints; unjustified restrictions of private correspondence and communication etc.).

5.4. The right to the highest attainable level of physical and mental health

Article 12 of the ICESCR guarantees the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The nature and scope of the States obligations regarding the right to health has been explained in detail by the UN Committee Economic, Social and Cultural Rights[117] and analyzed by the UN Special Rapporteur on the Right to Health concerning specifically people with mental disabilities in his recent report[118].

The importance of community-based treatment, care and support is given significant emphasis in all modern standards of care concerning mental disability and can be seen as related to the movement to treat mental disability health services as part of primary health care[119]. According to Paul Hunt, the UN Special Rapporteur on the right to health, “the segregation and isolation of persons with mental disabilities from society is inconsistent with the right to health, as well as the derivative right to community integration, unless justified by objective and reasonable considerations, grounded in law and subject to independent scrutiny and determination”.

Although many argue that economic and social rights, including the right to health are not “legal” rights in the same sense as the first generation rights because of the lack of judicial remedies to enforce these rights, it has been shown on numerous occasions that the right to health contains some concrete and enforceable elements subject to international and national (judicial) scrutiny[120]. There have been also examples to the protection of the right to health through other rights (guaranteed by the European Convention) at the European Court. These include the right to liberty, the right to respect for private and family life[121]. This is particularly important with regard to challenging institutionalization by referring to its unacceptability under

[116] *McGinley and Egan v. the United Kingdom*, judgment of 9 June 1998, § 98.
[117] *The Right to the Highest Attainable Standard of Health, General Comment 14(2000).* UN Doc. E/C.12/2000/4.
[118] UN Doc. E/CN.4/2005/51.
[119] See: Mental Health Organization. In: Mental Health Policy and Service Guidance Project. WHO, 2003.
[120] Toebes B. *The right to health as a human right in international law.* Antwerp, 1999.
[121] *Ibid.*

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modern standards of mental care which the European Court cannot analyze since the right to health is outside the protection afforded by the Convention. However these arguments may be addressed to challenge institutionalization on the national level in the Russian courts under article 41 of the Russian Constitution (right to health) and article 12 of the Covenant which is a part of the domestic legislation according to Article 15 of the Constitution[122].

The Vienna Declaration and Programme for Action reaffirmed indivisibility, interdependence and interrelation of all human rights[123]. The right to deinstitutionalization and the right to community integration of people with mental disabilities derive from a number of fundamental human rights and freedoms and some of them require immediate implementation by the State. Therefore the Vienna Declaration further states that "while the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms"[124]. This approach to monitoring realization of the right to health has been also adopted by the UN Committee on Economic, Social and Cultural Rights.

5.5. Prohibition of discrimination

International law of human rights provides a strong basis for challenging institutionalized mental health care as being discriminatory towards people with mental health problems. Although discrimination has been repeatedly prohibited in numerous international legal instruments, it is seldom defined in legal terms. Discrimination is not defined in the recent Protocol No. 12 to the European Convention on Human Rights which will prohibit discrimination in general upon its entry into force. One of the most widely used definitions can be found in MI Principles: "any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights"[125]. A similar definition has been adopted by the Working Group on the UN Convention on the Rights of Persons with Disabilities[126].

A number of international instruments guarantee fundamental rights to be enjoyed by all citizens, without exception (UDHR, ICCPR, ICESCR). The same purpose serves general prohibition of discrimination: both the ICCPR and the ICESCR were drafted to protect people against discrimination on the basis of "race, colour, sex, language, religion, … or other status"[127], but neither covenant *specifically* recognizes that discrimination on the basis of disability is unlawful. However in 1993

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[122] Article 15 reads: "The universally recognized norms of international law and international treaties and agreements of the Russian Federation shall be a part of its legal system. If an international treaty or agreement of the Russian Federation sets forth other rules than those envisaged by law, the rules of the international agreement shall be applied".

[123] Un Doc. A/CONF.157/23, par. 5.

[124] Ibid.

[125] Principles of Protection of Persons Suffering From Mental Diseases and Improvement of Mental Health Care. UN Doc. A/46/49 (1991). At the regional level the Inter-American Convention on the Elimination of Discrimination Against Persons with Disabilities requires states parties "to adopt the legislative, social, educational, labor-related, or any other measures needed to eliminate discrimination against persons with disabilities and to promote their full integration into society." AG/RES. 1608 (XXIX-0/99), 29th Sess. of the General Assembly. http://www.cidh.org.

[126] http://www.un.org/esa/socdev/enable/rights/ahcstata7wgtext.htm

[127] Article 2 of the ICESCR, Article 26 of the ICCPR.

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the Vienna Declaration of the World Conference on Human Rights declared that "all human rights and fundamental freedoms are universal and thus unreservedly include persons with disabilities"[128].

The Constitution of the Russian Federation contains a general non-discrimination clause and guarantees equality of human rights and freedoms regardless of "sex, race, nationality, language, origin, property and official status, place of residence, religion, convictions, membership of public associations, and also of other circumstances. All forms of limitations of human rights on social, racial, national, linguistic or religious grounds shall be banned"[129].

Until recently institutionalized mental health care has not been analyzed in the context of antidiscrimination norms although "one of the most egregious forms of discrimination is the involuntary segregation of people in institutions"[130]. The UN Committee on Economic, Social and Cultural Rights acknowledged in its General Comment no. 5 that "segregation and isolation achieved through the imposition of physical and social barriers" is a "subtle" form of discrimination prohibited by Article 2(2) of the Covenant.

