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**CDPF On-line Disability Equality Capacity Building Course Book**

**Module 3: Health: Mental Health and Covid-19**

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# **i) Introduction**

**“**Looking back, we had come to expect the slow but steady progress of the Convention on the Rights of Persons with Disabilities (CRPD) and especially the new framing on disability that it exemplifies. How wrong we were. Basic truths have a habit of coming to the surface during a crisis. So it was with the COVID-19 pandemic. Basic services were swept away. Preventive measures were not adequately communicated. Food, nutrition and health care services were rationed. Institutions became even more obviously dangerous places to be. Home became an incredibly dangerous place for women and girls with disabilities.

As the Disability Rights Monitor Report of October 2020 has vividly shown, the old framing of persons with disabilities as objects and not as subjects came to the surface during the crisis and we have been trying to put it to one side ever since.”[[1]](#footnote-1).

The CDPF agrees with this analysis based on two surveys, three on-line summits and two rounds of regional meetings held between April and November 2020[[2]](#footnote-2). The CDPF, following a survey and on-line summit of members in 44 countries, on 5th June wrote to British Prime Minister highlighting the following issues:

1. Disabled People’s Organisations are generally not being consulted by Government, with a few exceptions e.g. in Malaysia and Guyana.
2. Lack of information access has been addressed in most countries. Stigma is still an issue.
3. Lack of support for personal assistants, food, welfare, medicines and usual medical procedures.
4. Unemployment and lack of reasonable accommodations, especially for self-employed.
5. Lack of access to on-line schooling and erosion of support for disabled students.
6. Higher fatality rates for disabled people in institutions, people with Learning Difficulties and those with chronic conditions, who need shielding support from Government[[3]](#footnote-3).

The Disability Rights Monitor Report[[4]](#footnote-4) analysed over 2,100 responses to the survey which were received from 134 countries around the world. The vast majority were received from disabled individuals and their family members. Very few governments or independent monitoring institutions responded.

“*We have been forgotten about*” a disabled woman, New Zealand

The report highlights four major themes which concur with what CDPF had found earlier:

* The egregious failure to protect the lives of people in residential institutions, which have become hotspots during the pandemic. Instead of prioritising emergency measures to reintegrate people into the community, respondents pointed out that many institutions have been locked down, with fatal consequences.
* Widespread, rigid shutdowns that caused a dramatic breakdown in essential services in the community. People could not access basic goods, including food, and supports such as personal assistance. Strict enforcement of these lockdowns by police and security forces has sometimes had tragic results.
* Serious and multiple human rights violations against underrepresented populations of disabled people: Women and girls have experienced a major uptick in violence, disabled children have been denied access to on-line education and homeless disabled people have either been rounded up, detained, or left completely to fend for themselves.
* A concerning trend of denying basic and emergency healthcare, including worrying reports about the adoption of discriminatory triage procedures: In some cases, persons with disabilities were directly denied access to treatment for COVID-19 because of their impairment.

The survey collected over 3,000 separate pieces of testimony, many of which manifestly demonstrated a complete failure by states to adopt disability-inclusive responses. This was the case in many countries, regardless of their level of economic development, pointing to a collective failure on the part of leaders.

With regards to the rights of disabled people with mental health issues, their rights are widely ignored[[5]](#footnote-5) and many Commonwealth countries have laws that directly contradict the rights contained in Article 12 of the UNCRPD.

“In most of the State party reports that the Committee has examined so far, the concepts of mental and legal capacity have been conflated so that where a person is considered to have impaired decision-making skills, often because of a cognitive or psychosocial disability, his or her legal capacity to make a particular decision is consequently removed. ….This approach is flawed for two key reasons: (a) it is discriminatorily applied to people with disabilities; and (b) it presumes to be able to accurately assess the inner-workings of the human mind and, when the person does not pass the assessment, it then denies him or her a core human right — the right to equal recognition before the law… Article 12 does not permit such discriminatory denial of legal capacity, but, rather, requires that support be provided in the exercise of legal capacity”.

Much needs to be done to change the law to give disabled people with cognitive, psycho- social and mental health issues before the law and to change the stigmatising culture that impacts on these groups across the Commonwealth.

# **ii) The Language the CDPF Uses**

**Disabled People:** Why we still choose to call ourselves ‘disabled people’. In the Commonwealth Disabled People’s Forum (CDPF) we call ourselves ‘**disabled people’** because of the development of the **‘social model of disability’.** In the C19th and C20th, a disabled person’s medical condition was thought to be the root cause of their exclusion from society, an approach now referred to as the **‘medical’ or ‘individual model’** of disability. We use the **‘social model’** of disability, where the barriers of environment, attitude and organisation are what disable people with impairments and lead to prejudice and discrimination.To call ourselves ‘persons with disabilities’ is to accept that we are objects and powerless.We also view ourselves as united by a common oppression, so are proud to identify as ‘**disabled people’. When we are talking about the UN Convention on the Rights of Persons with Disabilities** we will use **‘people with disabilities’**

# **iii) Article 11 UNCRPD Situations of Risk such as pandemics. State Parties are required to take all appropriate additional measures to secure safety of persons with disabilities. How has this worked out during Covid-19?**

In countries across the world, UN Convention on the Rights of Persons with Disabilities (CRPD) is the primary political tool that is being used to advance the rights of disabled people. Therefore, the CRPD has formed part of the disability discourse during the COVID-19 pandemic and has been used by both disability advocates and the government as the relevant human rights framework. While the CRPD does not mention global pandemics specifically, Article 11 – **Situations of Risk and Humanitarian Emergencies** states

“*States Parties shall take…. all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters”.*

Article 11 reflects concerns that in situations of risk to the general population, persons with disabilities are often especially vulnerable if their particular needs are forgotten or ignored and access to services is discriminatory or does not cater to their needs[[6]](#footnote-6) . The COVID-19 pandemic has revealed how much the CRPD has not been implemented by those countries which have ratified it[[7]](#footnote-7) . As noted by the CRPD Committee:

*“****People with disabilities are not inherently vulnerable; it is attitudinal, environmental and institutional barriers that result in higher levels of vulnerability****. People with disabilities may have underlying health conditions that make them more susceptible to COVID-19, pre-existing discrimination and inequality means that persons with disabilities are one of the most excluded groups in terms of health prevention and response actions and economic and social support measures, and among the hardest hit in terms of transmission risk and actual fatalities[[8]](#footnote-8).*

When looking at the text of Article 11 it appears that a global pandemic is probably a kind of ‘natural disaster.’ However, it should be noted that even though infectious diseases are naturally occurring, pandemics differ from most other natural disasters, such as bushfires, floods, volcanic eruptions or earthquakes, in a number of ways.

i) A pandemic involves time lapse and disease modelling by humans which can influence preparation and planning as it approaches and passes.

ii) Unlike other natural disasters, healthcare facilities may transform from points of care to places of transmission, undermining trust in services and exposing healthcare workers to infection.

iii)Prolonged self-isolation and separation from families and communities in response to the pandemic can impact on mental health, even if a person is not affected by the disease itself[[9]](#footnote-9)

COVID-19 is certainly not an ‘armed conflict’ or a ‘humanitarian emergency’, although it may create a ‘double emergency’ in places which are already experiencing emergencies caused by armed conflict, natural disasters, and climate change[[10]](#footnote-10).

**That said, COVID-19 certainly represents a ‘situation of risk’** for people with mental, physical, and cognitive impairments. While COVID-19 usually results in mild illness for most people, new variants caused by mutation can seriously impact on some people across the whole population, but it is much more likely to cause serious illness and death for certain ‘at risk’ groups. Persons with mental impairments, especially those with Downs Syndrome, already have shorter lifespans than the rest of the population and often have co-occurring physical impairments, such as circulatory conditions or diabetes at higher rates than the rest of the population [[11]](#footnote-11).It is also thought that mental health conditions can increase the risk of infections including pneumonia. However, the exact numbers of persons with mental impairment and COVID-19 are presently unknown[[12]](#footnote-12). There is evidence from Public Health England that people with learning difficulty were 4 x more likely to die of Covid-19 than the rest of the English population, at a younger age and in residential settings. [[13]](#footnote-13)UK Office of National Statistics, as reported by BBC in November, had found from March to July Some 30,296 of the 50,888 deaths were disabled people with a disability accounting for 17.2% of the study population but nearly 60% of coronavirus deaths.[[14]](#footnote-14) A separate study found [Learning disabled Covid deaths 'six times higher'](https://www.bbc.co.uk/news/health-54924121) in England. For those under 30 years they had a death rate 30 x non-disabled peers. The study, which looked at deaths between 21 March and 5 June, found that 451 per 100,000 people registered with a learning disability had died with Covid-19 during that period. Due to gaps in the data, the researchers estimated that it could be as high as 692 per 100,000 - 6.3 times higher than the general population. The report suggests the huge disparity could be because people with learning disabilities are more prone to obesity and diabetes, which can increase the risk of dying from Covid-19.

