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**Promotion and protection of all human rights, civil,  
political, economic, social and cultural rights,  
including the right to development**

## **Rights of persons with disabilities**

### **Report of the Special Rapporteur on the rights of persons with disabilities**

#### *Summary*

In her report, the Special Rapporteur on the rights of persons with disabilities provides an overview of the activities undertaken in 2018 and a thematic study on disability-specific forms of deprivation of liberty, in the light of the standards set forth in the Convention on the Rights of Persons with Disabilities. The report reviews disability-specific forms of detention, their underlying causes and adverse consequences, and proposes alternative rights-based models. The report contains recommendations to assist States to develop and implement reforms to end deprivation of liberty based on disability. These include the abolition of laws and regulations allowing for deprivation of liberty on the basis of disability, the implementation of deinstitutionalization policies, and the conduct of awareness-raising campaigns.



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## I. Introduction

1. The Special Rapporteur on the rights of persons with disabilities, Catalina Devandas-Aguilar, submits the present report to the Human Rights Council pursuant to resolution 35/6. It contains a description of the activities she carried out in 2018 and a thematic study on disability-specific forms of deprivation of liberty. The study aims to provide guidance to States on how to guarantee the right to liberty and security of persons with disabilities, paying particular attention to the process of ending deprivation of liberty based on impairment.
2. In preparing the study, the Special Rapporteur commissioned two studies<sup>1</sup> and analysed the responses to a questionnaire sent to Member States, national human rights institutions, agencies of the United Nations system, civil society organizations and persons with disabilities and their representative organizations. She received 40 responses.<sup>2</sup>

## II. Activities of the Special Rapporteur

### A. Country visits

3. In 2018, the Special Rapporteur visited Kuwait from 26 November to 5 December (report to be presented at the forty-third session of the Council). She thanks the Government of Kuwait for its cooperation prior to, during and after the visit.
4. The Special Rapporteur has agreed to undertake visits to Botswana, Canada, China and Norway. The Special Rapporteur has requested invitations to visit Benin, Cambodia, El Salvador and Viet Nam, and notes with appreciation the invitations to visit Algeria, Egypt, and the United Arab Emirates.

### B. Engagement with stakeholders

5. During the year, the Special Rapporteur participated in numerous conferences and expert meetings, including the fifty-sixth session of the Commission for Social Development; the annual interactive debate on the rights of persons with disabilities at the Human Rights Council; the European expert and stakeholder meeting to provide inputs for the ninth session of the Open-ended Working Group on Ageing; the Human Rights Council's consultation on human rights and mental health; and the eleventh session of the Conference of States Parties to the Convention on the Rights of Persons with Disabilities. She also co-organized expert consultations on the right to health, the role of notaries and the role of the judiciary in the implementation of the Convention jointly with other United Nations experts, agencies, international civil society organizations, organizations of persons with disabilities and academia.
6. She continued actively promoting a system-wide approach to include the rights of persons with disabilities across the United Nations system, in coordination with the Executive Office of the Secretary-General and the Inter-Agency Support Group on the Convention on the Rights of Persons with Disabilities. As part of this effort, she conducted a baseline study that will serve as the basis for the design of the United Nations system-wide approach to disability inclusion.
7. As mandated by the General Assembly, she engaged with the United Nations Statistical Division, the Inter-Agency and Expert Group on Sustainable Development Goal

<sup>1</sup> P. Gooding and others, *Alternatives to Coercion in Mental Health Settings: A Literature Review* (University of Melbourne, 2018); and M. Gómez-Carrillo, E. Flynn and M. Pinilla, *Global Study on Disability-Specific Forms of Deprivation of liberty* (National University of Ireland Galway, forthcoming).

<sup>2</sup> See [www.ohchr.org/EN/Issues/Disability/SRDIsabilities/Pages/LibertyAndSecurity.aspx](http://www.ohchr.org/EN/Issues/Disability/SRDIsabilities/Pages/LibertyAndSecurity.aspx).

Indicators and several United Nations agencies to advocate for the collection and disaggregation of data on persons with disabilities.

8. On 6 March, the Special Rapporteur presented her annual report to the Human Rights Council on legal capacity and supported decision-making (A/HRC/37/56). On 22 October, she presented her annual report to the General Assembly on the right to health of persons with disabilities (A/73/161). Both reports are available in accessible formats.<sup>3</sup>

9. The Special Rapporteur continued to collaborate closely with the special procedures system, with treaty bodies and with other United Nations experts and agencies, including the International Labour Organization, the Office of the United Nations High Commissioner for Human Rights, the United Nations Population Fund, the World Health Organization and the United Nations Partnership to Promote the Rights of Persons with Disabilities.

10. The Special Rapporteur also engaged with several stakeholders, such as national human rights institutions, representative organizations of persons with disabilities, other non-governmental organizations, universities and the diplomatic community.

### C. Communications

11. Summaries of communications sent and replies received during the period covered by the present report are available in the communications reports of special procedures (see A/HRC/37/80, A/HRC/38/54 and A/HRC/39/27).

## III. Deprivation of liberty of persons with disabilities

12. Deprivation of liberty of persons with disabilities is a major global human rights concern. Although there is no comprehensive data on the number of persons with disabilities deprived of their liberty, available statistics and administrative information from a series of countries demonstrate that persons with disabilities are systemically incarcerated, imprisoned, detained or otherwise physically restricted across the globe, regardless of the economic situation of the country or its legal tradition.

13. Persons with disabilities are significantly overrepresented in mainstream settings of deprivation of liberty, such as prisons and immigration detention centres. While it is estimated that persons with disabilities represent 15 per cent of the population, in many countries the proportion of persons with disabilities in prisons represents as many as 50 per cent of prisoners.<sup>4</sup> Similarly, it has been well established that children with disabilities are overrepresented in juvenile detention facilities and residential institutions for children, such as orphanages, social care settings and small-group homes.<sup>5</sup>

14. Furthermore, persons with disabilities extensively experience unique, disability-specific forms of deprivation of liberty. A deprivation of liberty is disability-specific if there are laws, regulations and/or practices in place that provide for or permit such a deprivation based on a perceived or actual impairment; or where specific places of detention, designed solely or primarily for persons with disabilities, exist. Common forms of disability-specific deprivation of liberty include involuntary hospitalization in mental health facilities; placement into institutions; detention as a result of diversion from the criminal justice system; forced treatment in “prayer camps”; and home confinement. All of them share common characteristics, rationales and justifications that stem from the medical model of disability.

<sup>3</sup> See [www.ohchr.org/en/issues/disability/srdisabilities/pages/reports.aspx](http://www.ohchr.org/en/issues/disability/srdisabilities/pages/reports.aspx).

<sup>4</sup> J. Bronson, L. Maruschak and M. Berzofsky, “Disabilities among prison and jail inmates, 2011–12, special report” (United States of America, Department of Justice, 2015); and Australia, Australian Institute of Health and Welfare, *The Health of Australia’s Prisoners* (Canberra, 2015).

<sup>5</sup> G. Mulheir (2012), “Deinstitutionalisation – a human rights priority for children with disabilities”, *Equal Rights Review*, vol. 9, pp. 117–137; and C.A. Mallett (2014), “The ‘learning disabilities to juvenile detention’ pipeline: a case study”, *Children & Schools*, vol. 36, No. 3, pp. 147–154.