In 1999 the US Supreme Court adopted its famous decision in the *Olmstead v. L.C. ex rel. Zimring* case[131] which has greatly influenced subsequent legal interpretation of discriminatory nature of segregated mental health care[132]. The major findings of the Supreme Court are as follows[133]:

- The Court held that the undue segregation of individuals with mental disabilities in institutions constitutes discrimination in this case. The Court reasoned that undue institutionalization is discriminatory because it results in dissimilar treatment settings for individuals with mental disabilities vis-a-vis individuals without mental disabilities. It requires people with mental disabilities to forego life in the community and to remain confined to institutions in order to receive needed medical health treatment, unlike people without mental disabilities, who may receive medical treatment in the community. The Court considered this dissimilar treatment of institutionalized individuals in comparison to those without mental disabilities, who do not have to relinquish participation in community life to receive medical services, as illegal discrimination under the Americans with Disabilities Act.
- The Court explained that the unnecessary institutionalization of an individual with a disability constitutes dissimilar treatment or discrimination because

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[128] *Vienna Declaration and Programme of Action*, U.N. Doc. A/CONF.157/23 (1993), par. 63.
[129] Article 19.
[130] Rosenthal, E. & Sundram, C.J. The Role of International Human Rights in Domestic Mental Health Legislation. Submitted to the WHO. 2002.
[131] 527 U.S. 581 (1999)
[132] In this case the United States Supreme Court was asked to interpret the scope and coverage of the American with Disabilities Act (ADA) with regard to the permissibility of continued institutionalization. The case involved a woman, known as L.C., who was labeled with mild mental retardation and schizophrenia, and who sued the state of Georgia, claiming that the ADA protects her right to be free from discrimination in the receipt of services. She sought to receive whatever treatment she might need in the community, rather than confined in a state psychiatric hospital. Soon after her case was filed, another patient in the state institution, known as E.W., intervened to join in the case with an identical claim.
[133] The present summary is based on Rosenthal, E. & Kanter, A. The Right to Community Integration for People with Disabilities under United States and International Law. Available at www.mdri.org

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> such confinement itself perpetuates unwarranted assumptions that the individual is incapable of participating in community life. Moreover, this unnecessary confinement diminishes the individual's ability to have a social life and family relations, to receive an education, or to become economically independent through employment. Thus, undue institutionalization is discriminatory not only because it treats people with and without disabilities differently in terms of their access to mental health treatment, but also because it perpetuates negative stereotypes of people with mental disabilities as "incapable or unworthy of participating in community life," and deprives them of "everyday life activities" such as "family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment. Accordingly, the Supreme Court held that the unjustified isolation of the plaintiffs, L.C. and E.W., in state institutions constitutes prohibited discrimination under the ADA.

The Court's reasoning, that institutionalization of people with disabilities who are capable of living in the community may constitute unlawful discrimination under the Americans with Disabilities Act (ADA), may serve as a model for a similar recognition under international human rights law.

The ICESCR has also been interpreted to prohibit unnecessary segregation from society of people with disabilities. The United Nations Committee on Economic, Social and Cultural Rights has made clear that the protection against discrimination on the basis of "other status" under Article 2(2) of the ICESCR "clearly applies to discrimination on the grounds of disability"[134]. Additionally, in the context of health care, the Committee on Economic, Social and Cultural Rights has emphasized that as part of the right to access health services, the principle of non-discrimination means that "health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds"[135]. The Committee also stressed the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities[136].

Draft UN Convention the Rights of Persons with Disabilities specifically states that "discrimination shall include all forms of discrimination, including direct, **indirect** and **systemic**, and shall also include discrimination based on an actual or perceived disability"[137].

Prohibition of discrimination can be also argued with regard to other substantive rights guaranteed by the ECHR (for example, art. 14 taken together with art. 8): the provision of mental care in closed institutions is discriminatory as compared to medical care for other patients.

Although the Russian federal law "On social protection of people with disabilities" does not contain any language on discrimination, the law should be interpreted in the light of the general antidiscrimination clause of the Constitution and

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[134] *General Comment 5 to the International Convention on Economic, Social and Cultural Rights, on people with disabilities*. UN Doc. E/1995/22, par. 5.
[135] *The Right to the Highest Attainable Standard of Health, General Comment 14(2000).* UN Doc. E/C.12/2000/4 (2000), par. 12(b).
[136] *Ibid*, par. 30.
[137] http://www.un.org/esa/socdev/enable/rights/ahcstata7wgtext.htm

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international legal instruments and taking into account the aim of the law "to guarantee that people with disabilities have equal opportunities, as other citizens, in enjoying their civil, economic, political and other rights and freedoms guaranteed by the Constitution and in accordance with the generally accepted principles and norms of international law and international treaties of the Russian Federation"[138]. Accordingly social protection of the disabled is defined as a system of measures guaranteed by the State which provide the disabled with equal opportunities to participate in social life[139].

5.6. The right to be free from institutionalized mental health care?

Note on the terminology. The right to community integration used in the present paper is not a universally accepted term. Although it has not been explicitly recognized by any of the existing legal instruments the term has been recently adopted (but not defined) by the UN Special Rapporteur on the right to health[140]. Therefore we will use this term as synonymous to the right to be free from institutionalized mental health care. The scope of this right is defined below.

Although some international documents prohibit mistreatment and discrimination against people with (mental) disabilities, there is no universally recognized[141] human right to live in the community and not in an institution. The above analysis attempted to show that albeit this right is not justiciable *per se*, its certain elements can be protected by referring to classic civil rights and the right to health. Yet, this right can also be derived from other human rights principles found in international and domestic instruments[142].

According to MI Principles "every person with a mental illness shall have the right to live and work, as far as possible, in the community" (Principle 3), "the right to be treated and cared for, as far as possible, in the community" and "the right to return to the community as soon as possible" (Principle 7)[143]. Declaration on the Rights of Mentally Retarded Persons (1971)[144] states that "whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life".

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[138] *On social protection of people with disabilities*, Federal law of 24 November 1995 no. 181-FZ, Preamble. It should be noted that the law applies to those who have been officially recognized as disabled ("invalids") and issued a special certificate. The law has not been interpreted yet to include people with mental disabilities (who are still widely considered as a special group of the disabled) in designing rehabilitation services for people with disabilities.

[139] Ibid, Article 2.

[140] UN Doc. E/CN.4/2005/51, par. 83.

[141] By "universally recognized" we mean protected by a binding instrument.