While COVID-19 primarily presents as a respiratory illness, a sub-group of patients show neurological symptoms such as confusion, delirium, stroke, and seizures. Further research on whether these neurological effects have current or long Covid effects on mental health is urgently required. Also, persons who experience respiratory failure from COVID-19 and require ICU support may not be able to consent to medical treatment themselves[[15]](#footnote-15).In Kenya a very thorough report highlighted the above problems in Covid Pandemic for those with mental health issues.[[16]](#footnote-16)

Persons with mental, physical, or cognitive impairments are also more likely to experience social disadvantages like poverty, homelessness, and dependence on the care of others which make meeting their daily needs and staying safe during the pandemic more difficult. In addition, domestic violence, alcohol, and substance use have escalated with the imposition of state-mandated stay-at-home orders to counter the pandemic. Persons with mental impairments are both perpetrators and victims in this rise of pandemic-related domestic violence, especially where there is concurrent alcohol and substance abuse.[[17]](#footnote-17) Of particular concern is the impact on women and girls and the fact that many domestic violence support services are not accessible or equipped to deal with persons with disabilities who may be experiencing domestic violence[[18]](#footnote-18).

Domestic violence against disabled women and girls before the pandemic was 2-3 times higher than for non-disabled women. Now isolation, restricted movement, and stay-at-home measures to contain the spread of the infection have had a particularly acute impact on disabled women. The chances of disabled women and their children being exposed to violence has dramatically increased, as family members spend more time in close contact and household stress intensifies. The risk grows even greater when families also have to cope with potential economic or job losses.  **It is estimated that 83% of disabled women will be sexually abused in their lifetime.** And when women with disabilities experience abuse, it is often over a longer period of time. They often suffer more severe injuries as a result of that violence.[[19]](#footnote-19)

Further, large outbreaks in hospitals (such as the Alfred and Sunshine Hospitals in Melbourne), psychiatric institutions (such as the Albert Road Psychiatric Clinic in Melbourne) and nursing homes (such as Newmarch House in Sydney and Hawthorn Grange and Assisi Centre in Melbourne) in Australia and around the world demonstrate the difficulties of controlling COVID-19 infection in communal and closed environments in which persons with mental and cognitive impairments often live or are temporarily admitted. In South Korea a locked psychiatric ward with a COVID-19 outbreak became a medical disaster. The United Nations estimates that the percentage of COVID-19 deaths in care homes (which contain large numbers of older people, most with impairments and disabled people) is between 19% to 72% in countries where the official data is available.[[20]](#footnote-20)

The extra risk from COVID-19 to persons with mental, physical, and cognitive impairments is made worse by the anxiety caused by the pandemic and the government's response to it. Fear of catching the virus, panic buying and shortages, job losses, enforced social isolation to stop the spread of the virus, changes in routines, saturation media coverage, and barriers to accessing care like discrimination, stigma, and existing distrust of authority and the health system, are all stressors which can exacerbate mental impairments and in some cases precipitate suicide.[[21]](#footnote-21)

The importance of Article 11 of the CRPD can be seen by the fact that in Australia, UK and elsewhere disabled people, despite their heightened risk to an adverse outcome from COVID-19, were initially left out of the emergency response plan for COVID-19 unveiled in mid-February 2020[[22]](#footnote-22) . That is, in the words of Article 11, all necessary measures for the protection and safety of persons with disabilities were not taken, putting their lives and health at risk.

**DPOs and Covid** Recent Disability & Disaster, [Town Halls collected lived experience](https://wid.org/2020/06/25/launch-of-the-global-alliance-for-disaster-resource-acceleration/) of disabled people around the world. 633 people registered from 29 countries in six continents. 98% said that disability-led organisations did not have what they need to serve their communities. 100% believed disability-led organisations definitely or sometimes are left out of disaster relief funding from foundations, corporations, and government. In India, a quick shutdown limited the ability to reach people in need. Women with disabilities lacked access to food and security - inaccessible tele-health means no reproductive healthcare services. Homelessness and sexual abuse of women is a significant problem[[23]](#footnote-23). In Uganda’s lockdown, disabled people are unable to access food and deaf people abused by security forces in curfew. In the Bahamas, Hurricane Dorian’s aftermath compounds the lack of healthcare and access to supplies. Caregivers lack access to PPE. In Pennsylvania, USA, 70% of COVID deaths have been in congregate settings. There is a lack of funding for relief and relocation services.

In UK Inclusion London brought out a second report in February 2021 showing that things have not improved for disabled people [Locked Down and Abandoned: Disabled People’s Experiences of Covid-19](https://www.inclusionlondon.org.uk/disability-in-london/coronavirus-updates-and-information/campaigns-news-during-coronavirus-crisis/locked-down-and-abandoned-disabled-peoples-experience-of-covid-19/) has revealed disabled people “continue to experience hardship across all areas of life: increasing mental distress, social isolation and loneliness, food poverty, financial difficulties, workplace discrimination, problems accessing healthcare, and unequal access to medicine, vaccines, and social care. Despite the messages about protecting and supporting those in greatest need, the UK government’s approach has been to introduce legislation, guidance and policies which have actively undermined our ability to protect ourselves and our rights to critical support”.

**Case Study 1 Uganda**

This report presents findings from telephone interviews with 40 members from five partner DPOs in Uganda in August 2020, to ask about the response to and impact of Covid-19 pandemic among disabled people. We asked interviewees about their response to the Covid-19 outbreak and the impact the crisis has had on their livelihood and their risk of experiencing violence. Findings from this report show evidence that some disabled people face multiple types of jeopardy during Covid-19. They are at an increased risk of violence and are suffering a dramatic loss in household earnings. They are also taking action. Many plan to adapt their livelihood and are mobilising resources for their communities. Disabled People ask government and NGOs to do more and to be more inclusive in their response to the crisis.

* **Three of four respondents report increased risk of violence since the pandemic began**. 77% of women and 80% of men report an increase in economic, physical, psychological and/or sexual violence after Covid-19.
* **One in three women respondents report experiencing an increased risk of physical and/or sexual violence**.
* **Livelihood support could reduce violence risk.** Three in four (76%) of respondents say livelihood support, such as start-up capital for small business, would be very or extremely useful to them in order to reduce their risk of experiencing violence during Covid-19.
* **Respondents report losing 64% of their monthly household income since the outbreak.** After adjusting for purchase power parity, this is the equivalent of falling from 181 GBP to 65 GBP per month.
* **Covid-19 support is unequal and insufficient for many.** Where support has been distributed, one in two report that they do not receive the same protection support (i.e. PPE) as others; one in four report that they do not receive the same Covid-19 survival support (i.e. food); one in three report they do not receive the same Covid-19 information; and one in three say that support does not meet need.
* **Most respondents will try something new.** 59% indicate that they will start something new to make ends meet if the situation continues.
* **DPOs are obtaining food support through lobbying, providing vital psychosocial support and information.**
* **Some DPOs are not able to respond because they are capacity-constrained.**
* **Government and NGOs can do more[[24]](#footnote-24).**

**Case Study 2 Bangladesh**

“Presents the findings from telephone interviews with 91 representatives from 15 Disabled People’s Organisation (DPO) partners in Bangladesh, to ask about the impact of the Covid-19 pandemic on persons with disabilities in Bangladesh. The report finds that, in the Covid-19 pandemic, some persons with disabilities experience double jeopardy—not only are persons with disabilities disproportionately impacted by the pandemic, but they are also disproportionately excluded from protection and survival support.

Persons with disabilities report being **disproportionately excluded** from Covid-19 support. 63% of respondents report not receiving the same protection and survival support as others. Two-thirds of those who described their personal experiences reported supply shortage or diversion of essential food and medical supplies as reasons for why they had been excluded.

**Relief that has been provided has not met need.** Many respondents (84%) report that survival support does not meet their basic needs. Support received has mostly been food instead of cash. Some (17%) report difficulty in following Covid-19 advice, mostly because they cannot afford protection materials.

**Persons with multiple disabilities are being left further behind**. Respondents with multiple functional difficulties experience more exclusion than respondents with one functional difficulty. This finding of disproportionate exclusion is statistically significant and consistent with qualitative responses, which show that most of those that did report challenges in following received advice were persons with multiple functional difficulties. This strongly suggests that persons with multiple functional difficulties experience more barriers. Persons with multiple functional difficulties who were excluded tended to report difficulties in communicating, remembering, self-care and walking.

**The economic impact of the pandemic is acute** for persons with disabilities. On average, respondents report losing 65% of their income since the Covid-19 crisis began, which in absolute terms, after adjusting for purchase power parity, is the equivalent of moving from £167 to £58 in monthly earnings.

Some respondents report that they are **skipping meals and going hungry**. Anecdotal reports reveal that families are reverting to one main meal every two days, or two main meals every three days. Many are borrowing and relying on family support to meet their daily needs to survive, and some of those who already depended on family support have had that support reduced or withdrawn.