15. Involuntary commitment to mental health facilities for short or long periods of time is the most recognized form of deprivation of liberty on the basis of impairment. Unfortunately, such acknowledgement has not resulted in its abolition, but instead has led to the enactment of legislation setting out criteria for the detention and procedural safeguards. Indeed, a majority of countries regulate involuntary commitment through mental health laws. In 2017, 111 States reported having a stand-alone law on mental health.<sup>6</sup> In addition to the threshold criterion of being diagnosed with a “mental illness” or “mental disorder”, common criteria include alleged risk to oneself or others and/or alleged need for care and treatment, as determined by medical professionals. In most jurisdictions, involuntary commitment leads to forced medication or other interventions.

16. Involuntary commitment is commonly purported to be a last-resort exception, but evidence shows that this is not the case. Despite the overall reduction of inpatient beds in mental health facilities globally, compulsory admission rates seem to be rising across regions, particularly in high-income countries. For example, a significant increase is reported in several European countries.<sup>7</sup> Involuntary admissions are also increasing in many countries from the Americas, the Middle East and East Asia.<sup>8</sup> Even when admissions are formally voluntary, in most countries “acute inpatient psychiatric wards” are locked and individuals cannot leave the facilities at will. Moreover, voluntary admissions may not truly reflect the individual’s free and informed consent as they may be expressed under the threat of involuntary commitment. Long-term hospitalization of 12 months or longer is still prevalent in some countries.<sup>9</sup>

17. Institutionalization is another widespread form of deprivation of liberty targeting persons with disabilities. The need for “specialized care” is often the justification for this type of placement. A major study that included 25 European countries estimated nearly 1.2 million persons with disabilities are living in institutions, most of them without their consent and without opportunities to challenge their placement.<sup>10</sup> Social care institutions for persons with disabilities are also still prevalent in many countries of Africa, Asia and Latin America. Where public institutions do not exist, charity-run and traditional or religious centres operate. For example, “prayer camps” led by traditional and faith healers are common in a number of African countries. In such centres, persons with disabilities frequently live in extremely unsanitary conditions, often shackled or secluded, under the complete discretion of a “faith healer”.<sup>11</sup>

18. Although institutionalized settings differ in size, name and set-up, they share certain defining elements. Among these are: isolation and segregation from independent life within the community; lack of control over day-to-day decisions; lack of choice over whom to live with; daily schedule and routine irrespective of personal will and preferences; identical activities in the same place for a group of persons under a certain authority; a paternalistic approach in service provision; supervision of living arrangements; obligatory sharing of assistants with others and no or limited influence over whom one has to accept assistance from; and usually also a disproportion in the number of persons with disabilities living in

<sup>6</sup> World Health Organization, *Mental Health Atlas 2017* (2018), p. 18.

<sup>7</sup> A. Turnpenny and others, *Mapping and Understanding Exclusion: Institutional, Coercive and Community-based Services and Practices across Europe* (Mental Health Europe and University of Kent, 2017).

<sup>8</sup> M. Lebenbaum and others, “Prevalence and predictors of involuntary psychiatric hospital admissions in Ontario, Canada: a population-based linked administrative database study”, *British Journal of Psychiatry Open*, vol. 4, No. 2 (2018), pp. 31–38; J.A. Bustamante Donoso and A. Cavieres Fernández, “Internación psiquiátrica involuntaria. Antecedentes, reflexiones y desafíos”, *Revista Médica de Chile*, vol. 146 (2018), pp. 511–517; A. Bauer and others, “Trends in involuntary psychiatric hospitalization in Israel 1991–2000”, *International Journal of Law and Psychiatry*, vol. 30, No. 1 (2007), pp. 60–70; and A. Kim (2017), “Why do psychiatric patients in Korea stay longer in hospital?”, *International Journal of Mental Health Systems*, vol. 11, No. 2.

<sup>9</sup> Turnpenny and others, *Mapping and Understanding Exclusion*, p. 41.

<sup>10</sup> J. Mansell and others, *Deinstitutionalisation and Community Living – Outcomes and Costs: Report of a European Study, Volume 2: Main Report* (Canterbury, University of Kent, 2007).

<sup>11</sup> Human Rights Watch, “‘Like a death sentence’: abuses against persons with mental disabilities in Ghana”, 2 October 2012.

the same environment.<sup>12</sup> To the extent that persons with disabilities are placed in institutions without their free and informed consent or are not free to leave, they are deprived of their liberty.

19. Children are particularly vulnerable to institutionalization on the basis of impairment. Many jurisdictions permit the forced removal of children with disabilities from their families and their placement in institutions, on the basis of the disabilities of the children and/or parents or guardians. As a result, millions of children with disabilities are confined to institutions, isolated and segregated from their communities.<sup>13</sup> In these institutions, they are routinely locked, forced to take medication and often exposed to torture, abuse and neglect. The detrimental effects on child development of the placement of a child in any residential institution, even in small residential homes or “family-like” institutions, have been vastly demonstrated.<sup>14</sup> Any placement of children in a residential setting outside a family must be considered placement in an institution and subject to the protections against deprivation of liberty.

20. Deprivation of liberty as a result of diversion from the criminal justice system is also a common practice across jurisdictions (A/HRC/37/25). When persons with intellectual or psychosocial disabilities have been deemed unfit to stand trial, or declared not responsible for their criminally relevant actions, they are usually diverted to a forensic facility or civil institutions. Frequently, in these facilities, they will have less access to procedural guarantees than others in the criminal justice system and be subjected to forced interventions, solitary confinement and restraint. In such facilities, they are also subject to stricter regimes, and have less access to recreational, educational and health services than those available in mainstream prisons, as well as fewer procedural guarantees. The criterion of “dangerousness” is usually used to assess the need for imposition of these security measures. Police and social services may also act as diversion agents and are in many cases entitled to initiate involuntary hospitalization.

21. In many contexts, despite the absence or limited use of institutions and involuntary hospitalization, many persons with disabilities remain deprived of liberty in their communities. For example, the practice of shackling persons with psychosocial disabilities has been reported in a number of countries.<sup>15</sup> In such instances, persons with disabilities are restrained by families and traditional and religious healers using chains or ropes and/or locked up in a confined space, such as a room, shed or cage. In many cases, they are left outdoors naked for days or even years. These practices are usually the result of deeply rooted stigma and stereotypes, but also a lack of community-based support services.

22. Deprivation of liberty of persons with disabilities at home is not a practice limited to low-income settings. In most parts of the world, many children with disabilities are systematically locked up at home, with little or no interaction with the community.<sup>16</sup> Many adults with disabilities living in supported housing are also in practice deprived of their liberty, as they are not free to leave the house. Similarly, older persons with dementia are frequently impeded from leaving their own homes purportedly for their own safety.<sup>17</sup>

<sup>12</sup> General comment No. 5 (2017) on living independently and being included in the community.

<sup>13</sup> United Nations Children’s Fund, *The State of the World’s Children 2013, Children with Disabilities* (New York, May 2013), pp. 46–47.

<sup>14</sup> M. Dozier and others, “Consensus statement on group care for children and adolescents: a statement of policy of the American Orthopsychiatric Association”, *American Journal of Orthopsychiatry*, vol. 84, No. 3 (2014), pp. 219–225; A.E. Berens and C.A. Nelson, “The science of early adversity: is there a role for large institutions in the care of vulnerable children?”, *Lancet*, vol. 386, No. 9991 (2015), pp. 388–398; and K. Maclean, “The impact of institutionalization on child development”, *Development and Psychopathology*, vol. 15, No. 4 (2003), pp. 853–884.