[142] For a more comprehensive overview see: Quinn, G., and Degener, T. with Bruce, A., Burke, C., Castellino, J., Kenna, P., Kilkelly, U. and Quinlivan, S., (2002) Human Rights and Disability: The current use and future potential of United Nations human rights instruments in the context of disability. http://www.unhchr.ch/disability/hrstudy.htm; Gostin, L.O., Gable, L. Gostin, L.O., Gable, L. The human rights of persons with mental disabilities: a global perspective on the application of human rights principles to mental health. 63 Md. L. Rev. 20.

[143] See among others: UN Declaration of the Rights of Disabled Persons, UN Doc. A/10034 (1975); MR Declaration.

[144] UN Doc. A/8429 (1971).

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The Vienna Declaration of the World Conference on Human Rights reaffirmed that “persons with disabilities should be guaranteed equal opportunity through the elimination of all socially determined barriers, be they physical, financial, social or psychological, which exclude or restrict full participation in society”[145].

Additionally the Standard Rules on Equalization of Opportunities for Persons with Disabilities (1993) also guarantee the right to community integration[146]. As the Preamble to the Standard Rules states, "intensified efforts are needed to achieve the full and equal enjoyment of human rights and participation in society by persons with disabilities." The Standard Rules apply to all people with mental or physical disabilities, and recognize the right to community-based services to make such integration possible.

The UN Convention on the Rights of the Child[147] recognizes in Article 23 that “a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community”. It further states that “assistance to a disabled child shall be provided free of charge” and shall be designed “to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development”.

According to General Comment 5 to the International Convention on Economic, Social and Cultural Rights[148] on persons with disabilities (1994) the right to physical and mental health implies the right to have access to, and benefit from, those medical and social services which enable persons with disabilities to become independent, prevent further disabilities and support their social integration. In the Committee’s view institutionalization of persons with disabilities, unless rendered necessary for other reasons, cannot be regarded as an adequate substitute for the social security and income-support rights of such persons[149].

Other principles related to the right to community integration (and which can be considered as reinforcing the meaning of this right) include the right to individualized treatment (MI Principles 8[150] and 9); the right to rehabilitation and treatment that enhances autonomy (MI Principle 9(4)); the right to the least restrictive treatment (MI Principle 9(1); Recommendation R(2004)10[151], Article 8) and the right to refuse treatment (MI Principle 11).

In 2001 the United Nations General Assembly adopted a resolution calling for the creation of an Ad Hoc Committee “to consider proposals for a comprehensive and integral international convention to promote and protect the rights and dignity of

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[145] Vienna Declaration and Programme of Action, UN Doc. A/CONF.157/23 (1993), par 63.
[146] Standard Rules on the Equalization of Opportunities for Persons with Disabilities, UN Doc. A/Res/48/49 (1993).
[147] UN Doc. A/44/49 (1989). As of today the CRC is the only binding international document which explicitly recognizes the right to community integration.
[148] UN Doc. E/1995/22, par. 34.
[149] Ibid, par. 29.
[150] Right to receive social and health care which is appropriate to his or her health needs.
[151] Council of Europe Recommendation of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder. Rec(2004)10 of 22 September 2004. See also Explanatory Memorandum, par. 63-68.

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persons with disabilities"[152]. The draft articles of the Convention provide a useful example of formulating the scope of the right to social integration in legal terms[153]:

1. States Parties to this Convention shall take effective and appropriate measures to enable persons with disabilities to live independently and be fully included in the community, including by ensuring that:

- *(a) persons with disabilities have the equal opportunity to choose their place of residence and living arrangements;*
- *(b) persons with disabilities are not obliged to live in an institution or in a particular living arrangement*
- *(c) that 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;*
- *(d) community services for the general population are available on an equal basis to persons with disabilities and are responsive to their needs;*
- *(e) persons with disabilities have access to information about available support services;*

2. States Parties shall also take appropriate measures to promote the provision of life assistance in order to enable persons with disabilities to live independently.

Although many of the cited documents are international soft law[154] and not binding they reflect general approach to policies towards people with mental disabilities which the governments are encouraged to implement on the national level. These instruments can also provide guidelines to interpretation of the states obligations under the existing legally binding international treaties to which they are parties[155]. Since most of the binding instruments (like for example ICESCR or CRC) have no judicial (like ECHR) or quasijudicial (like Committee on Human Rights for ICCPR) no jurisprudence is available which could prove applicability of the said "soft law" standards to interpretation of legally binding rights contained in these treaties. "United Nations human rights treaty bodies have considerable potential in this field but have generally been underused so far in advancing the rights of persons with disabilities"[156].

Obviously, the right to participate in the community life (social integration) requires that the state not just refrain from placing disabled people in the institutions but imposes a positive obligation on the state to help the disabled people to realize this right by providing services alternative to institutional and suitable for the disabled to ensure social integration. The existing Russian legislation has a great potential in advocating for realization of this right. According to the Russian law on Social Protection of People with Disabilities in the Russian Federation (1995)[157], the aim of rehabilitation provided by the State to the disabled is "recovery of the social status of a disabled person, achievement of his economic independence and his social adaptation" (Article 9). Further the Law on Psychiatric Care explicitly states that all persons with mental disorders shall have the right to:

- psychiatric care under the last restrictive conditions, if possible close to their place of residence;

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[152] UN Doc. A/56/583/Add.2 (2001).
[153] http://www.un.org/esa/socdev/enable/
[154] Soft law means non-binding international acts of a recommendatory nature.
[155] See: Malanczuk, P. Modern introduction to international law. 7th ed. London, 1997. pp. 54-55.
[156] Human Rights are for All: A Study on the Current Use and Future Potential of the United Nations Human Rights Instruments in the Context of Disability, UN Doc E/CN.4/2002/18/Add.1, 12 February 2002.
[157] Federal Law on Social Protection of People with Disabilities in the Russian Federation of 24 November 1995 No. 181-FZ.

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- hospitalization only for the period essential for diagnosis and treatment[158].