Government can do more. Many respondents said government should prioritise persons with disabilities and provide more relief. Many voiced concerns about how relief was being distributed or stolen, and that it is not reaching those most in need. The majority of respondents said that NGOs and wealthy people should play a role in support efforts”. [[25]](#footnote-25)

**Case Study 3** **Swabhiman in Odisha, India** is a cross disability organization, advocating for the rights of disabled people

A rapid assessment was conducted involving 1048 disabled respondents from across Odisha. It was found that there were four areas of concern that were common to most respondents.

**Priority Areas of Concern**

Food and Essentials 86%

Financial Stress 79%

Health, Care Giver and Assistive Devices 79%

Communication and Accessible Information 81%

**Greater Risk**

Physical barriers to access hygiene 84%

Need to touch things 71%

Difficulty in enacting social distance 67%

Difficulty Accessing Information 74%

Of the 387 disabled students who were telephonically interviewed, only 220 (56.48%) had smartphone, either personally, or collectively in the family to access learning in lockdown.

Swabhiman responded to the situation by providing supplies of food, PPE and directing people to medical support and much else concentrating in the areas in particular.[[26]](#footnote-26)

The COVID-19 pandemic has demonstrated the need for governments to take disability rights into account in future emergency response planning and to be able to “respond rapidly to future public health emergencies and to ensure that ‘no-one is left behind.’”[[27]](#footnote-27). It also illustrates the need for disabled people and our DPOs to be consulted and to participate in the development and implementation of government policies and programmes in accordance with Articles 4.3 & 33 of the UNCRPD.

The CRPD also covers a broad range of human rights many of which are engaged by the COVID-19 pandemic beyond Article 11. A holistic approach to the interpretation of the CRPD considers *all* of the rights of persons with cognitive, physical and mental impairments and how they interact with each other. The most relevant rights to the COVID-19 pandemic form two broad groups. The first are those which ensure the protection of the life, health and well-being of persons with mental, physical and cognitive impairments from COVID-19 infection and the government responses to it, while the second relate to the civil and political rights of persons with mental, physical and cognitive impairments which can be more affected than those of the general population, even when the general population is itself in “lockdown.”

***Follow Up Activities 1, 2***

*1) Investigate sources on-line for information and write a profile of how disabled people were treated under the COVID 19 pandemic in your country?*

*2) From this work, formulate a list of demands on your Government to prevent a recurrence in a similar health emergency.*

# **iv) Article 25 Right to Equal Access to same standards of Health Care and Services as others and must take all appropriate measures (and SDG 3)**

**Disability ─ a public health issue**

Over 1 billion people are estimated to live with some form of long-term impairing condition which in interaction with barriers disabled them. This corresponds to about 15% of the world's population, with up to 190 million (3.8%) people aged 15 years and older having significant difficulties in functioning, often requiring healthcare services. The number of people living with disability is increasing, in part due to ageing populations and an increase in chronic health conditions.

Disability is extremely diverse. While some health conditions associated with disability result in poor health and extensive healthcare needs, others do not. However, all people with disability have the same general healthcare needs as everyone else, and therefore need access to mainstream healthcare services. [Article 25 of the UN Convention on the Rights of Persons with Disabilities (CRPD)](https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-25-health.html) reinforces the right of disabled people to attain the highest standard of healthcare, without discrimination. However, the reality is that few countries provide adequate quality services for disabled people.

Also, very few countries collect data to enable disaggregation by disability in the health sector.  This became very apparent during the COVID-19 pandemic where countries failed to include disability consistently in their response to control the pandemic. This left disabled people exposed to three increased risks with devastating consequences:

i) the risks of contracting COVID-19 and developing severe symptoms from COVID-19 or dying from the disease,

ii) not having the same access as the rest of the population to information, support and treatment, and

iii) having poorer health during and after the pandemic, whether or not they are infected with COVID-19.

**SDG 3**

The Sustainable Development Goals (SDG), established in 2015, are a set of 17 goals put together to help achieve the 2030 agenda for global sustainable development. The SDGs were developed in response to the progress and the challenges of the previous Millennium Development Goals (MDG) (2000-2015) which did not mention disabled people, whereas the SDGs do. While the SDGs aim to address similar goals to the MDGs, they have broadened their scope to focus globally rather than just on low and middle income countries, and also encompass environmental sustainability. The SDGs recognize that individuals and communities are not only affected by their own personal and socio-economic circumstances, but also by a complex interplay of structural forces that influence an individual’s place in society and his/her wellbeing. Hence, the SDGs aim to incentivise development efforts towards the removal of these structural barriers, by addressing and reducing poverty, and improving health, education, and employment for all. An additional new aspect in the SDGs is the emphasis on increased inclusion across the spectrum of goals and sectors so that we can ‘Leave no one behind’.

Disabled people are an important ‘disadvantaged and marginalized’ group to consider within the SDGs, as they are a large group, making up an estimated 1 billion people worldwide, and they experience a range of exclusions owing to multiple forms of discrimination and inaccessible environments in many spheres of life, including those that are targets of the SDGs (e.g. health, education, employment). Health is a core focus of the SDGs, with goal 3 aiming **to ‘ensure healthy lives and promotion of well-being for all at all ages’**, in part through the target to ‘achieve universal health coverage’ (UN, 2015). This Goal is an important and ambitious aspiration as the WHO estimates that 400 million people worldwide lack access to healthcare services [[28]](#footnote-28)Access is lower still for certain marginalised groups defined by age, gender, income, ethnicity, sexual orientation and disability. Foremost here are disabled people, as evidence shows that 80% of disabled people live in low income countries, are poor, and have limited access to healthcare[[29]](#footnote-29). However, this goal and its targets do not specifically mention disabled people. This absence is part of a broader trend, as unfortunately, disabled people are often not discussed or included in the development of strategies for improving access to healthcare services or in the development of programs or initiatives that may play an important role in provision of healthcare for the general population and for disabled people. This is demonstrated by the lack of literature including disabled people as a group of consumers who could benefit from changes in healthcare services or health policies that aim to improve access and ease of service provision, both at regional and global levels. This neglect has its roots in **medical model thinking** amongst health professionals who view us clinically rather than as an oppressed group.

**Barriers to healthcare**

Disabled people encounter a range of barriers when they attempt to access healthcare including the following:

**Prohibitive costs** Affordability of health services and transportation are two main reasons why disabled people do not receive much needed healthcare in low-income countries. Just over half of disabled people are unable to afford healthcare compared to about a third of non-disabled people.

**Limited availability of services** There is a lack of appropriate services for disabled people. Many studies reveal high unmet needs for healthcare among disabled people due to unavailability of services, especially in rural and remote areas.

**Physical barriers** Uneven access to buildings (hospitals, health centres), inaccessible medical equipment, poor signage, lack of interpretation, narrow doorways, internal steps, inadequate bathroom facilities, and inaccessible parking areas create barriers to healthcare facilities. For example, women with mobility impairments are often unable to access breast and cervical cancer screening because examination tables are not height-adjustable and mammography equipment only accommodates women who are able to stand.

**Negative and unreconstructed attitudes** Disabled people are still viewed through the lens of their impairment, even when they see the Doctor about something unrelated or that we are ‘*life unworthy of life’* which leads to decisions not to resuscitate us which come from the eugenicist murky background of medical science.

**Inadequate skills and knowledge of health workers** Disabled people were more than **twice** as likely to report finding healthcare provider skills inadequate to meet their needs, **four** times more likely to report being treated badly, and nearly **three** times more likely to report being denied care.

Article 25 combined general duties and Article 12 equal recognition before the law are not being applied to people who are Mental Health system users and survivors in the main. Appreciate synergy SDG [3: Good Health and Well-being](http://www.un.org/development/desa/disabilities/envision2030-goal3.html). How can this be improved?

# **v) The right to the highest attainable standard of physical and mental health**

Providing the best possible health care is not just a desirable social goal, it is a fundamental human right and it applies to all people no matter who they are or what their illness.[[30]](#footnote-30) Associated with the concept of a ‘right to health’ is a growing body of international law of a ‘right to health services’ requiring ‘nation states to take affirmative steps to assure that residents of the country have access to population-based health protection measures and also affordable health care in the context of the nation’s economic resources and cultural mores’. The international human right to health is established both via international treaties and a growing body of international customary law.[[31]](#footnote-31)

**Topic 1: The right to the highest attainable standard of physical and mental health. What this means.** Article 25 of the CRPD requires that States Parties recognize that persons with disabilities have the right to the enjoyment of the highest possible standard of health without discrimination on the basis of disability. This is not a right to be healthy; rather, it consists of *entitlements* and is closely linked to a number of other rights and freedoms. It is also based on the principles of non-discrimination and participation.[[32]](#footnote-32)

*-What entitlements are comprised in the right to the highest attainable standard of physical and mental health? What are the underlying determinants of health?*

There are several entitlements under the right to the highest attainable standard of physical and mental health. By ***entitlement***we mean a right to facilities, goods, services, and conditions that help any person to achieve the highest attainable standard of physical and mental health. These include the entitlement to a system of health protection, including health care. As well as granting an *entitlement* to a system of mental health care, the State must protect other rights, such as housing, employment, and education. These other rights are sometimes described as the *underlying determinants of health* because enjoying these rights can contribute to enjoying the right to health.[[33]](#footnote-33)

International human rights law requires health services, goods, and facilities, including the underlying determinants of health, to be:

* ***available***- enough mental health related facilities and services and trained medical and other professionals must be available,
* ***accessible***- appropriate facilities, goods and services must be affordable, not too far away, and available without discrimination. Information on such matters must also be easy to read and understand,
* ***acceptable***- facilities, goods and services must respect different cultures and medical ethics, and of *good quality* - facilities, goods and services must meet medical and scientific standards.[[34]](#footnote-34)

*What must states do to realize the right to the highest attainable standard of physical and mental health for its citizens?*

States that have ratified the CRPD must use as many available resources as possible, over time, to fulfil everyone’s right to the highest attainable standard of physical and mental health. In short, this means that states must be doing better today than they were doing five years ago. And in five years they must be doing much better. This obligation continues despite tough economic times – state parties to the CRPD must retain the duty to make progress towards realizing this right.