<sup>15</sup> Human Rights Watch, “Living in hell: abuses against people with psychosocial disabilities in Indonesia”, 20 March 2016.

<sup>16</sup> F. Ellery, G. Lansdown and C. Csáky, “Out from the shadows: sexual violence against children with disabilities” (Save the Children and Handicap International, 2011), p. 14.

<sup>17</sup> J. Askham and others, “Care at home for people with dementia: as in a total institution?”, *Ageing & Society*, vol. 27, No. 1 (2007), pp. 3–24.

23. While disability-specific forms of deprivation of liberty are particularly prevalent among persons with intellectual or psychosocial disabilities, they affect the whole diversity of persons with disabilities. In some countries, deaf and blind children continue to be institutionalized for no reason other than access to education. Persons with cerebral palsy are regularly placed into institutions for the purpose of “treatment” and “rehabilitation”. Persons with albinism are sometimes de facto deprived of their liberty in sheltered homes and protection centres. Persons affected by leprosy were sent for life to leprosariums.

24. Persons with disabilities deprived of their liberty are invariably placed into an extremely vulnerable position. They are at serious risk of sexual and physical violence, sterilization and human trafficking. They also experience a higher risk of being subjected to torture and inhuman and degrading treatment, including forced medication and electroshock, restraints and solitary confinement. They are even denied medical care and left to die.<sup>18</sup> Moreover, persons with disabilities deprived of their liberty are often formally stripped of their legal capacity, without opportunities to challenge the deprivation of liberty, and in the long run invisible and forgotten by the wider community. Indeed, due to the mistaken belief that those practices are benevolent and well intentioned and do not constitute deprivation of liberty, the situation of persons with disabilities deprived of their liberty is hardly monitored by national preventive mechanisms or national human rights institutions.

#### **IV. Underlying causes of disability-specific forms of deprivation of liberty**

25. The causes of disability-specific forms of deprivation of liberty are universally misunderstood. While most people believe that triggers are related to the impairment, at the core the underlying causes are largely social.

26. Stigma often lies at the root of the various forms of deprivation of liberty experienced by persons with disabilities. In most countries, they are extremely stigmatized as a result of widespread misconceptions. For example, there is a predominant view that some persons with disabilities are unable to live in the community, as they need “specialized care” provided in institutions. Cultural or religious beliefs may also feed stigma. The perception that persons with disabilities are possessed by evil spirits, or that impairments are the result of sin or witchcraft, make families feel fearful and/or ashamed, prompting the social rejection and segregation of persons with disabilities. Some people also believe that impairments are contagious and therefore persons with disabilities should be separated from society.

27. A central aspect of the prejudice against persons with psychosocial disabilities is the baseless belief that they are prone to violence. This assumption has proven to be wrong, in fact, evidence shows that they are actually more likely to be victims of violence.<sup>19</sup> However, the stereotype of dangerousness has significantly increased over the last decades, fuelled by negative media coverage that emphasizes a psychiatric history of a perpetrator or, failing that, speculates about an “untreated” diagnosis.<sup>20</sup> Moreover, it negatively impacts on how service providers and the general public react in situations involving persons with psychosocial disabilities, leading to social distance, discriminatory behaviour and recourse to coercive practices.<sup>21</sup>

28. Furthermore, there is evidence that mental health professionals hold negative conceptions about the dangerousness of people labelled with a diagnosis of schizophrenia,

<sup>18</sup> Disability Rights International, *Left behind: the exclusion of children and adults with disabilities from reform and rights protection in the Republic of Georgia* (2013).

<sup>19</sup> S. Desmarais, “Community violence perpetration and victimization among adults with mental illnesses”, *American Journal of Public Health*, vol. 104, No. 12 (2014), pp. 2,342–2,349.

<sup>20</sup> J.P. Stuber and others, “Conceptions of mental illness: attitudes of mental health professionals and the general public”, *Psychiatric Services*, vol. 65, No. 4 (2014), pp. 490–497.

<sup>21</sup> K. McAleenan, “Perceptions of mental illness and mental health policy”, *Psychology Honors Papers*, No. 34 (2013), available at <http://digitalcommons.conncoll.edu/psychhp/34>.

which in turn serves to justify more restrictive policies in psychiatric facilities.<sup>22</sup> Similarly, in many countries health-care and social care professionals encourage parents to place their children with disabilities in institutions under the false claim that they will receive better care than at home (see A/HRC/37/56/Add.2). Child protection authorities may also separate children from their families based on real or perceived disabilities of the parents without offering them the support they may need to keep their children.

29. Sometimes the lack of appropriate community-based support is behind an alleged need for treatment and care, which is used to justify involuntary commitment in mental health facilities or other forms of institutionalization. Regardless of a country's income level, all persons with disabilities face significant barriers in accessing health, education, employment opportunities and financial support. Furthermore, overall, persons with disabilities have limited access to support services, including personal assistance, support in decision-making and communication, non-medical crisis support, mobility support and housing arrangement services (A/HRC/34/58). This long-term and cumulative impact of exclusion and discrimination often results in deprivation of liberty.

30. Persons with disabilities are regularly deprived of liberty in order to access services that should have been delivered in the community. For example, many families send their children with disabilities to institutions (e.g. special education boarding schools, social institutions, vocational centres) because there is no other way to ensure access to education. Many persons with disabilities are also placed into residential institutions as a way to access social protection benefits. Lack of awareness also plays a role as it is often considered that persons with disabilities need specialized care that cannot be provided in the community.

31. Furthermore, when States fail to provide families with the necessary support, it may result in placement of their relatives with disabilities in institutions. Families that lack the social and financial support to provide adequate assistance to those with disabilities, or are unable to cope with the stress and pressure of providing around-the-clock support, are left with very limited options and driven to take them to institutions or hospitals.

32. Until very recently, and still in many countries today, mental health services were predominantly provided in inpatient settings. While some countries are shifting from institutionalized care to community-based interventions, responses to intense distress and crisis situations (often referred as "acute and emergency situations") continue to be generally addressed on an involuntary basis within inpatient wards, subjecting individuals to even greater distress and trauma. However, evidence shows that community-based crisis services can deliver the desired outcomes in assisting people during crisis situations.<sup>23</sup> There is a need for psychiatry to transform and embrace a human rights-based approach.

33. The relationship between poverty, homelessness and disability is well recognized.<sup>24</sup> Persons with intellectual or psychosocial disabilities are overrepresented among the homeless population. When the State fails to secure income and housing assistance to this population, it is likely they will end up involuntarily committed or institutionalized. Furthermore, homeless persons with disabilities are continuously exposed to the risk of being deprived of their liberty, as survival behaviours (e.g. begging, sleeping in public spaces, sitting down on sidewalks, loitering) are treated as criminal activity under laws that criminalize homelessness.<sup>25</sup>

34. In fact, the criminalization of disability is a worrisome trend. In many jurisdictions, legislation is increasingly penalizing atypical behaviours (e.g. running rampant, temper

<sup>22</sup> J.F. Sowislo and others, "Perceived dangerousness as related to psychiatric symptoms and psychiatric service use – a vignette based representative population survey", *Scientific Reports*, vol. 7, No. 45716 (2017).