The argument which the State often relies on when denying community services is their prohibitive costs. Although the issue of cost-benefit is quite complicated, there have been successful examples of using judicial remedies in defending positive rights of the disabled under the existing laws in Russia[159]. This concept is still very recent for Russian authorities and the courts are reluctant to issue orders requiring the State to implement the existing provisions of anti-discriminatory laws.

What is even more important is the nature of cost-prohibitive arguments. As noted by Eric Rosenthal "such a defense, based on cost factors alone, seems highly inappropriate given the liberty interests at stake. The potential for abuse and the lack of rights afforded people confined in institutions is a human rights issue, and cannot and should not be relegated to a cost-benefit analysis". As the 2004 report on community-based care in 25 EU states concluded, it is not acceptable to violate fundamental human rights of citizens because of budgetary considerations, and many studies have also demonstrated that the financial argument for institutions is of very limited validity[160]. However, the quality of life offered by community-based services tends to be much better.

Although the states are free to choose specific methods for implementation of the right to community integration and other related rights discussed above, such measures should guarantee progressive implementation of community-based alternatives to segregated care according to the to the formula of "maximum of available resources with a view to achieving progressively the full realization" of such rights recognized in international and domestic law.

In 2003 Parliamentary Assembly of the Council of Europe noted with satisfaction that "in certain member states policies concerning people with disabilities have been gradually evolving over the past decade from an institutional approach, considering people with disabilities as "patients", to a more holistic approach, viewing them as "citizens" who have a right to individual support and self-determination"[161].

6. Deinstitutionalization: experience of other countries

The present section attempts to provide some background for mental health care reforms processes focused on deinstitutionalization in foreign countries with the aim of giving an example of radical policy decisions. Although evaluating mental health reforms is difficult because they are driven by broad social, cultural and scientific trends in a particular national context, but with countries of the European region moving closer together and sharing the same values, such an evaluation can have practical policy-related outcomes for Russia and other newly independent states. It is beyond the scope of this study to give an exhaustive overview of the

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[158] Article 5.

[159] For example, in a recent case a family who had a child with intellectual disabilities successfully brought a claim before a Russian court challenging local administration failure to provide her with an integrated kindergarten for her child. The court obliged the State to set up the required services.

[160] Included in Society (2004). Results and Recommendations of the European Research Initiative on Community-Based Residential Alternatives for Disabled People. P. 16.

[161] Towards full social inclusion of people with disabilities. Council of Europe Parliamentary assembly Recommendation 1592 (2003)161.

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deinstitutionalization successes or shortcomings from a policy perspective[162]. Our goal is to demonstrate that the demand for deinstitutionalization in Russia finds its strong basis not only in the human rights law but is strongly supported by other countries' experience.

The last twenty years has seen an explosion of progressive mental health policy statements in a number of jurisdictions. Canada has published four such policy documents and each policy document has taken an approach to shifting the mental health system paradigm from an institutional system to a community focused system that promises consumers and their families a home, a job and a friend as well as access to treatment services as close to home as possible[163]. The UK, Australia and New Zealand have published similar national policy documents and set national standards to measure system performance. The recent report of the President's New Freedom Commission (2003) indicts US state mental health service systems (many of which have been handed off to behavioral health companies) and proposes major reforms to ensure that the mentally ill and their families have good access to community-based recovery focused services and supports[164].

6.1. The case of Italy

In 1978, the Italian Parliament passed the law, which prohibited first admissions to mental hospitals after May 1978 and all admissions after December 1981. The law required a comprehensive and integrated system of community psychiatric care be instituted, which included psychiatric units of up to 15 beds in general hospitals and community mental health centers to provide ambulatory psychiatric care to geographically defined areas. Consistent with other locations, the number of residents in the public mental hospital declined form 179 per 100,000 in 1965 to 44 per 100,000 in 1987[165].

In spite of the decline in residential census of psychiatric patients, the application of the law has varied enormously from region to region because implementation of new services was locally determined. In some progressive communities, such as Trieste and Arrezzo, community mental health services were fully implemented, and an aggressive approach resulted in the discharge of long-stay patients from the psychiatric hospital. In Trieste, most patients were discharged to group homes including one for the severely disabled. In South Verona, a more gradual process of deinstitutionalization has occurred. Community services were set up in response to the law requiring no new admissions, however, less emphasis was placed on discharging long-stay patients who were in psychiatric hospital. The long-stay population has declined gradually mainly from the death of aging patients. In contrast to these regions, other communities throughout Italy were slow to establish

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[162] For more information see: Rothbard, A.B. & Kuno, E. The Success of Deinstitutionalization. Empirical Findings from Case Studies on State Hospital Closures. International Journal of Law and Psychiatry, Vol. 23, No. 3–4, pp. 329–344, 2000; Krieg, R.G. An interdisciplinary look at the deinstitutionalization of the mentally ill. Social Science Journal 38 (2001) 367–380; Emerson, E. Deinstitutionalization in England. Journal of Intellectual and Developmental Disability. Vol. 29, No. 1, pp. 79-84, March 2004; Pijl, Y. J., Sytema S. The effect of deinstitutionalization on the longitudinal continuity of mental health care in the Netherlands Soc Psychiatry Psychiatr Epidemiol (2004) 39: 244–248.

[163] See: www.phac-aspc.gc.ca/mh-sm/mentalhealth/problems.htm

[164] See: www.mentalhealthcommission.gov

[165] Giannichedda, M.G. Evaluation of the Mental Health Law Reform in Italy: Lessons Learned. 2nd WHO International Meeting of Faculty Mental Health, Human Rights and Legislation. Geneva, 2003.

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community psychiatric services and continue to admit patients to psychiatric hospitals, renamed rehabilitation centers.

A significant feature of communities that have genuinely implemented the law was their ability to treat patients without the backup of long-stay hospital beds. Since the psychiatric reform in 1978, there was negligible build up of new long-stay patients, indicated by only 1 or 2 patients became long-stay over a 3-year follow-up period.