**Topic 2: Protection of the right to the highest attainable standard of physical and mental health under the International Human Rights Laws.**

*International instruments*

**Universal Declaration of Human Rights, Article 25(1)**

Everyone has the right to a standard of living adequate for the health and well-being of herself and of her family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond her control.

**International Covenant on Economic Social and Cultural Rights, Article 12**

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

• The right to the highest attainable standard of physical and mental health (Article 12 ICESCR; Article24 CRC)

• The right to an adequate standard of living including food, clothing, and housing (Article 11 ICESCR; Article 27 CRC)

• The right of children to an environment that fosters the health, self-respect, and dignity of a children where they are in need of psychological recovery from neglect, exploitation, torture or trauma (Article 39 CRC)

• Where children have been placed under mental health programs, they have the right to periodic review (Article 25 CRC)

• The right of children with disabilities to access appropriate health and rehabilitation services (Article23 CRC)

UNCRPD Article 25-Health

“States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes

b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons

c) Provide these health services as close as possible to people's own communities, including in rural areas

d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner

f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability”.

***Follow Up Activities 3.3, 3.4 and 3. 5***

***3.3 Look up the legislation on Mental Health and Human Rights in your country and identify the main changes so that it can comply with the UNCRPD.***

***3.4 Find an example of a progressive approach to the health care of disabled people in your country and write it up briefly.***

***3.5 If you cannot find an example for (v) take a real health inequality situation for disabled people in your country and write the changes that need to take place and how they might come about.***

# **vi) What legislative principles will ensure rights for people with Mental Health Issues?**

**Article 12** The right to equal recognition before the law is concerned with legal personality – the ability to bear rights and duties under law, and legal capacity – whether and how one can exercise, claim or defend those rights, and the assumption of legal liability. Article 12 of the UN Convention on the Rights of Persons with Disabilities (CRPD) is concerned with how legal systems themselves enable and disable people as legal actors. In the view of the UN Committee on the Rights of Persons with Disabilities (‘CRPD Committee’) Article 12, introduces a new paradigm of ‘universal legal capacity’, that cannot be limited on grounds of disability or mental incapacity[[35]](#footnote-35) The CRPD Committee maintains that this requires the abolition of all forms of substitute decision making.

“Forced psychiatric interventions violate the universal prohibition of torture, The UNCRPD lays the basis for this argument to develop in a series of steps, starting from its recognition of equal legal capacity and free and informed consent of people with disabilities, and equal right to respect for physical and mental integrity, as well as freedom from torture and cruel, inhuman or degrading treatment or punishment. These obligations. Contained in Articles 12, 25, 17 and 15 respectively, will require immediate cessation of forced psychiatric interventions. But there is a need to go further and examine the serious nature and consequences of forced psychiatric interventions as a violent assault, in most cases sanctioned, if not perpetrated by the state affecting every aspect of a person’s life.”[[36]](#footnote-36)

This leaflet below which the International Disability Caucus distributed to delegates at the 7th Ad Hoc Committee was powerful in persuading delegates to support the radical change that the IDC prompted by World Network of Users and Survivors of Psychiatry (WNUSP) was arguing for around Article Protection from Torture and Article 12 for Universal Legal Capacity(ULC) [[37]](#footnote-37)

**“IMAGINE...**

Imagine if someone else was making decisions for you. They could decide to take you away, lock you up, not listen to you, give you medication, block you from doing your work and living your life with your body and mind the way they are.

**WOULD YOU WANT THIS TO HAPPEN TO YOU?**

* Wouldn’t you have the feeling that you have lost your dignity and want it back?
* Wouldn’t you feel your integrity has been violated?
* Wouldn’t you want to have support in making decisions without being taken over and to ask for help without being seen any the less for it?
* Wouldn’t you want to maintain your inherent dignity and be supported to make your own decisions?
* Wouldn’t you want to retain your integrity and continue to be you?

Would you want a Convention that allows forced interventions and does not respect your inherent dignity as a person?

The principles established in this Convention are universal and will apply to all human beings, as much to you as to me.

Let us make a Convention for a world where we can all grow and develop with mutual support.

**IMAGINE A CONVENTION FOR ALL”**

People with psycho-social impairments are routinely denied the right to exercise their legal capacity. Through guardianship and other substitute decision-making measures, they are often prevented from making decisions and choices about their lives, including on issues related to their living arrangements, their medical care, their personal and

financial affairs and other matters. Instead, these decisions are often made by families,

carers, guardians, or health professionals. The aim of the United Nations *Convention on the Rights of Persons with Disabilities* is to end this situation. Article 12 of the Convention recognizes that people with disabilities, including mental disabilities, have the right to exercise their legal capacity, i.e. to make decisions and choices on all aspects of their lives, on an equal basis with others. The Convention also recognizes that some people may on occasion require assistance in making decisions about their lives and promotes a supported decision-making model as the means for providing this assistance.

**The right to legal capacity**

Most people take it for granted that they can make decisions and have them respected by others.

Legal capacity is the ability to hold rights and duties and the ability to exercise those rights and duties.

Its about both big and small decisions and is a prerequisite to enjoying all human rights.

**How is legal capacity denied?**

Full or partial guardianship.

Mental health laws that allow for involuntary admission, forced treatment and deprivation of liberty on the basis of disability.

Informal guardianship – this is an informal regime of substituted decision making e.g., where family members make decisions on behalf of persons with disabilities.

**Paradigm in the CRPD**

All persons with disability are presumed to have legal capacity and states must take all appropriate measures to ensure this is realised.

Prohibits all involuntary practices e.g., involuntary admission, treatment, or restraint.

Embraces a Supported decision-making paradigm.

Recognises personal will and preference to be the underlying principle in all decision-making process.

Provides for safeguards again abuse and undue influence.

Recognise the right of persons with disabilities to own property and access all financial services on an equal basis with others.

Distinguishes between mental capacity and legal capacity.

**Supported decision making**

This ensures that:

Information is provided in an accessible format that a person can understand.

There is an evaluation of all available alternatives and their consequences.

Support is provided to implement a decision.

Appropriate safeguards are provided.

**Examples of Supports**

* Peer support
* Advance directives (General or Health)
* Circles of friends
* Support agreements
* Family support
* Social capital – social workers

**What happens in difficult situation or crisis..?**

General Comment No 1-where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the “best interpretation of will and preferences” must replace the “best interests” determinations.

**How do we make a best interpretation of will and preference?**

Evaluate previously manifested preferences attitudes, narratives, and actions.

This could be verbal or non-verbal.

Provide unconditional and intensive support.

Use of advance directives.

**Supported decision-making** involves the nomination by people with mental disabilities of a trusted person or a network of people with whom they can consult and discuss issues affecting them. Such people may assist service users in understanding the choices and options available to them in relation to their mental health treatment (e.g. whether to get treatment, where to get treatment, what type of treatment) and in communicating their choices and preferences to others when necessary. They may help others to realize that a person with significant disabilities is also a person with a history, interests and aims in life and is someone capable of exercising his or her legal capacity. In supported decision-making, the presumption is always in favour of the person with a disability who will be affected by the decision.

Staff at mental health and social care facilities can play a vital role in promoting supported decision-making by:

• encouraging service users to nominate support people or networks of people,

• facilitating contacts between service users and their support people,

• ensuring that service users and their support people are given the space and time

to discuss issues related to mental health treatment and care.

Forms of supported decision-making include support networks, personal ombudspeople,

peer support, advocates, and personal assistants. Canada and Sweden

offer models of supported decision-making, which are currently being implemented:

• Canadian Association for Community Living: http://www.cacl.ca/

• Nidus Personal Planning Resource Centre and Registry (British Columbia, Canada):

http://www.rarc.ca/textual/home.htm

• Sweden Personal Ombudsman Model – PO-Skane: http://www.po-skane.org/[[38]](#footnote-38)

“The United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) was adopted in 2007 and has since been ratified by 182 countries. It represents a paradigm shift from an impairment-focused, biomedical model of disability to a socially focused, human rights–based model. Impairment arising out of a mental health condition is termed “psychosocial disability” in this model, and laws and clinical protocols governing mental health practice are likely to be informed by the CRPD’s provisions. The Indian Mental Health Care Act of 2017 (MHCA) states that it was drafted because “it is necessary to…harmonize existing laws with [the CRPD]” [[39]](#footnote-39). Similar processes have taken place or are in motion in 32 countries,[[40]](#footnote-40)illustrating the CRPD’s potential impact on the lives of people living with psychosocial disabilities. This evolution also applies to intellectual disabilities and degenerative conditions (e.g., dementia). Although not covered in detail in this paper, all of these conditions are likely to be affected by the CRPD’s approach to legal capacity, as discussed below.