<sup>23</sup> Gooding and others, *Alternatives to Coercion*, pp. 67–81.

<sup>24</sup> C. Mercier and S. Picard, "Intellectual disability and homelessness", *Journal of Intellectual Disability Research*, vol. 55 (2011), pp. 441–449; and K. Salkow and M. Fichter, "Homelessness and mental illness", *Current Opinion in Psychiatry*, vol. 16, No. 4 (2003), pp. 467–471.

<sup>25</sup> National Law Center on Homelessness and Poverty, *No Safe Place: the Criminalization of Homelessness in U.S. Cities* (2014).



tantrums, yelling or self-injury) as well as public displays of poverty and lack of support (e.g. lack of maintenance of properties).<sup>26</sup> If persons with disabilities violate such codes of conduct, they can face criminal penalties, including fines, community service or even arrest. Accumulation of minor offences may lead to deprivation of liberty.<sup>27</sup> Moreover, persons with disabilities are repeatedly criminalized because the police take their non-compliant behaviour as a threat.<sup>28</sup> Persons with epilepsy or who are deaf have also been mistaken as unruly.<sup>29</sup>

35. Prevention of suicide and self-harm are common justifications for compulsory admission into psychiatric facilities. However, medical literature cannot provide strong evidence on whether the risk for suicide decreases after involuntary treatment.<sup>30</sup> Moreover, a number of studies reported higher rates of suicide after psychiatric hospitalization.<sup>31</sup> Negative subjective experiences with compulsory admission can further lead to lower rates of seeking or using services from the mental health system. Additionally, there is compelling evidence that suicide is very difficult, if not impossible, to predict.<sup>32</sup> Prevention of suicide demands comprehensive multisectoral strategies, including safe and supportive spaces to discuss suicide and self-harm, free from any potential coercive intervention.

36. Liability for malpractice and the ensuing risk management philosophy have proven to be a galvanizing factor. In many jurisdictions, preventing people from harming themselves is within the scope of the duty of care of service providers and families. This increasing prospect of liability is making service providers err on the side of caution and thus to resort to coercive measures. Furthermore, suicide rates increase when potential tort liability is expanded to include mental health professionals, as those facing potential liability may choose not to work with individuals considered to be at high risk of suicide.<sup>33</sup>

37. The interplay between disability and other identity traits produces further inequalities in the enjoyment of the right to personal liberty. Based on gender and disability stereotypes, women with disabilities are at risk of being viewed as “burdens” and being placed in psychiatric facilities or other institutions, including the idea that they are unable to fulfil the traditional role of mother and caregiver. Similarly, many older persons with disabilities are placed in institutions or confined within homes, owing to prejudices based on both age and disability. There are many reports of minority populations being overrepresented in psychiatric facilities.<sup>34</sup>

<sup>26</sup> A. Fang, “Hiding homelessness: ‘quality of life’ laws and the politics of development in American cities”, *International Journal of Law in Context*, vol. 5, No. 1 (2009), pp. 1–24.

<sup>27</sup> Australia, Parliament of Victoria, Law Reform Committee, *Inquiry into Access to and Interaction with the Justice System by People with an Intellectual Disability and their Families and Carers* (2013).

<sup>28</sup> S. Krishan and others, “The influence of neighbourhood characteristics on police officers’ encounters with persons suspected to have a serious mental illness”, *International Journal of Law and Psychiatry*, vol. 37, No. 4 (2014), pp. 359–369; and K. Gendle and J. Woodhams, “Suspects who have a learning disability: police perceptions toward the client group and their knowledge about learning disabilities”, *Journal of Intellectual Disabilities*, vol. 9, No. 1 (2005), pp. 70–81.

<sup>29</sup> S. Nevins, “The US prison system perpetuates ‘the criminalization of disability’”, 14 November 2014.

<sup>30</sup> D. Giacco and S. Priebe, “Suicidality and hostility following involuntary hospital treatment”, *PLOS One*, vol. 11, No. 5 (2016); C. Katsakou and S. Priebe, “Outcomes of involuntary hospital admission – a review”, *Acta Psychiatrica Scandinavica*, vol. 114, No. 4 (2006), pp. 232–241.

<sup>31</sup> D. Chung and others, “Suicide rates after discharge from psychiatric facilities: a systematic review and meta-analysis”, *JAMA Psychiatry*, vol. 74, No. 7 (2017), pp. 694–702.

<sup>32</sup> M. Chan and others, “Predicting suicide following self-harm: systematic review of risk factors and risk scales”, *British Journal of Psychiatry*, 209 (4) (2016), pp. 277–283.

<sup>33</sup> S. Dillbary, G. Edwards and F.E. Vars, “Why exempting negligent doctors may reduce suicide: an empirical analysis”, *Indiana Law Journal*, vol. 93, No. 2 (2018).

<sup>34</sup> R. Gajwani and others, “Ethnicity and detention: are Black and minority ethnic (BME) groups disproportionately detained under the Mental Health Act 2007?”, *Social Psychiatry and Psychiatric Epidemiology*, vol. 51, No. 5 (2016), pp. 703–711; L. Snowden, J.F. Hastings and J. Alvidrez (2009), “Overrepresentation of black Americans in psychiatric inpatient care”, *Psychiatric Services*, vol. 60, No. 6 (2009), pp. 779–785.

## V. Right to liberty and security of persons with disabilities

### A. Universal recognition of the right to personal liberty

38. The right to liberty and security is widely recognized in international and regional instruments as one of the most fundamental rights. Liberty of person concerns freedom from confinement of the body, and security of person concerns freedom from injury to the body and the mind.<sup>35</sup> Hence, it is inextricably linked to the enjoyment of other human rights, including the right to personal integrity, the right to privacy, the right to health, the right to freedom of movement, and the right to freedom of assembly, association and expression. Moreover, persons deprived of their liberty are invariably placed into an extremely vulnerable position and experience a higher risk of being subjected to torture and inhuman and degrading treatment or punishment.

39. The right to personal liberty, as found in international human rights law, is not an absolute right. It can be restricted in accordance with the law, for example, in the enforcement of criminal laws or in the interest of public safety or public health. However, the right to liberty and security of person acts as a substantive guarantee that deprivation of liberty will not be unlawful or arbitrary. It is unlawful when it contradicts domestic or international human rights law, whereas it is arbitrary when it is imposed in a manner that is inappropriate, unjust, disproportionate, unpredictable, discriminatory or without due process. These two prohibitions often overlap.<sup>36</sup>

40. Deprivation of liberty involves a more severe restriction on physical freedom than mere interference with liberty of movement. Individuals are deprived of their liberty when they are confined to a restricted space or placed in an institution or setting, not free to leave, and without free and informed consent.<sup>37</sup> Examples of deprivation of liberty include police custody, pretrial detention, imprisonment after conviction, house arrest, administrative detention, involuntary hospitalization, and placement of children in institutional care. They also include certain further severe restrictions on liberty, for example, solitary confinement or the use of restraints.

41. The universal nature of human rights means that the right to liberty and security cannot be denied on the basis of prohibited grounds, such as race, sex, age, disability, religion, national, ethnic, indigenous or social origin, or other status. Such deprivations of liberty are discriminatory and, thus, unlawful and arbitrary. However, for too long deprivation of liberty on the basis of actual or perceived impairment has been widely justified. As discussed, in most jurisdictions, administrative, civil and/or criminal legislation authorize the deprivation of liberty of persons on the basis of impairment or in combination with other factors (e.g., when the individual presents an alleged “risk to self or to others” or is in need of treatment or care).