6.2. The case of the United Kingdom[166]

The UK began an aggressive program of psychiatric hospital closure in the 1990's following the policy measures in the 1970's focused on moving funds from the health service (responsible for institutions) to local government. The key policy decisions during this period (1980's – 1990's) included[167]:

- Governmental committee recommended housing-based services as the main future model of care and several reports outlined the necessary elements of community services;
- Following these decisions a national demonstration project was launched. It showed government's acceptance of the policy goal of deinstitutionalization and gave many local service agencies experience of the work involved;
- The first large-scale institutional closures happened in the second half of the 1980's and deinstitutionalization became tacitly accepted as a general policy goal;
- Concerns about the rapidly increasing number of old people entering residential care funded by social security, and evidence that there was considerable inefficiency, led to a major legislative reform aimed to close the social security funding and to impose on local authorities, the responsibility for funding residential care;
- In future, hospital care was to be almost solely concerned with short-term treatment. A further innovation was the requirement that, in future, most residential services purchased by local authorities were to be run by private sector or voluntary organizations.

By 2000 British Government closed 90 of its 120 psychiatric hospitals and moved the bulk of its long stay psychiatric patients to group homes and community care[168]. In 1999 the government published a National Service Framework to guide its investment of 700 million pounds to improve mental health services[169]. The National Service Framework caps a decade of activity which successfully transferred long stay patients to community settings, but has yet to resolve the care of revolving-door or "new long stay" patients. There has been an expansion of community treatment teams since 1985. On the legislative front, there is continuing debate on amending legislation to more easily commit patients to hospitals and community treatment.

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[166] For a detailed analysis see: Rogers, A. & Pilgrim, D. Mental Health Policy in Britain. 2nd ed. 2001; Sayce, L. From Psychiatric Patient to a Citizen: Overcoming Discrimination and Social Exclusion. 2000.

[167] Summary by Camilla Parker. In: Included in Society (2004). Results and Recommendations of the European Research Initiative on Community-Based Residential Alternatives for Disabled People.

[168] Rogers, A. & Pilgrim, D. Mental Health Policy in Britain. 2nd ed. 2001. P. 174.

[169] National service framework for mental health: modern standards and service models, http://www.dh.gov.uk/assetRoot/04/07/72/09/04077209.pdf.

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Despite the policy advances and achievements shifting care to the community, mental health services in the UK are getting mixed reviews. The Commission for Health Improvement recently reviewed the performance of mental health trusts, the CHI chief executive said, "Mental health services have historically been given low priority. Unfortunately, despite evident progress, mental health is still the poor relation of the NHS"[170]. Still, the British experience serves as an excellent example of a thoroughly planned and consistent policy driven by the understanding of unacceptability of institutional care by the national government.

6.3. The case of the United States

Between 1960 and 1980 the United States closed the bulk of their state hospital beds and turned their policy attention to the development of community support systems. During the 1970's the National Institute of Mental Health developed a community support system model, which proposed providing a basket of comprehensive, flexible and individualized support services to people with serious and persistent mental illness[171]. During the 1980's and 90's the US government and its agencies provided block grants and demonstration project funding to states and local communities to implement "wrap around" services such as intensive case management, supportive housing, or assertive community treatment teams. During the Carter administration, (1976-80) legislation that focused on the provision of community support services to the seriously mentally ill was drafted but not passed.

In 2003 the President's New Freedom Commission presented its report which called for a radical transformation of mental health services, because their review found major problems across the country[172]. The report found system problems including: stigma, limitations due to private insurance and fragmented service delivery. The Commission recommended a transformed system to promote recovery and "replace unnecessary institutional care with efficient, effective community services that people can count on"

The Commission report is an ambitious attempt to shift the mental health care paradigm to a recovery focus that is responsive to the needs of consumers and families. However the federal government and many state governments are experiencing fiscal deficits. It therefore appears unlikely that funding to implement the Commission's strategies will materialize any time soon.

Additionally, on June 19, 2001, President Bush issued an Executive Order supporting swift implementation of the *Olmstead* decision[173]. The order requires the Attorney General and Secretaries of Health and Human Services, Education, Labor, and Housing and Urban Development to help states and localities assess their compliance with the *Olmstead* decision, provide technical guidance, work cooperatively with states to achieve the goals of American with Disabilities Act, and ensure that federal resources are used in the most effective manner to support the goals of the Act. These federal officials must also evaluate the policies, programs, statutes, and regulations of their respective agencies to determine whether any modifications are required to improve the availability of community-based services for qualified individuals with disabilities[174].

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[170] Commission For Health Improvement, 2003
[171] www.nimh.nih.gov
[172] New Freedom Commission: www.mentalhealthcommission.gov.
[173] The text of the order is available at www.whitehouse.gov/news/releases/2001/06/20010619.html
[174] *Ibid.*

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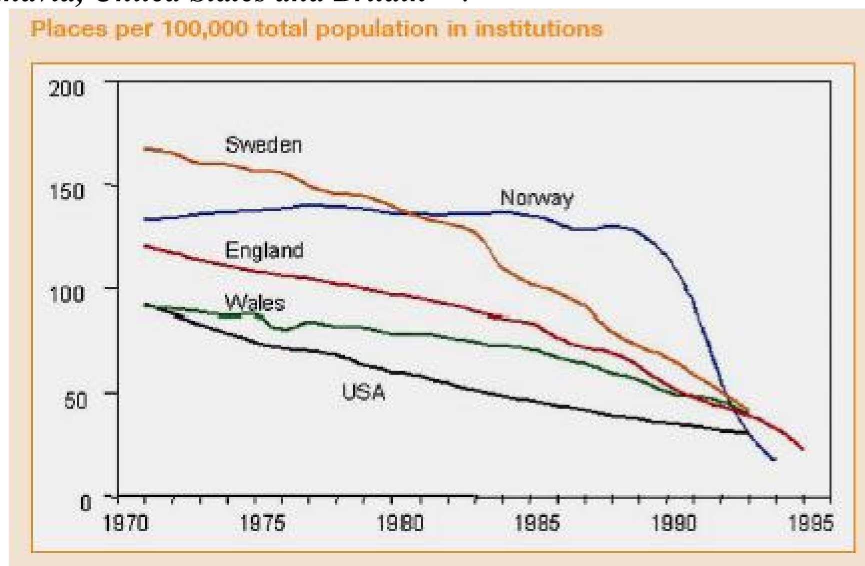
The *Olmstead* decision's recognition of the right to receive services in integrated settings continues to have far-reaching effects. In addition to the litigation that has occurred to enforce the integration mandate and the steps taken by the executive branch of government to promote its implementation, the vast majority of states have undertaken efforts to promote community integration of individuals with disabilities. The progress of those efforts, however, has been remarkably slow. Nine years after the integration mandate of the Americans with Disabilities Act became binding law for public entities, states are largely engaged in the preliminary stages of a planning process to reduce unnecessary institutionalization of individuals with disabilities.