**Biomedical approaches** to mental health have allowed for substitute decision-making (i.e., the judgment of a proxy superseding that of an individual when that individual is deemed to be “incapacitated”), leading to considerable maltreatment and abuse of people with psychosocial disabilities[[41]](#footnote-41). With this history in mind, disability rights advocates, including the World Network of Users and Survivors of Psychiatry (WNUSP), argued strongly for the right to equal recognition before the law, resulting in Article 12 of the CRPD asserting this right. Further interpretation of Article 12 takes the form of General Comment 1 on Article 12 (GC1)[[42]](#footnote-42). GC1 affirms universal legal capacity (ULC), meaning that all people should be treated as having equal decision-making competency at all times, and mandates a regime of supported decision-making, in which an individual’s will and preference are sought in matters regarding treatment, and assistance is provided to make it possible to ascertain such will and preferences.

In the event that this is deemed impossible, the clinician and/or adjudicator is required to **apply a standard of the “****best interpretation of the individual’s will and preference” instead of the traditional “best interests” principle**[[43]](#footnote-43). The former standard seeks an implicit or explicit communication of the individual’s choices, including through nonverbal communication, while the latter relies on the judgment of an external “trusted” person. This shift is, therefore, a recognition of the equal “personhood” of people with psychosocial disabilities, regardless of cognition[[44]](#footnote-44).It should be noted that, while the CRPD requires states to adhere to these principles, it does not offer guidance on how they can harmonize their mental health systems with them”.

Efforts to engage with supported decision-making have been gaining traction. Advance directives predate the CRPD in some contexts[[45]](#footnote-45). Peer support models, such as the “circle of support,” bringing together supporters of MHCUs to discuss their will and preferences, have been utilized[[46]](#footnote-46). The process of “open dialogue,” whereby discussion is generated in family and treatment systems, has been proposed [[47]](#footnote-47), while the introduction of a personal ombud for MHCUs in Sweden has also demonstrated potential[[48]](#footnote-48) Even so, implementation requires adaptability for contexts in which resources are limited. Research is needed to develop best practices in culturally and economically diverse contexts. A 2012 review found that supported decision-making provisions were particularly wanting in low- and middle-income countries [[49]](#footnote-49)despite isolated efforts such as the “circle of care” implemented in India[[50]](#footnote-50). The UN Special Rapporteur on the Rights of People with Disabilities reported in 2017 that research projects were underway in 17 countries on six continents[[51]](#footnote-51). Considering the crucial need for locally developed solutions, this should be supported. Similarly, efforts to engage with MHCUs directly on their preferences regarding supported decision-making through means such as surveys and social media can contribute significantly to this discourse”[[52]](#footnote-52).

***Follow Up Activity 3.6***

***3.6 i) Explain the main arguments why mental health service users should have Universal Legal Capacity***

***ii) Describe three ways that Psychiatrists who argue they should have charge of the best interests of disabled people in the Mental Health System are wrong.***

***iii) Explain 3 good ways the best interpretation of the individual’s will and preference of the disabled person can be ascertained.***

The Quality Rights Toolkit produced by WHO is a useful tool to evaluate the services and position of those with psychosocial impairment with regard to their rights. It takes the sensible view that a whole series of Rights are linked and not much progress will be made in altering the position of those with psychosocial impairment unless progress is made on these.

**Five themes, drawn from the CRPD, are covered by the tool kit:**

**1.** **The right to an adequate standard of living and social protection (Article 28 of the CRPD).** Many people staying in residential facilities have inhuman living conditions, including overcrowding and poor sanitation and hygiene. Residents lack proper clothing, clean water, food, heating, decent bedding, and privacy. The social environment is often no better: people are denied the opportunity to communicate with the outside world, their privacy is not respected, they experience excruciating boredom and neglect and little or no intellectual, social, cultural, physical, or other form of stimulation. Article 28 of the CRPD requires, among other things, that people with disabilities are provided with an adequate standard of living, including adequate food, clothing, clean water, devices and other assistance for disabilities and continuous improvement of their living conditions.

**2. The right to enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD).** In many countries, people do not have access to the basic mental health care and treatment that they require. Services are often too far from their homes or unaffordable. In other cases, the services themselves are of poor quality: ineffective or harmful treatments are applied, and comorbid general health problems are ignored. Institutional services are emphasized to the detriment of outpatient community-based facilities, and the focus of many services is on detaining people rather than helping them to develop their abilities in order to recover and (re)integrate into the community (See Annex 1 for the principles related to recovery). Furthermore, people living in residential facilities are often unable to access services for general and sexual and reproductive health. Article 25 of the CRPD requires that people with disabilities be given the health services they need, as close as possible to their communities. It also requires that they be given the same range, quality and standard of free or affordable health care, including sexual and reproductive health, as all other people.

**3. The right to exercise legal capacity and the right to personal liberty and the security of person (Articles 12 and 14 of the CRPD**). People with mental and intellectual disabilities routinely experience violations of their right to exercise their legal capacity. They are often considered incapable of making decisions about their own lives, and key choices that concern them (e.g., about their place of residence, their medical treatment, their personal and financial affairs) are made by families, carers, guardians, or health professionals. Furthermore, people in countries all over the world are given medical treatment or admitted to residential facilities without their express informed consent. Article 12 of the CRPD states that people with disabilities have the right to recognition everywhere as persons before the law. It also re-asserts the rights of people with disabilities to exercise their legal capacity on an equal basis with others in all aspects of life. They must therefore remain central to all decisions that affect them, including about their treatment, where they live and their personal and financial matters. Article 12 also states that, when needed, people should be given support in exercising their legal capacity. This means that they should have access to a trusted person or group of people, who can explain issues related to their rights, treatment, and other relevant matters and who can help them to interpret and communicate their choices and preferences. The people providing support could include advocates, a personal ombudsperson, community services, personal assistants, and peers (see Annex 2 for further information on supported decision-making). Article 14 of the CRPD (the right to liberty and security of person) is an important provision in relation to admission without informed consent. It states that people with disabilities must not be deprived of their liberty unlawfully or arbitrarily, that any deprivation of liberty must be in conformity with the law and that the existence of a disability shall in no case justify deprivation of liberty.

**4. Freedom from torture or cruel, inhuman, or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16 of the CRPD).** People in inpatient facilities and social care homes in many countries are exposed to physical, sexual, and mental abuse. Many spend days, months and even years living aimless, inactive lives in excruciating boredom and total social isolation. They are often secluded (for example in isolation cells) or placed in restraints (such as chains, shackles, and caged beds). In addition, they are often over-medicated, so that they remain docile and ‘easy to manage’. In many instances and according to international human rights law, this treatment amounts to ill-treatment and in some cases even torture. Article 15 requires that all appropriate measures be taken to prevent people with disabilities from being subjected to torture or cruel, inhuman, or degrading treatment or punishment. This Article also states that no one must be subjected to medical or scientific experimentation without his or her free consent. Article 16 requires that all measures be taken to protect people against and prevent all forms of exploitation, violence, and abuse. This Article also requires that all appropriate measures be taken to promote the physical, cognitive, and psychological recovery, rehabilitation, and social reintegration of people with disabilities who become victims of any form of exploitation, violence, or abuse, including by the provision of protection services. In addition, recovery and reintegration must take place in an environment that fosters the health, welfare, self-respect, dignity, and autonomy of the person and takes into account gender- and age-specific needs. Importantly also, Article 16 requires that all facilities and programmes designed to serve people with disabilities be effectively monitored by independent authorities.

**5. The right to live independently and be included in the community (Article 19 of the CRPD).** People with disabilities experience wide-ranging violations and discrimination, which prevent them from living and being included in the community. They are denied opportunities to work and get an education and access to the social and financial support they require to live in the community. They are also restricted in the exercise of their right to vote and to join and participate in political, religious, social, and self-help or advocacy organizations. They are unable to exercise their religious or cultural practices and are denied opportunities for leisure, fitness, and sports activities. Part of the problem is that both inpatient and outpatient services for people with mental disabilities are focused on treatment and care rather than on providing or facilitating access to the full range of support to allow these people to live independently in the community and participate fully in society. Article 19 states that people with disabilities have the right to live in the community and that governments must take effective, appropriate measures to facilitate their full inclusion and participation in society. It further states that people have the right to decide where and with whom they live; they must not be obliged to live in a particular living arrangement. Significantly also, Article 19 states that people must be given access to a range of in-home, residential, and other community support services, including the personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community. The concepts of inclusion and participation outlined in Article 19 are further articulated in other articles of the Convention, including those on the rights to education, to work and employment and to participation in political, public and cultural life and in recreation, leisure and sport”[[53]](#footnote-53).