42. Furthermore, the jurisprudence of international and regional human rights bodies has been historically supportive of these exceptions, despite the fact that no core human rights treaty states that disability can be used as a legitimated ground for deprivation of liberty. As a consequence, all these practices have been normalized, resulting in persons with disabilities worldwide experiencing disproportionately high levels of unlawful and arbitrary deprivation of liberty in various forms, from disability-specific forms of deprivation of liberty to detention in mainstream settings.

43. In that context, the adoption of the Convention on the Rights of Persons with Disabilities represented a milestone in the recognition of the right to liberty of persons with disabilities. Reaffirming the universality of human rights, the Convention reminds States parties of their obligation to respect, protect and fulfil the right to liberty of all persons with disabilities. Its article 14 stresses that persons with disabilities must enjoy the right to personal liberty on an equal basis with others and, therefore, that they cannot be deprived of

<sup>35</sup> Human Rights Committee, general comment No. 35 (2014) on liberty and security of person, para. 3.

<sup>36</sup> *Ibid.*, para. 11.

<sup>37</sup> *Ibid.*, paras. 5–6.

their liberty unlawfully or arbitrarily. Article 14 further clarifies that deprivation of liberty on the basis of impairment<sup>38</sup> is discriminatory and, thus, contrary to the letter and spirit of the Convention. In doing so, the Convention has fundamentally challenged the prevailing understanding of the right to liberty in relation to persons with disabilities, superseding previous standards and interpretations.

## **B. Normative content of article 14 of the Convention**

44. Article 14 of the Convention articulates the content of the right to liberty and security of person as it applies to persons with disabilities. Article 14 (1) (a) reaffirms the right to liberty and security of all persons with disabilities on an equal basis with others. Article 14 (1) (b) stipulates that persons with disabilities cannot be deprived of their liberty unlawfully or arbitrarily, and further clarifies that disability shall in no case justify a deprivation of liberty. Finally, article 14 (2) reaffirms that all persons with disabilities deprived of their liberty are entitled to procedural and substantive guarantees on an equal basis with others, including conditions of accessibility and reasonable accommodation. States parties thus have an obligation, with immediate effect, to: (a) refrain from engaging in any action that unlawfully or arbitrarily interferes with the right to liberty, and from authorizing such practices; (b) protect this right against practices by private actors such as health professionals, and providers of housing and/or social services; and (c) take positive action to facilitate the exercise of the right to liberty.

45. The right to liberty of persons overlaps and interacts with other human rights and fundamental freedoms under the Convention. Those rights include, but are not limited to, equality and non-discrimination (art. 5), life (art. 10), equal recognition before the law (art. 12), access to justice (art. 13), freedom from torture or cruel, inhuman or degrading treatment or punishment (art. 15), freedom from exploitation, violence and abuse (art. 16), integrity (art. 17), liberty of movement and nationality (art. 18), living independently and being included in the community (art. 19), freedom of expression and opinion, and access to information (art. 21), privacy (art. 22), health, including the right to free and informed consent (art. 25), work and employment (art. 27), an adequate standard of living and social protection (art. 28), and participation in political and public life (art. 29).

46. Article 14 establishes an absolute ban on deprivation of liberty on the basis of impairment. While persons with disabilities can be arrested or detained lawfully, on an equal basis with others, article 14 (1) (b) does not permit any exception whereby persons can be deprived of their liberty on the basis of their actual or perceived impairment. Any deprivation of liberty on such grounds would be discriminatory in nature and, thus, both unlawful and arbitrary. These cases include, *inter alia*, the placement of persons with disabilities into institutions, their involuntary commitment to mental health facilities, their detention resulting from a declaration of unfitness to stand trial, exemption from criminal responsibility or other diversionary mechanisms.

47. The Committee on the Rights of Persons with Disabilities has further stipulated that this absolute ban also applies when additional factors are used to justify the deprivation of liberty; commonly, being regarded as a “danger to self or to others” or in need of treatment or care.<sup>39</sup> In this respect, the Committee has recalled that, during the drafting process of the Convention, there were extensive discussions on the need to include a qualifier (“solely” or “exclusively”).<sup>40</sup> States opposed those proposals, arguing that they could lead to misinterpretation and allow cases of deprivation of liberty based on impairment if other factors were present. Similarly, a proposal to include a provision on periodic review was not included because such a provision would contradict the outright ban on the deprivation of liberty on the grounds of impairments, and might lead to an interpretation that detention

<sup>38</sup> See Committee on the Rights of Persons with Disabilities, “Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: the right to liberty and security of persons with disabilities” (2015), para. 6.

<sup>39</sup> *Ibid.*

<sup>40</sup> *Ibid.*, para. 7.

based on disability was permitted but required safeguards. Hence, the preparatory work of the Convention confirms the intention of setting an absolute ban.

48. Placing a person with disabilities into an institution, either without their consent or with the consent of a substitute decision maker, contradicts the right to personal liberty and the right to live independently in the community (art. 19). The failure of the State to provide persons with disabilities with the appropriate support to live independently in the community cannot constitute a legitimate ground for deprivation of liberty. Likewise, placing a child outside the family in an institution or residential home on the basis of an actual or perceived impairment of the child and/or of his or her parents or legal guardian is discriminatory and, therefore, arbitrary and unlawful.

49. Involuntarily admitting a person to a mental health facility on the basis of an alleged mental illness or mental disorder contradicts the right to liberty and security of person and the principle of free and informed consent (art. 25 (d)). Everyone has the right to be provided with desired mental health services and/or other supports based on their free and informed consent, and to refuse any unwanted services without being deprived of their liberty, including those experiencing severe distress or extreme mental states. When admission leads to involuntary treatment and forced medication, involuntary commitment also violates the rights to security of person, personal integrity (art. 17) and freedom from torture and ill-treatment (art. 15).

50. Deprivation of liberty resulting from declarations of unfitness to stand trial or non-criminal responsibility due to “insanity” or “unsound mind” are contrary to the right to personal liberty and access to justice (art. 13). In such cases, the person is usually diverted from the proceedings and subjected to security measures entailing deprivation of liberty and involuntary treatment, often indefinitely or for significantly longer periods of time than if they had been convicted of a crime in accordance with usual procedures, thereby denying them the same due process guarantees as others (A/HRC/37/25, para. 36). States have an obligation to ensure that judicial guarantees and safeguards protecting the rights of those accused of a crime apply to all persons with disabilities, highlighting the presumption of innocence, the right to stand trial and the right to a fair trial, including the provision of procedural and age- and gender-appropriate accommodations.

51. Placement of children with disabilities outside a family into institutions or residential homes for the purpose of care constitutes an arbitrary deprivation of liberty that also contravenes the right to home and family (art. 23). Accordingly, where the immediate family is unable to care for a child with disabilities, States must provide alternative care within the wider family and, failing that, within the community in a family setting. The notion of “suitable institutions” under article 20 of the Convention on the Rights of the Child and the Guidelines for the Alternative Care of Children should be reviewed under the higher standards upheld by the Convention on the Rights of Persons with Disabilities. As article 41 of the Convention recognizes, its implementation should not affect any provisions of international law that are more conducive to the realization of the rights of the child.