The following chart illustrates progress and pace of deinstitutionalization in Scandinavia, United States and Britain[175]:



6.4. Central and Eastern European countries: general remarks

- Transition involved significant changes not only in these countries' socio-political and administrative organization but also in the structure of health services. The process of transforming psychiatric care in CEE countries, therefore, must be interpreted in the context of these changes.
- Fiscal problems greatly influence the process as, for example effective psychotropic medications and psychosocial interventions are not freely available in many regions.

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[175] Included in Society (2004), p. 15. In the United States the picture is of steady substantial decline over the whole period, slightly less steep in the later years. In Sweden, England and Wales the decline during the 1970s increases during the 1980s and 1990s. In Norway the onset of deinstitutionalization is much later, although this is in due to the fact that many of the institutions were small and would be called group homes in other countries. The different rates of institutional provision across the different countries must be interpreted with caution, since they may to some extent reflect a different balance between types of service rather than different overall levels of provision of residential care. Nevertheless, it is plausible that Sweden and Norway, with a long tradition of investment in public services, should provide the most services, and that England and Wales, where institutional care is provided through a National Health Service, should also provide more services than the United States, with its commitment to free enterprise and its caution about public services.

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- The legislative framework concerning community-based support services in the CEE countries is usually very general and not directed specifically to the persons with mental health problems.
- The current legislative framework and state policies in the sphere of community-based services are declarative. The main or even the sole role in establishing facilities alternative to institutions (especially group homes and daily activity centers), is played by disability NGOs (especially in Lithuania, Poland, Slovenia) funded by private donors.
- Although this is a very expensive task to carry out and the financial assistance of the state is rather limited and unstable.
- As a result the majority of mentally ill and intellectually disabled people still live with their families or in institutions.

6.5. The case of Russia

Reforms of the mental health care system in Russia since the breakdown of the USSR have paid little attention to its deinstitutionalization and development community-based alternatives. Mental health statistics is self-evident: although a number of psychiatric beds slightly decreased during the past years, a number of mental hospitals increased in 2003[176], more than 50% of them have over 1000 beds. The structure of services does not allow for any community-based services alternative to the existing system of outpatient mental services in psycho-neurological dispensaries which bear a lot of stigma[177].

In 2002 the Government adopted a new program for reorganization of mental health care in Russia for the period of 2003-2008[178]. Although the program lists among its goals decentralization of inpatient and outpatient mental health care and development of the network of outpatient services[179], its main focus is on geographical reorganization. The program does not provide basis for development of any alternative forms of care (community-based services) and relies on the existing models of outpatient care through dispensaries and day-hospitals at these dispensaries. This policy document indicates no commitment of the Russian government to support non-state forms of care. No attention has been given to human rights standards in psychiatry. One of the few positive objectives is continued integration of mental health services into general medicine.

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[176] For a detailed overview of mental health statistics in Russia see Appendix 1.

[177] See: Poloshij, B. & Saposhnikova, I. Psychiatric reform in Russia. Acta Psyciatr Scand 2001: 104 (Suppl. 410): 56-52

[178] Program of Reorganization of Mental Health Care in the Russian Federation in 2003-2008. Approved by the Ministry of Health Order No. 98 of 27 March 2002.

[179] It should be emphasized that community-based services are not equivalent to outpatient services. For instance, there are 13 outpatient psychiatric clinics St. Petersburg (population over 6 million), known as "psycho-neurological dispensaries" or PNDs - outpatient clinics for people with mental or intellectual disabilities. Although these services are outpatient they can hardly be considered community-based as they are structurally distinct from general health care services (known as "policlinics"), not covered by public health insurance programs and bear a lot of stigma. In many cases such dispensaries are structurally a part of a large inpatient institution and conceptually not different from mental hospitals. Also in the majority of regions such outpatient services cover large areas and large numbers of population which does not promote the idea of receiving mental health care in the community. For example, PND no. 2 in St. Petersburg covers two large City districts with the total population about 700,000.

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6.6. The case of Slovenia

The best situation among CEE countries is in Slovenia, where the Government since 1999 has started to encourage new forms of community-based support services for intellectually and mentally disabled people to be developed by different contractors as part of a framework of public services[180]. The new policy includes:

- Moratorium on new admission to psychiatric hospitals
- No extra funding available for mental hospitals
- Rent apartments for mental health users

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To sum up, the philosophy of psychiatric reform in European countries has implicitly or explicitly been based upon some key principles of community psychiatry and incorporated actions along the following trends[181]:

a) the deinstitutionalization process and closure of the old mental hospitals;
b) the development of alternative community services and programs;
c) integration with health services; and
d) integration with social and community services.

Although deinstitutionalization has not necessarily been followed by an adequate provision of alternative community-based resources in developed countries this again stresses the need for adequate planning but does not invalidate the concept of deinstitutionalization itself.

7. Summary of the research findings

Deinstitutionalization and human rights standards

1. There has been a clear international trend in western (and recently some CEE) countries to move from institutionalized mental health care to community-based services. This approach is based on scientific researches and is strongly supported by World Health Organization. Deinstitutionalization is explicitly included into governmental mental health policy statements in a number of states. The human rights paradigm for moving from institutionalized mental health care has been receiving a growing attention by various judicial and quasijudicial bodies in Europe and North America which offers a considerable potential for advocating deinstitutionalization in Russia and other CEE countries in transition.