The tool kit provides a range of criteria to assess where the country is on these five areas showing how rights are indivisible and interdependent. The position a number of Psychiatrists and Governments are taking against Article 12 and Universal Capacity Law is because they cannot see a way around involuntary treatment as they are not taking the holistic view above required by the paradigm shift in the UNCRPD.

# **vii) What are the particular issues that have arisen for disabled people during the Covid -19 Pandemic?**

***COVID-19: Who is protecting the people with disabilities? – UN Special Rapporteur Disability[[54]](#footnote-54)****“Little has been done to provide people with disabilities with the guidance and support needed to protect them during the ongoing COVID-19 pandemic, even though many of them are part of the high-risk group, today warned the UN Special Rapporteur on the rights of persons with disabilities, Catalina Devandas.*

*"People with disabilities feel they have been left behind," the UN human rights expert said. "Containment measures, such as social distancing and self-isolation, may be impossible for those who rely on the support of others to eat, dress and bathe."*

*"This support is basic for their survival, and States must take additional social protection measures to guarantee the continuity of support in a safe manner throughout the crisis."*

*The UN expert stressed that reasonable accommodation measures are essential to enable people with disabilities to reduce contacts and the risk of contamination. They should be allowed to work from home or receive paid leave to guarantee their income security. Family members and caregivers may also require reasonable accommodation to provide support to people with disabilities during this period.*

*"Access to additional financial aid is also vital to reduce the risk of people with disabilities and their families falling into greater vulnerability or poverty," she explained.*

*"Many people with disabilities depend on services that have been suspended and may not have enough money to stockpile food and medicine or afford the extra cost of home deliveries."*

*Devandas also noted that the situation of people with disabilities in institutions, psychiatric facilities and prisons is particularly grave, given the high risk of contamination and the lack of external oversight, aggravated by the use of emergency powers for health reasons.*

*"Restrictions should be narrowly tailored and use the least intrusive means to protect public health" she said. "Limiting their contact with loved ones leaves people with disabilities totally unprotected from any form of abuse or neglect in institutions.*

*"States have a heightened responsibility towards this population due to the structural discrimination they experience."*

*The UN expert stressed that persons with disabilities deserve to be reassured that their survival is a priority and urged States to establish clear protocols for public health emergencies to ensure that, when medical resources are scarce, access to healthcare, including life-saving measures, does not discriminate against people with disabilities.*

*"To face the pandemic, it is crucial that information about how to prevent and contain the coronavirus is accessible to everyone", she explained.*

*"Public advice campaigns and information from national health authorities must be made available to the public in sign language and accessible means, modes and formats, including accessible digital technology, captioning, relay services, text messages, easy-to-read and plain language."*

*"Organizations of people with disabilities should be consulted and involved in all stages of the COVID-19 response," Devandas concluded.*

**Article 25 and 12 violated during Covid19**

The COVID-19 pandemic, which is overwhelming health care systems and posing a dramatic threat to public health worldwide, highlights the issue of explicit and implicit bias against persons with disabilities in accessing health care and being treated equally and with full dignity therein. Reports from around the globe show how biases that have always been present have become magnified by COVID-19. For instance, Romanians with disabilities with full-blown COVID-19 in institutional care have been quarantined instead of hospitalized, something that is not being done to those without disabilities.[[55]](#footnote-55) Descriptions of Guatemala’s sole public psychiatric hospital note that it is a “dumping ground” for persons with disabilities and a COVID-19 breeding ground.[[56]](#footnote-56) In the United States, there are claims of persistent discrimination against individuals with disabilities trying to access COVID-19-related health services, such as ventilators.[[57]](#footnote-57)

Globally, the COVID-19 Disability Rights Monitor Dashboard—an organization that monitors experiences of injustice by persons with disabilities—has received approximately 1,600 complaints from people in more than 120 countries.[[58]](#footnote-58) Moreover, clinical triage and treatment criteria, predicated on social constructions rather than evidence-based studies, have been promulgated and may result in standards that further discriminate against patients with disabilities when apportioning ICU beds, ventilators, and other care. At the start of the COVID-19 pandemic in the United States, for example, the state of Alabama explicitly recommended that patients with intellectual and developmental disabilities be viewed as ineligible for ventilators.[[59]](#footnote-59)

Hope is crucial for the therapeutic alliance and treatment success. Patients with disabilities have enough barriers to adequate care, ranging from lack of physical and sign-language accessibility and inadequate insurance coverage to “inadvertent” discrimination (for example, CT machines that little people cannot reach) to outright stigma (declining in vitro fertilization to women with disabilities because they would be “inappropriate” parents). Clinical life is ever more precarious if the biases of clinicians dissolve some of the hope that would otherwise be present between patient and clinician. While it is true that clinicians need to know more about their legal obligations to persons with disabilities related to required accommodations, everyday moral decisions are also important and probably more immediate, especially during pandemics such as COVID-19.

A lesson that ought to be reinforced from the experiences of the COVID-19 pandemic is that, at its most humane, clinical medicine is and should be situated in life as it is lived, for better or worse. Patients should be acted on as non-interchangeable precious particulars with unique needs, not generic abstractions or aggregates with equal baseline social situations. Another lesson is one that patients with disabilities have always known: even with the same diagnosis and treatment plan, life is more precarious not because of inequality in pathophysiology but due to inequity in cultural, historical, and social psychological factors, as well as normative anti-human rights presuppositions that creep into philosophical formulations of what constitutes “ethical” health care. Disparities arise from the degree to which we see dignity in one another as fully and equally human and as bearers of human rights. Finally, clinicians can be disability rights agents for change by resisting the scrupulous ethical myopia of utilitarian thinking in the clinic. They should empower their patients with disabilities and their colleagues to see clinical life and the health care needs of those with disabilities not with a lens of bias and burdensomeness, but with a lens of dignity, equality, and disability-based human rights.

# **viii) What are the key demands we must campaign around to build back better for disabled people after Covid-19 Pandemic and how can we achieve them?**

CDPF Demands drawn from CDPF Surveys and Summits[[60]](#footnote-60) and Disability Rights Monitoring Report[[61]](#footnote-61)

The CDPF also calls on governments to take the following longer-term steps to avoid future human rights emergencies:

1. Actively involve disabled people and their representative organisations, and civil society, in planning the recovery process and emergency deinstitutionalisation plans.

2. Allocate adequate financial and human resources to support the transition from institutions to the community, in line with Article 19 of the CRPD.

**A. De-Institutionalisation**

1.Develop an emergency deinstitutionalisation plan in line with Article 19 of the CRPD and General Comment No. 5: Right to independent living (2017) of the CRPD Committee.

2.Implement an immediate no-admissions policy to large- and small-scale institutions.

3.Closely monitor the situation in institutions and release data and information on the number of infections and fatalities in institutions.

4.Guarantee immediate, unfettered access to independent national human rights authorities, including NHRIs and NPMs, to all institutions, ensuring safety protocols and procedures are in place to enable independent monitoring and direct communication between monitors and residents.

5.Provide immediate access to food, PPE, social distancing measures, and appropriately trained staff.

6.Provide accessible information in multiple formats about the state of emergency.

7.Ensure full access to healthcare on an equal basis with other citizens.

8.Implement immediate measures to ensure that residents can contact law enforcement and complaints mechanisms, and to ensure contact with family and friends.

9.Ensure that persons within institutions have access to mental health supports and services.

10. Prevent family separation and institutionalisation of children (or parents) due to COVID-19 pandemic.

**B. Disabled People living in the Community**

1. Guarantee full participation and meaningful involvement of disabled people and their representative organisations at every stage of the response.

2. Safeguard community-based services including personal assistance, home supports, and assistive technology.

3. Provide information about the state of emergency in multiple, accessible formats.

4. Enact emergency measures to ensure adequate and affordable food and medication distribution throughout the country, including rural and remote areas.

5. Provide immediate financial assistance to disabled people to cover the additional cost of living and the rise in the cost of food, medications, and other essential supplies.

6. Work with private sector companies such as supermarkets to ensure that food is delivered to the homes of disabled people who are unable to leave and encourage them to allocate dedicated times for at risk shoppers, including disabled people.

7. Investigate and hold accountable police and other security services which abuse, injure, or kill disabled people.

8. Put in place necessary measures to protect disabled people who are in situations of risk, especially during curfews, lockdowns, shielding orders, or shelter at home orders related to the COVID-19 pandemic.

 9. Ensure all security briefings and reports take into consideration the perspectives and rights of persons with disabilities during the COVID-19 pandemic.

10. Ensure police officers and security forces are trained to be mindful of the specific needs of disabled people during the COVID-19 pandemic.

**C. Disproportionate impact on underrepresented groups of disabled people**

1. Guarantee full participation and meaningful involvement of underrepresented disabled people and their representative organisations in decision and policy-making processes. These include women and girls, homeless persons, children, and those living in rural and remote areas.