52. States have an obligation to take appropriate measures to protect the right to liberty and security of persons with disabilities against deprivation by third parties.<sup>41</sup> States must protect persons with disabilities against detention in institutions or community-based settings run by non-governmental or private entities. They should also protect them against wrongful deprivation of liberty by employers, schools and hospitals. Additionally, States must protect persons with disabilities against home-based deprivation of liberty, including home confinement, shackling and *pasung*.<sup>42</sup>

53. The denial of legal capacity is often both a cause and an effect of deprivation of liberty; it can be used as a trigger for institutionalization or involuntary hospitalization, and

<sup>41</sup> Human Rights Committee, general comment No. 35, para. 7.

<sup>42</sup> *Pasung* involves confinement and neglect in addition to shackling. See N.H. Laila and others, “Perceptions about *pasung* (physical restraint and confinement) of schizophrenia patients: a qualitative study among family members and other key stakeholders in Bogor Regency, West Java Province, Indonesia 2017”, *International Journal of Mental Health Systems*, vol. 12, No. 35 (2018).

is deeply connected with diversion from criminal justice systems into forensic services. Deprivation of liberty may also result in restrictions to legal capacity. For example, in certain jurisdictions, being placed in an institution leads automatically to formal deprivation of legal capacity through legal incapacitation, and the institution itself becomes the person's guardian. Likewise, involuntary hospitalization in most cases entails forced medical interventions. Furthermore, persons deprived of their legal capacity have limited opportunities for challenging their placement or involuntary admission, as their capacity to seek legal representation and participate in legal proceedings are often denied.

54. Persons with disabilities deprived of their liberty must enjoy all the procedural and substantive guarantees established in national and international law on an equal basis with others, including the right to be informed promptly of the reasons for arrest, the right to judicial control of the lawfulness of detention, and the right to immediate release and compensation for unlawful or arbitrary arrest or detention.<sup>43</sup> Article 14 (2) of the Convention clarifies that all these procedural and substantive guarantees apply when persons with disabilities are deprived of their liberty "through any process", that is, under any type of criminal, civil or administrative arrest or detention, including mental health-related deprivation of liberty.

55. Access to justice is essential in protecting the right to personal liberty. States have an obligation to ensure effective access to justice for persons with disabilities deprived of their liberty, on an equal basis with others, in order to facilitate their participation in all legal proceedings to review the lawfulness of their detention, and to obtain redress and reparation. This obligation includes ensuring the accessibility of police stations and courts, effective access to information and communication, and the provision of procedural accommodations.

56. The notion of support embedded in the Convention can play a role in deterring the application of disability-specific detention regimes and other coercive measures (see A/HRC/34/58). For example, whereas the current default response during crisis situations in most jurisdictions is to override the legal capacity of the person and to authorize their involuntary commitment, the support paradigm of the Convention calls for non-coercive support responses within or outside the health sector. However, it must be underscored that the obligation to end deprivation of liberty on the basis of impairment is independent of the provision of support. States must fulfil their obligation to provide support alongside their obligation to eliminate disability-based deprivation of liberty. The lack of support in the community can never justify deprivation of liberty.

### C. Impact of the Convention on international and regional standards

57. The paradigm shift of the Convention towards an absolute ban on the deprivation of liberty on the basis of impairment has already had an important impact on the work of the United Nations. Different entities, treaty bodies and special procedures have endorsed the standards of article 14 of the Convention, including the Office of the United Nations High Commissioner for Human Rights,<sup>44</sup> the World Health Organization,<sup>45</sup> the Committee on the Elimination of Discrimination against Women (CEDAW/C/IND/CO/4-5, para. 37), the Working Group on Arbitrary Detention<sup>46</sup> and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/35/21, para. 66).

58. Nevertheless, since the adoption of the Convention, three human rights mechanisms have challenged the absolute ban on deprivation of liberty on the basis of impairment: the

<sup>43</sup> International Covenant on Civil and Political Rights, art. 9.

<sup>44</sup> A/HRC/10/48, paras. 43–47; A/HRC/34/32, paras. 25–28; A/HRC/36/28, paras. 32, 40, 42 and 50; and A/HRC/39/36, para. 46.

<sup>45</sup> World Health Organization, QualityRights guidance and training tools, available at [www.who.int/mental\\_health/policy/quality\\_rights/en](http://www.who.int/mental_health/policy/quality_rights/en).

<sup>46</sup> United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court, paras. 38 and 103.

Human Rights Committee,<sup>47</sup> the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT/OP/27/2, paras 5–11) and the former Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan Méndez (A/HRC/22/53, para. 69). While they have ruled out the possibility of depriving a person of their liberty on the basis of medical necessity or need of care, they still maintain an exception in the case of risk to self or to others.

59. At the regional level, neither the Inter-American Court of Human Rights nor the African Court on Human and Peoples' Rights have addressed the issue of deprivation of liberty on the basis of impairment since the adoption of the Convention. However, the newly adopted Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa builds on article 14 of the Convention, prohibiting any deprivation of liberty on the basis of impairment (art. 8 (5)). In the Inter-American system, the Inter-American Court of Human Rights has embraced article 14 (2) of the Convention arguing for accessibility and reasonable accommodation measures for prisoners with disabilities,<sup>48</sup> whereas the Inter-American Commission on Human Rights has referred to article 14 (1) (b) of the Convention in a precautionary measure related to a psychiatric facility and a recent country report.<sup>49</sup>

60. The Convention for the Protection of Human Rights and Fundamental Freedoms from 1950 constitutes the only human rights instrument at either the regional or global level that contemplates an exception to the right to liberty and security based on impairment (art. 5 (1) (e)). In this respect, the European Court of Human Rights has developed a set of standards to determine when an individual can be deprived of their liberty on the basis of “unsound mind”.<sup>50</sup> These standards not only contradict article 14 of the Convention on the Rights of Persons with Disabilities, but also fall below those developed by the international human rights mechanisms referred to above.

61. Against this background, the Special Rapporteur reiterates that the detention of persons with disabilities based on “danger to self or others”, “need of care” or “medical necessity” is unlawful and arbitrary. First, it is discriminatory insofar as it only, or disproportionately, applies to persons with an actual or perceived impairment, particularly persons with intellectual or psychosocial disabilities, persons with autism and persons with dementia. Second, it carries with it the denial of the person’s legal capacity to decide about care, treatment and admission to a hospital or institution, as well as violating the rights to personal integrity and freedom from torture and ill-treatment. Third, it is neither necessary nor proportionate as it breaches the essential content of the right to liberty and security of person and it does not achieve the purpose sought by the lawmaker. Moreover, it can obstruct people’s recovery and re-traumatize those who have previously experienced abuse. Furthermore, there is a growing body of evidence on the positive value of non-coercive support practices within and outside the health sector.<sup>51</sup>

62. The criterion of “danger to others” is arbitrary and unjust in and of itself as it results in the deprivation of liberty of persons with disabilities who have committed no actual offence whatsoever, contradicting the general principle of presumption of innocence. An individual who has actually committed an offence should have an opportunity to access justice on an equal basis with others, benefiting from the same procedural guarantees and safeguards. Notwithstanding the above, a radically different approach to criminal punishment is needed to avoid the overrepresentation of persons with disabilities in prisons due to discrimination in legal proceedings and social exclusion. The approach of restorative justice, which focuses on the rehabilitation of offenders by repairing the harm done to victims and the community at large, is a path to be explored.