2. Most of the arguments against deinstitutionalization are not aimed at its concept but rather refer to the shortcomings in its implementation. Therefore it is wrong to equate deinstitutionalization and psychiatric reform with closure of psychiatric hospitals without admitting that there are some positive measures that must be taken in order to achieve effective right to community integration.

3. While it is true that the right to be free from institutionalized mental health care as a human right has yet to be recognized explicitly under general

[180] Svab V, Tomori M. Mental health services in Slovenia. Int J Soc Psychiatry.2002 Sep;48(3):177-88.
[181] Becker, T., Vazquez-Barquero, J.L. The European perspective of psychiatric reform. Acta Psyciatr Scand 2001: 104 (Suppl. 410): 8-14.

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international human rights covenants, this right has gained some recognition over the past 20 years in various human rights documents. The «right to deinstitutionalization» can be claimed by referring to a number of universally accepted and interrelated fundamental human rights including the right to liberty and personal security, the right to be free from inhuman and degrading treatment, the right to private and family life, the right to health and prohibition of discrimination.

4. Certain elements of the right to be free from an institutionalized mental care can be subject to judicial scrutiny under the existing international and Russian norms.
5. The present study concluded that there is an emerging positive right to community integration understood as the right of a mentally disable person to be able to participate in the community life to the maximum extent possible, equally with other citizens which naturally implies living in the community.
6. Segregated mental health care in large institutions has been shown to be in violation of many fundamental rights recognized in international and Russian law.
7. Although the states are free to choose specific methods for implementation of the right to community integration and other related rights, such measures should guarantee progressive implementation of community-based alternatives to segregated care according to the to the formula of "fullest possible extent". Moreover, fundamental human rights of people with mental disabilities must not be violated because of budgetary considerations, especially when a number of studies demonstrated that the financial argument for institutions are not always valid and the quality of life offered by community-based services is much better.
8. Russian legislation and international human rights instruments adopted by Russia offer a strong basis for challenging institutionalized mental health care. However, this potential will unlikely be effectively used due to the lack of strong advocacy groups in the field of mental health and human rights. Russian policymakers have been reluctant to pursue changes to mental health policy without a pressure to modify the existing policies to comply with law. Therefore, there is need for more specific legislative measures to advance mental health policies aimed at creation of community-based care. Specific legislation can reinforce the existing policy goals and objectives included into the 2005 Mental Health Declaration for Europe (signed by Russia) and Program of Reorganization of Mental Health Care in the Russian Federation in 2003-2008.

Major obstacles to deinstitutionalization and community-based mental health care in Russia:

- Mental health policies aimed at shifting towards community-based care have not been given due attention by the Russian law and policymakers. There is a lack of awareness of the need of reforms among policymakers.
- Organization of mental health services in Russia offers a limited range of services (hospital or dispensary care and internats) and does not allow for a broader spectrum of services.

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- There is a strong organizational pressure to maintain large residential institutions.
- Absence of social welfare infrastructure
- Absence of a legislative framework
- Financial incentives for local governments to place individuals in residential institutions funded by federal or regional government. Fudging is based on the size of institutions and does not follow the clients as in other countries. All social care funding goes to support *internats*.
- No effective evaluation methods are used to assess quality of mental health services in Russia.
- The lack of effective human rights monitoring and enforceable legal protections which permits abuses to go on unchecked. (Due process protections)
- Insufficient development of nongovernmental initiatives in mental health sector and very little debate on issues of mental disabilities and human rights among civil society.
- Public opinion supportive of discrimination and stigmatization of people with mental disabilities.
- Insufficient qualifications of mental health professionals regarding human rights paradigm in mental health care.
- Human rights of people with mental disabilities have been understood primarily as social and economic rights, fundamental rights and freedoms have been neglected.

8. Policy recommendations: initial steps towards a comprehensive strategy of deinstitutionalization[182]

General recommendations to the Russian Government regarding provision of mental health care

1. Promote culture of respect for human rights values in mental health care at all the levels: policymakers, mental health administrators, care providers, mental health professionals. A greater emphasis must be placed on equality of rights and the right to social inclusion.
2. Establishing community-based services should be regarded as a priority in mental health care. A comprehensive action plan should be developed to promote deinstitutionalization of mental health care.
3. Set up effective procedures for monitoring human rights and quality assessment in mental health care.

Recommendations regarding implementation of the existing mental health and human rights legislation

[182] For a more detailed analysis see: Mental Health Organization. In: Mental Health Policy and Service Guidance Package. WHO, 2003; Moving from Residential Institutions to Community-Based Social Services in Central and Eastern Europe and the Former Soviet Union. The World Bank. Washington, D.C. 2000; Included in Society (2004). Results and Recommendations of the European Research Initiative on Community-Based Residential Alternatives for Disabled People.

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1. Take concrete steps in order to guarantee observance of most basic rights enshrined in the law in the existing institutions, including:
   - the right to respectful treatment which is not inhuman or degrading (Article 5(2) of Law on Psychiatric Care);
   - the right to information, including information on mental health services (Article 5(2) of Law on Psychiatric Care);
   - the right to be treated in settings which meet sanitary-hygienic standards (Article 5(2) of Law on Psychiatric Care);
   - the right to privacy (Article 5 of Law on Psychiatric Care);
   - the right to confidentiality of medical information (Articles 8 and 9 of Law on Psychiatric Care)
   - the right to individualized treatment and care (Article 5 of Law on Psychiatric Care)

2. Establish an independent advocacy service in accordance with Article 38 of Law on Psychiatric Care. This service should be financially supported by the state, but function independently of any state organs or mental health institutions. It should be able to receive patients' and users' complaints freely and communicate them to administration or law enforcement bodies. This will help governmental and non-governmental structures to monitor human rights violations within institutions.