2. Ensure that legislation and policies are disability-sensitive and recognise diversity among disabled people and the intersectionality of rights.

3. Closely monitor the situation of underrepresented groups of disabled people and collect data and information on their needs.

4. Ensure that implementation of legislation and policies, especially emergency response, is sensitive to the specific, overlapping needs of disabled people.

5. Provide access to justice, women’s shelters, social workers, trauma counselling, and other supports for survivors of domestic violence and sexual abuse.

6. Ensure that disabled children have equal access to healthcare, education, food and medicine, and other community services on an equal basis with all children.

 7. Guarantee that essential services, such as healthcare and mental health services, are age-appropriate and gender-sensitive.

8. Provide accessible, community-based accommodation for homeless disabled people.

9. Guarantee long-term housing and community integration support services for homeless disabled people.

10. Establish a coordination mechanism within the government to ensure equal access to support services throughout the country, including remote and rural areas.

**D. Denial of Access to Healthcare**

1. Guarantee full participation and meaningful involvement of disabled people and their representative organisations at every stage of health policy making.

2. Prevent denial of health information, health care, or health services, on the basis of disability. Provide access to justice for those who have been denied access to healthcare.

3. Disabled people, including persons living in institutions, enjoy the highest attainable standard of health without discrimination, on the basis of disability.

4. Require health professionals to provide healthcare and health information to disabled people on an equal basis with other citizens, including persons in institutions.

5. Raise awareness of disability rights among health professionals, including the right to access information and give free and informed consent to medical treatment.

6. Ensure access to specialised health services including rehabilitation.

7. Guarantee free or affordable healthcare, food and medicine, and prohibit discrimination against disabled people in the provision of health insurance.

8. Provide health information and services as close as possible to people’s own communities, including in remote and rural areas.

9. Ensure that health information and services are age- and gender-sensitive.

10. Provide information about healthcare in multiple, accessible formats.

**E. Education**

1. With up to 1.6 billion children locked out of education recognise that disabled children, girls, and poor children are least likely to continue learning or to return to school.

2.Governments need to make every effort to get all children back to school.

3.Develop inclusive and engaging teaching to meet children where they are in terms of learning.

4.Strengthen education workforce with teachers leading child-centred teams drawing together parents and community to enhance learning.

5.Expand the scope of education technology to provide teacher training and learning at home in future lockdowns.

6. Ensure all learners get access to online or radio learning.

7. Protect and enhance funding especially for reasonable accommodations and support for disabled learners.

8. Mobilise international resources to fill the resource gap internationally to achieve SDG 4 has increased to $150 to $450 billion.

9. Cancel loans and debt servicing to Low Income countries.

10. Improve organisation focused on learner’s achievements at every level.

***Follow Up Activity 3.7***

***3.7 Take 3 of the above demands that relate to each other and work out and then write up how you would***

***i) Research the situation in your local area;***

***ii) How you would plan a campaign to achieve your identified objectives;***

***iii) Who you would mobilise to support your campaign and how you would use the media and social media?***

**C.** **Future Implementation Strategies on Health-Covid-19 and Mental Health**

**Write up what needs to happen in your country to implement the following:**

i) Covid-19 has shown up the cracks in welfare and support for disabled people across the Commonwealth and the lack of inclusive equality and rights perspective. What strategy should be adopted to change this?

ii) Disabled People have been disproportionately negatively impacted in access to information, health, food, support and education. Write a short news piece on this and try to put it on-line or get it published in the press.

iii) Governments must commit to working with DPOs/OPDs to ‘Build Back Better’ by implementing the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and Sustainable Development Goals (SDGs) to specifically remove barriers to disabled people and bring about real cultural and attitudinal change. Identify the key levers of change you will need to mobilise to make this happen in your country.

iv) Many countries have adopted policies for people with Mental Health Issues that are out of date and run counter to the UNCRPD. How would you get the Government to undertake a review and change these in collaboration with people with Mental Health Issues and their representative organisations?

1. Gerard Quinn UN Rapporteur Disability Remarks to 13th Conference State Parties UN 30th November 2020 <https://www.un.org/development/desa/disabilities/wp-content/uploads/sites/15/2020/12/Mr-Gerald-Quinn-SR-Disabilities-Speech.pdf> [↑](#footnote-ref-1)
2. <https://commonwealthdpf.org/covid-19/> [↑](#footnote-ref-2)
3. <https://commonwealthdpf.org/letter-to-uk-prime-minister-from-general-secretary-richard-rieser-09-06-20/> [↑](#footnote-ref-3)
4. <https://covid-drm.org/en/statements/covid-19-disability-rights-monitor-report-highlights-catastrophic-global-failure-to-protect-the-rights-of-persons-with-disabilities> [↑](#footnote-ref-4)
5. <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenEleme> OHCHR 2014 para 15 [↑](#footnote-ref-5)
6. Bruno G.C. Article 11 [Situations of risk and humanitarian emergencies] In: Fina V.D., editor. *The United Nations Convention on the Rights of Persons with Disabilities.* Springer; 2017. pp. 253–261 [↑](#footnote-ref-6)
7. [United Nations, Policy Brief A disability-inclusive response to COVID-19. May 2020.](https://www.un.org/sites/un2.un.org/files/sg_policy_brief_on_persons_with_disabilities_final.pdf) [↑](#footnote-ref-7)
8. Ibid [↑](#footnote-ref-8)
9. Huremovic D. Introduction. In: Huremovic D., editor. *Psychiatry of Pandemics.* Springer; 2019. pp. 1–6 [↑](#footnote-ref-9)
10. United Nations Office for the Coordination of Humanitarian Affairs OCHA and COVID-19. 2020. [https://unocha.org](https://unocha.org/) [↑](#footnote-ref-10)
11. [Australian Institute of Health and Welfare (AIHW), Mental Health Services in Australia 2020.  last accessed 16 June 2020](https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary/prevalence-and-policies) [↑](#footnote-ref-11)
12. #  [Wilson K The COVID-19 pandemic and the human rights of persons with mental and cognitive impairments subject to coercive powers in Australia](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7318936/#bb0195) 2020

 [↑](#footnote-ref-12)
13. Deaths of people identified as having learning disabilities with COVID-19 in England in the spring of 2020 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/933612/COVID-19__learning_disabilities_mortality_report.pdf> Public Health England, Nov.2020 [↑](#footnote-ref-13)
14. <https://www.bbc.co.uk/news/uk-56033813> [↑](#footnote-ref-14)
15. Ibid point 6 [↑](#footnote-ref-15)
16. <https://commonwealthdpf.org/wp-content/uploads/2020/06/Memoranda-on-mental-health-during-the-COVID-19-pandemic-KNCHR-and-CSOs-Forum-on-Mental-Health-08-04-2020-1-1.pdf> [↑](#footnote-ref-16)
17. Ibid point 6 [↑](#footnote-ref-17)
18. [United Nations, Policy Brief A disability-inclusive response to COVID-19. May 2020.](https://www.un.org/sites/un2.un.org/files/sg_policy_brief_on_persons_with_disabilities_final.pdf) [↑](#footnote-ref-18)
19. <https://humanity-inclusion.org.uk/en/news/blog-women-with-disabilities-at-higher-risk-of-domestic-and-sexual-violence-with-covid-19> [↑](#footnote-ref-19)
20. Ibid point 10 [↑](#footnote-ref-20)
21. Ruiz R. Coronavirus reveals everything that’s wrong with our mental health care system. *Mashable Australia.*14 March 2020 <https://mashable.com/article/coronavirus-anxiety/> [↑](#footnote-ref-21)
22. OCHR ‘Months in fear, anxiety and confusion: The life of people with disabilities in COVID-19’ 9 June 2020, 2020b https:[www.ohchr.org/EN/NewsEvents/Pages/CRPD-COVID-19.aspx](http://www.ohchr.org/EN/NewsEvents/Pages/CRPD-COVID-19.aspx) ; http://equalityupdates.org.uk/covid-19-supercharges-existing-inequalities-faced-by-glasgows-150000-disabled-people/ [↑](#footnote-ref-22)
23. ##  [COVID-19 in India: Locked Down & Left Behind](https://commonwealthdpf.org/covid-19-in-india-locked-down-left-behind/)