<sup>47</sup> Human Rights Committee, general comment No. 35, para. 19.

<sup>48</sup> *Chinchilla Sandoval et al. v. Guatemala, Preliminary Objections, Merits, Reparations, and Costs, Judgment of 29 February 2016*, para. 209.

<sup>49</sup> Precautionary measure No. 440-16, Zaheer Seepersad regarding Trinidad and Tobago, 4 August 2017, para. 21; and *Situation of Human Rights in Guatemala*, OEA/Ser.L/V/II, Doc. 208/17 (2017).

<sup>50</sup> *Stanev v. Bulgaria* (application No. 36760/06), judgment of 17 January 2012, para. 153.

<sup>51</sup> Gooding and others, *Alternatives to Coercion*.

63. Only 4 of the 177 States parties to the Convention have made declarations with the intention of limiting the implementation of article 14.<sup>52</sup> In addition, other countries have issued reservations and declarations on articles 12 and 15 that may have an impact on the realization of the right to personal liberty.<sup>53</sup> According to article 19 of the Vienna Convention on the Law of Treaties and article 46 of the Convention itself, reservations and declarations incompatible with the object and purpose of the treaty are not permitted. Given the centrality of the right to personal liberty to the enjoyment and exercise of all rights set out in the Convention, such reservations and declarations contradict its object and purpose. The Special Rapporteur urges the concerned States parties to withdraw all their reservations and declarations.

## **VI. Ending deprivation of liberty on the basis of disability**

### **A. Law reform**

64. States have an obligation to immediately repeal all legislation that allows for deprivation of liberty on the basis of actual or perceived impairment, whether in public or private settings. States must also repeal apparently disability-neutral legislation that has a disproportionate and adverse impact on the right to liberty of persons with disabilities. Mental health legislation, as long as it authorizes and regulates the involuntary deprivation of liberty and forced treatment of persons based on an actual or perceived impairment (i.e. diagnosis of “mental health condition” or “mental disorder”), must be abolished. For that purpose, States should initiate a comprehensive law review process, encompassing different areas of law, with the active participation of persons with disabilities and their representative organizations.

65. States must recognize the right of persons with disabilities to access a wide range of rights-based support services, including support services for persons experiencing crises in life and emotional distress. Legislation must ensure that those support arrangements are available, accessible, adequate and affordable; are provided on a voluntary basis; and respect the rights and dignity of persons with disabilities (A/HRC/34/58). Additionally, States must establish a legal framework that facilitates the creation and implementation of such support measures.

66. States should review their civil and criminal legislation to ensure that regulations on the legal liability and the duty of care of service providers and families do not encourage or result in coercive practices. Criminal laws must also be reviewed to eliminate laws and practices that criminalize homelessness and/or disability.

### **B. Deinstitutionalization**

67. States must eradicate all forms of institutionalization of persons with disabilities and set up clear deinstitutionalization processes. This process should include the adoption of a plan of action with clear timelines and concrete benchmarks, a moratorium on new admissions, the redistribution of public funds from institutions to community services and the development of adequate community support, such as housing assistance, home support, peer support and respite services (A/HRC/34/58). Deinstitutionalization initiatives should include all kinds of institutions, including psychiatric facilities. Ill-conceived and under-resourced deinstitutionalization processes have been shown to be counterproductive and detrimental to the rights of persons with disabilities. Deinstitutionalization strategies must refrain from simply relocating individuals into smaller institutions, group homes or different congregated settings.

<sup>52</sup> Australia, Ireland, the Netherlands and Norway.

<sup>53</sup> Canada, Egypt, Estonia, France, Georgia, Kuwait, Malaysia, Poland, Singapore and the Bolivarian Republic of Venezuela.

68. Many strategies are required to end the institutionalization of children with disabilities. These include building up family support, the provision of child services within the community, child protection strategies, inclusive education and the development of disability-inclusive family-based alternative care, including extended kinship care, foster care and adoption. All these forms of alternative care need to be provided with appropriate training, support and monitoring to ensure the sustainability of such placements. States should adopt an immediate moratorium on the institutional placement of children under the age of 3.

69. States must take immediate action to end deprivation of liberty within private and/or faith-based institutions, such as orphanages, small group homes, rehabilitation centres and prayer camps. States have an obligation to protect persons with disabilities against wrongful deprivation of liberty by third parties, including through preventive institutional frameworks, education and monitoring. States must take immediate action to end all forms of home confinement and shackling.

### C. Ending coercion in mental health

70. States must end all forms of deprivation of liberty and coercion in mental health. For those purposes, States must transform their mental health systems to ensure a rights-based approach and well-funded community-based responses, including peer-led services. Evidence shows that when Governments, service providers, courts and communities take concerted action to move away from coercive practices, they are likely to be successful.

71. States must create support services for persons experiencing crises. The existence of community-based services that do not resort to the use of force or coercion has proven to be effective and is critical to ensure a right-based response. Non-coercive and non-medical community programmes for persons in extreme distress have been established in several places in the world as alternatives to hospitalizations (e.g. crisis or respite houses, crisis respite services, host families and emergency foster care for children).<sup>54</sup> Features of these settings include fewer residents compared with hospital wards, a home-like environment, a de-emphasis on medication and greater contact with staff. The availability of these programmes has been shown to reduce instances of involuntary hospitalization and higher satisfaction rates.<sup>55</sup>

72. Advance planning can be useful to support the exercise of legal capacity in crisis situations.<sup>56</sup> Advance directives allow people to set out their will and preferences as to how they wish to be treated in any future event. They may also include refusals of certain treatments and/or advance requests for particular options the person has found helpful in the past. To be effective, it is critical to ensure that the advance directive is freely chosen by the person, that they have full control over when it should take effect, and that it remains subject to the person's decision to change their will and preferences at all times.

### D. Access to justice

73. Persons with disabilities should have access to justice on an equal basis with others to challenge any deprivation of liberty. For that purpose, States must ensure that persons with disabilities have access to procedural, age- and gender-appropriate accommodations, including supported decision-making, in all legal proceedings before, during and after trial. States must also promote appropriate training for those working in the field of the administration of justice.

<sup>54</sup> Gooding and others, *Alternatives to Coercion*, pp. 67–81.

<sup>55</sup> C. Obuaya, E. Stanton and M. Baggaley, "Is there a crisis about crisis houses?", *Journal of the Royal Society of Medicine*, vol. 106, No. 8 (2013), pp. 300–302.

<sup>56</sup> M.H. de Jong and others, "Interventions to reduce compulsory psychiatric admissions: a systematic review and meta-analysis", *JAMA Psychiatry*, vol. 73, No. 7 (2016), pp. 657–664.



74. States must guarantee that all persons with disabilities who have experienced any form of arbitrary deprivation of liberty and/or exploitation, violence or abuse in the context of such practices have access to adequate redress and reparations, including restitution, compensation, satisfaction and guarantees of non-repetition, as appropriate. When detention is found to be arbitrary, restitution necessarily implies the restoration of liberty.<sup>57</sup>

75. National preventive mechanisms, national human rights institutions and independent mechanisms for the promotion, protection and monitoring of the implementation of the Convention must be expressly mandated to carry out inquiries and investigations in relation to the deprivation of liberty of persons with disabilities and provide them with assistance in accessing representation and legal remedies. Disability-specific settings of deprivation of liberty, such as psychiatric facilities and other institutions, must be effectively monitored. Having accurate data on the numbers of persons with disabilities deprived of their liberty will also allow monitoring of the trends and changes over time, thus enabling better preventive and deinstitutionalization strategies.