3. Stop establishing new large mental health institutions and consider gradual downsizing the existing ones.

4. Support development of community initiatives in mental health care (peer support groups, users' organizations, family organizations, and other NGOs) by providing funding, logistical and informational support and required training. Governmental investment in these initiatives will help to establish committed and cost-effective partners who can assist in the future development of effective, culturally appropriate, and sustainable programs.

5. Take concrete steps to implement the Program of Reorganization of Mental Health Care in the Russian Federation in 2003-2008 according to its principles of decentralization, integration of mental health services into general medicine and replacing in-patient services with outpatient services where appropriate.

6. According to this Program as well as to recently-pledged promises (WHO 2005 Mental Health Declaration for Europe signed by the Russian Government) the Government must take concrete steps to move from institutionalized mental care towards community-based forms of care to implement the right to be treated in the least restrictive settings (Article 5 of Law on Psychiatric Care):
   a. Develop a step-by-step comprehensive program of replacing large institutions with community-based / out-patient alternatives according to the Program of Reorganization of Mental Health Care in the Russian Federation in 2003-2008.
   b. Allocate adequate funding for in-patient and out-patient services. The existing system of mental health financing fails to provide finances guaranteeing minimal human rights standards. Funding should be

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based on up-to-date assessment of patients' needs in mental hospitals, taking into account WHO guidelines. The system of financing should also be person-centred rather than institution-centred; funding hospitals or social care homes according to the number of residents provides disincentives for deinstitutionalization. Money should follow individuals' choice of treatment, so that community-based service providers can also be funded on this basis.

c. Re-investment in existing large mental health institutions should be avoided as much as possible with the view of gradually moving towards small-scale units.
d. Promote non-governmental forms of social and psychiatric care especially in the out-patient sector. Consider creating community-based social service programs as pilot projects, which will in turn reduce the flow of individuals entering institutions.
e. Clarify discharge procedures. The current discharge system does not take into account the best interests of the person concerned.

Recommendations regarding improvement of existing legislation

1. Strengthen individual's position in the mental health care by offering individualized care or treatment solutions based on the respect for the choices of the persons receiving services (by means of allowing more flexibility in developing individual rehabilitation plans funded by the State which people with disabilities are entitled to).
2. Reconsider the existing financing schemes: state-funded rehabilitation programs must not be limited exclusively to those offered by the State providers and funding must be used as an incentive for development of quality services.
3. Reconsider the existing system of quality assurance: a system for monitoring quality of mental health services must take into account feedback of the care users and their relatives.
4. Simplify procedures for establishing services alternative to institutional care (for instance, sanitary legislation to allow small-scale establishments).
5. Set up clear procedures for approval of NGO monitoring of human rights in mental health and social care institutions in accordance with Article 46 of Law on Psychiatric Care. These procedures should be transparent and enforced by the authorities.
6. Strengthen guardianship legislation. Under international and national law, people with mental disabilities have the same rights as other citizens. Thus, guardianship should be limited to those activities for which an individual is found to be incapacitated. In other words, the government should create a system whereby partial guardianship can be designated by the courts. Persons could then exercise their rights according to the extent of their ability. These changes would entail:
   - Avoidance of total incapacitation.
   - Designating guardianship in a tailored and flexible fashion
   - Using guardianship only as a last resort
   - Developing alternatives to guardianship such as those developed in Sweden, Canada, and the United States. In Sweden, a special representative or trustee may be designated, who has fewer rights than a

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guardian. In Canada, there is an umbrella tool that includes various ways of planning ahead and anticipating needs without resorting to guardianship, while in the United States, the court has the possibility to grant the guardian only the powers necessary to provide for demonstrated needs.

7. Strengthen the existing legislation regarding the right to court review of involuntary placement in accordance with European Court of Human Rights standards.

Recommendations regarding mental health and social care policies

1. Revise requirements for continued education for mental health professionals to include a human rights approach to mental health care, incapacity issues, up-to-date diagnostic systems (ICD-10) and the use of psychotherapy.
2. Establish effective transparent systems of controlling funds in social care homes (internats).
3. Support anti-stigma/public awareness campaigns.

Key principles of community-based mental health services:

- CBS must be provided in the familiar environment, close to where the users live and where they have families and friends.
- CBS should promote an individual's independence and help to develop his or her potential.
- CBS should offer a broad range of services to recognize individual needs of different users.
- Funding for CBS should not be limited to state providers and must be available to non-governmental actors.

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10. Mental health statistics in Russia[183] (population of 140 million)

Outpatient mental health services:
- 171 outpatient psychiatric clinics or “psycho-neurological dispensaries”
- 2271 psycho-neurological rooms (outpatient units) in rural areas
- 4 psycho-endocrinological rooms
- 1117 psychotherapeutic rooms (decreased in comparison with 2001 and 2002)

Hospital mental health services (387 mental hospitals in total):
- 277 mental hospitals (increased at 1 in comparison with 2002)
- More than 50% of hospitals have over 1000 beds
- 110 inpatient departments at outpatient psychiatric clinics (increased at 1 in comparison with 2002)

Specialized social care facilities:
- Psycho-neurological hostels (“internats”) 124,600 beds in 442 hostels

Number of mental health professionals:
- 14439 psychiatrists (decreased at 0.2% in comparison with 2002) or 1.01 per 10,000 of population
- 1939 psychotherapists or 0.14 per 10,000 of population

Psychiatric beds:
- 164,752 beds in total (decreased at 1442 or 0.9% in comparison with 2002) or 11.6 per 10,000 of population
- Day-hospital services – very few – 15,287 places in total
- 672,000 psychiatric hospitalizations in 2003, or 471.6 per 100,000 (increased at 0.4% in comparison with 2002)
- Average duration of hospital stay – 75.4 days
- Number of patients who stay over 1 year – 21.4% (21.2% in 2002; 20.7% in 2001)

People with certified disabilities because of mental illness:
- 934,200 (increased at 2,9% in comparison with 2002) or 655.7 per 100,000

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