## **E. Community support**

76. States should implement a comprehensive system to coordinate the effective access of persons with disabilities to rights-based support, including access to a range of in-home, residential and other community support services (A/HRC/34/58). General services and programmes, including education, health care, employment and housing, as well as other community services, must also be inclusive of and accessible for persons with disabilities. Persons with disabilities should have the opportunity to choose where and with whom to live, and not be obliged to live in a particular living arrangement.

77. Children with disabilities and their families must be provided with different types of information and support services, including early intervention, day care, education, child protection and social services, to avoid family separation and institutionalization. Families may also need assistance to understand disability in a positive way and to know how to support their children in accordance with their age and maturity. When family separation is unavoidable, States must ensure placement of children in appropriate family-based alternative care arrangements that meet their best interests. Smaller institutions, group homes or “family-like” institutions are no substitute for the right and the need of all children to live with a family.

78. Disability-inclusive social protection systems can contribute significantly to reducing deprivation of liberty of persons with disabilities by ensuring income security and access to social services. States must implement comprehensive and inclusive social protection systems that mainstream disability in all programmes and interventions, and ensure access to specific programmes and services for disability-related needs (A/70/297). Disability benefits must promote the independence and social inclusion of persons with disabilities and not lead to their wrongful deprivation of liberty in institutions. All persons with disabilities, including those with multiple and severe impairments, have a right to live in the community and to be provided with the support they need to do so.

## **F. Participation**

79. In the process of law and policy reform to end all forms of deprivation of liberty based on impairment, States must closely consult with and actively involve persons with disabilities and their representative organizations, in particular those groups whose rights are directly affected, including children with disabilities. Likewise, persons with disabilities and their representative organizations must participate in all decision-making processes related to the design, implementation, monitoring and evaluation of mental health systems, including the development of non-coercive community-based responses.

<sup>57</sup> Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of His or Her Liberty by Arrest or Detention to Bring Proceedings Before Court, para. 26.

80. States should establish outreach and flexible mechanisms to enable the effective participation of groups of persons with disabilities disproportionately targeted by deprivation of liberty on the basis of impairment, as they may be inadequately represented by existing representative organizations (A/HRC/31/62).<sup>58</sup> States should also promote collaboration and partnerships between public authorities and civil society organizations, including representative organizations of persons with disabilities, in the area of the provision of support.

## G. Capacity-building and awareness-raising

81. Changes to legal and policy frameworks will not be sufficient, unless accompanied by a major shift in the societal perception of persons with disabilities. States must complement law and policy reform efforts with training and awareness-raising activities for authorities, public officials, service providers, the private sector, media, persons with disabilities, families and the general public.

82. There is an urgent need to shift the public narrative about violence and persons with psychosocial disabilities. States must adopt effective measures to combat stereotypes, negative attitudes and harmful and involuntary practices against persons with disabilities. Higher education centres should review their curricula, particularly within the schools of medicine, law and social work; to ensure that their curricula adequately reflect the innovations of the Convention.

## H. Resource mobilization

83. States must stop funding services that deprive persons of their liberty on the basis of impairment. Involuntary commitment and institutionalization are not only wrong but also represent an unnecessary and ineffective use of public resources. Evidence demonstrates that providing adequate support to persons with disabilities is a much more successful and cost-effective option than putting them in institutions of any kind.<sup>59</sup> Moreover, compulsory admission to psychiatric facilities and other institutions exposes Governments to expensive safeguards systems, as well as protracted and expensive litigation.

84. States have an obligation to take immediate steps, making full use of their available resources, including those made available through international cooperation, to ensure that persons with disabilities have their right to personal liberty respected and protected. State's planning and budgeting should incorporate funding for disability-specific support services, as well monitoring. International cooperation should refrain from funding practices contrary to the human rights-based approach to disability (e.g., institutionalization or coercive psychiatric interventions).

## VII. Conclusions and recommendations

**85. The deprivation of liberty on the basis of impairment is a human rights violation on a massive scale. Persons with disabilities are systematically placed into institutions and psychiatric facilities, or detained at home and other community settings, based on the existence or presumption of having an impairment. They are also overrepresented in traditional places of deprivation of liberty, such as prisons, immigration detention centres, juvenile detention facilities and children's residential institutions. In all these settings, they are exposed to additional human rights violations, such as forced treatment, seclusion and restraints.**

<sup>58</sup> See also Committee on the Rights of Persons with Disabilities, general comment No. 7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention.

<sup>59</sup> D. Tobis, *Moving from Residential Institutions to Community-based Services in Central and Eastern Europe and the Former Soviet Union* (Washington, D.C., World Bank, 2000).

86. Deprivation of liberty on the basis of impairment is not a “necessary evil” but a consequence of the failure of States to ensure their human rights obligations towards persons with disabilities. As this report illustrates, deprivation of liberty of persons with disabilities is rooted in intolerance, and in States’ inaction to implement human rights, particularly the rights to legal capacity, integrity, access to justice, living independently in the community, the highest attainable standard of health, an adequate standard of living and social protection. In the absence of appropriate support and livelihoods, persons with disabilities are sent to institutions and mental health facilities as if there were no other option. As designed, institutional care and mental health services will only add to this accumulated structural discrimination.

87. The Special Rapporteur makes the following recommendations to States with the aim of assisting them in developing and implementing reforms towards the full implementation of the right to personal liberty and security:

(a) Recognize the right of persons with disabilities to liberty and security, on an equal basis with others, in domestic legislation;

(b) Conduct a comprehensive legislative review process to abolish all laws and regulations that allow for deprivation of liberty on the basis of impairment or in combination with other factors;

(c) Implement a policy for the deinstitutionalization of persons with disabilities from all kinds of institutions, including the adoption of a plan of action with clear timelines and concrete benchmarks, a moratorium on new admissions and the development of adequate community support;

(d) End all forms of coercive practices, including in mental health settings, and guarantee respect for a person’s informed consent at all times;

(e) Guarantee access to effective remedies to all persons with disabilities arbitrarily deprived of their liberty and take immediate action to restore their liberty;

(f) Ensure the development of support services for persons experiencing crises and emotional distress, including safe and supportive spaces to discuss suicide and self-harm;

(g) Actively involve and consult with persons with disabilities and their representative organizations in all decision-making processes to end all forms of deprivation of liberty based on impairment;

(h) Raise public awareness, particularly among policymakers, public officers, service providers and media, about the right to liberty and security of persons with disabilities, including combating stereotypes, prejudices and harmful practices;

(i) Refrain from allocating funding to services infringing the right to liberty and security of persons with disabilities and progressively increase funds allocated to fund research and technical assistance towards ending all disability-specific forms of deprivation of liberty, and to ensure access of persons with disabilities to community-based services and social protection programmes.

(j) Encourage international cooperation actors, including non-profit organizations, to refrain from funding disability-specific places or settings of deprivation of liberty.

88. The Special Rapporteur also recommends that the United Nations system enhance its capacities and adequately consider the standards on the right to liberty and security of persons upheld by the Convention on the Rights of Persons with Disabilities in all its work, including when supporting the legislative and policy reforms of States.