 [↑](#footnote-ref-23)
24. Covid-19 Income loss, risk of violence and the response of persons with disabilities and their representative organisations in Uganda,ADD International Nov 2020 <https://add.org.uk/file/4321/download?token=U-U2lhDu> [↑](#footnote-ref-24)
25. Covid Double Jeopardy Bangladesh ADD International July 202 <https://add.org.uk/file/4225/download?token=jFGRN8_7> [↑](#footnote-ref-25)
26. <https://57e7b526-0150-4fbc-b3e5-0f9fa1536427.filesusr.com/ugd/50c137_22cf48729fb0413b858bf7aec73934b0.pdf?index=true> [↑](#footnote-ref-26)
27. CRPD Committee ‘Statement on COVID-19 and the human rights of persons with disabilities’ 9. June 2020. [http://www.ohchr.org/EN/NewEvents/Pages/DisplayNews.aspx?](http://www.ohchr.org/EN/NewEvents/Pages/DisplayNews.aspx?NewsID=25942&LangID=E) [↑](#footnote-ref-27)
28. World Report on Disability (2011) WHO and World Bank <https://www.who.int/disabilities/world_report/2011/report.pdf> [↑](#footnote-ref-28)
29. ibid , 2011 [↑](#footnote-ref-29)
30. Mental Health Council of Australia, ‘Not for Service – Experiences of Injustice and Despair in Mental Health Care in Australia: A Report of the Consultations by the Mental Health Council of Australia and the Brain and Mind Research Institute in Association with the Human Rights and Equal Opportunity Commission 2005’ <<http://humanrights.gov.au/disability_rights/notforservice/index.html>> accessed 5 December 2012 [↑](#footnote-ref-30)
31. Elianor D. Kinney, ‘The International Human Right to Health: What Does This Mean for our Nation and World?’ 2001<<http://journals.iupui.edu/index.php/inlawrev/article/viewFile/3499/3445>> accessed 6 December 2012 [↑](#footnote-ref-31)
32. Amnesty International, ‘Mental Health and Your Human Rights: A Brief Guide’ <http://www.amnesty.ie/sites/default/files/file/MentalHealth/WEB_GUIDE_SINGLE_SPREADS.pdf> accessed 10th February 2021 [↑](#footnote-ref-32)
33. Ibid [↑](#footnote-ref-33)
34. Ibid [↑](#footnote-ref-34)
35. CRPD Committee, ‘General comment No 1 (2014) Article 12: Equal recognition before the law’ UN Doc CRPD/C/GC/1 (19 May 2014); Amita Dhanda, ‘Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future’ (2006-7) 34 *Syracuse Journal of International Law and Commerce* 429; Amita Dhanda, ‘Universal Legal Capacity as a Universal Human Right’, in Michael Dudley, Derek Silove and Fran Gale (eds) *Mental Health and Human Rights: Vision, praxis, and courage* (OUP 2012); Eilionóir Flynn and Anna Arstein-Kerslake, ‘Legislating Personhood: Realising the Right to Support in Exercising Legal Capacity’ (2014) 10 *International Journal of Law in Context* 81–104). [↑](#footnote-ref-35)
36. Tina Minkowitz The UNCRPD and the Right to be Free From Nonconsensual Psychiatric Interventions. “006 Syracuse Jo Int’ Law , 405, [↑](#footnote-ref-36)
37. IDC 31st January 2006 <http://www.chrusp.org/media/AA/AG/chrusp-biz/downloads/39191/IDC_special_edition_on_Articles_12_and_17.doc> [↑](#footnote-ref-37)
38. WHO(2012) Quality Rights Toolkit <https://apps.who.int/iris/bitstream/handle/10665/70927/9789241548410_eng.pdf?sequence=3> [↑](#footnote-ref-38)
39. . The Mental Health Care Act, No. 10 of 2017. 2017 Apr 7 [cited 11 April 2018] [Internet]. [http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20Healthcare%20Act,%202017.pdf](http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20Healthcare%20Act%2C%202017.pdf) [↑](#footnote-ref-39)
40. United Nations General Assembly. Report of the Special Rapporteur on the rights of persons with disabilities. 2017 Dec 12 [cited 11 April 2018] [Internet]. <http://www.un.org/en/ga/search/view_doc.asp?symbol=A/HRC/37/56> [↑](#footnote-ref-40)
41. Minkowitz T. The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Non-consensual Psychiatric Interventions. *Syracuse Journal of International and Comparative Law*. 2006; 34: 405–428 [↑](#footnote-ref-41)
42. United Nations Committee on the Rights of Persons with Disabilities. General comment No. 1: Article 12, Equal recognition before the law. 2014 April 11 [cited 28 Sep 2018] [Internet]. <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement> [↑](#footnote-ref-42)
43. Browning M, Bigby C, Douglas J. Supported Decision Making: Understanding How Its Conceptual Link to Legal Capacity Is Influencing the Development of Practice. *Research and Practice in Intellectual and Developmental Disabilities*. 2014; 1: 34–45. [[Google Scholar](https://scholar.google.com/scholar_lookup?journal=Research+and+Practice+in+Intellectual+and+Developmental+Disabilities&title=Supported+Decision+Making:+Understanding+How+Its+Conceptual+Link+to+Legal+Capacity+Is+Influencing+the+Development+of+Practice&author=M+Browning&author=C+Bigby&author=J+Douglas&volume=1&publication_year=2014&pages=34-45&)] [↑](#footnote-ref-43)
44. Flynn E, Arstein-Kerslake A. Legislating personhood: realising the right to support in exercising legal capacity. *International Journal of Law in Context*. 2014; 10(1): 81–104. [[Google Scholar](https://scholar.google.com/scholar_lookup?journal=International+Journal+of+Law+in+Context&title=Legislating+personhood:+realising+the+right+to+support+in+exercising+legal+capacity&author=E+Flynn&author=A+Arstein-Kerslake&volume=10&issue=1&publication_year=2014&pages=81-104&)] [↑](#footnote-ref-44)
45. Davis JK. How to justify enforcing a Ulysses contract when Ulysses is competent to refuse. *Kennedy Institute of Ethics Journal*. 2008; 18(1): 87–106; Henderson C, Swanson JW, Szmukler G. A typology of advance statements in Mental Health Care. Psychiatric Services. 2008; 59(1)(63): 160–172. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/18561579)] [[Google Scholar](https://scholar.google.com/scholar_lookup?journal=Kennedy+Institute+of+Ethics+Journal&title=How+to+justify+enforcing+a+Ulysses+contract+when+Ulysses+is+competent+to+refuse&author=JK+Davis&volume=18&issue=1&publication_year=2008&pages=87-106&pmid=18561579&)] [↑](#footnote-ref-45)
46. Circles Network. Circles of support. c2011 [cited 11 April 2018] [Internet]. <https://www.youtube.com/watch?v=w6RX_WQmSf4&feature=youtu.be&t=54> [↑](#footnote-ref-46)
47. Seikkula J, Aaltonen J, Alakare B, Haarakangas K, Keränen J, Lehtinen K. Five-year experience of first episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes and two case studies. *Psychotherapy Research*. 2006; 16(2): 214–28. [[Google Scholar](https://scholar.google.com/scholar_lookup?journal=Psychotherapy+Research&title=Five-year+experience+of+first+episode+nonaffective+psychosis+in+open-dialogue+approach:+Treatment+principles,+follow-up+outcomes+and+two+case+studies&author=J+Seikkula&author=J+Aaltonen&author=B+Alakare&author=K+Haarakangas&author=J+Ker%C3%A4nen&volume=16&issue=2&publication_year=2006&pages=214-28&)] [↑](#footnote-ref-47)
48. National Board of Health and Welfare of Sweden. A New Profession is Born: Personligt ombud, PO. 2008 Nov [cited 11 Apr 2018] [Internet]. <http://www.personligtombud.se/publikationer/pdf/A%20New%20Proffession%20is%20Born.pdf> [↑](#footnote-ref-48)
49. Pathare S, Shields LS. Supported Decision-Making for Persons with Mental Illness: A Review. *Public Health Reviews*. 2012; 34(2): 1–40. [[Google Scholar](https://scholar.google.com/scholar_lookup?journal=Public+Health+Reviews&title=Supported+Decision-Making+for+Persons+with+Mental+Illness:+A+Review&author=S+Pathare&author=LS+Shields&volume=34&issue=2&publication_year=2012&pages=1-40&pmid=26236074&)] [↑](#footnote-ref-49)
50. Satyamev Jayate. Circles of care. 2018 [cited 11 April 2018] [Internet]. <http://www.satyamevjayate.in/nurturing-mental-health/episode-5article.aspx?uid=s3e5-ar-v1> [↑](#footnote-ref-50)
51. United Nations General Assembly. Report of the Special Rapporteur on the rights of persons with disabilities. 2017 Dec 12 [cited 11 April 2018]. <http://www.un.org/en/ga/search/view_doc.asp?symbol=A/HRC/37/56> [↑](#footnote-ref-51)
52. Involuntary mental health treatment in the era of the United Nations Convention on the Rights of Persons with Disabilities 2018 Mahomed,F., Stein M.A, & Pater,V. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6193619/> [↑](#footnote-ref-52)
53. WHO(2012) Quality Rights Toolkit <https://apps.who.int/iris/bitstream/handle/10665/70927/9789241548410_eng.pdf?sequence=3> [↑](#footnote-ref-53)
54. Speech by Catalina Devandas *GENEVA, 17 March 2020* [*https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25725*](https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25725) [↑](#footnote-ref-54)
55. European Network on Independent Living, *Urgent appeal requesting access to COVID-19 medical treatment in Romania*(June 2020). Available at <https://enil.eu/news/urgent-appeal-requesting-access-to-medical-care-in-romania> [↑](#footnote-ref-55)
56. N. Larsson, “Officials conceal conditions at Guatemala mental health hospital during pandemic,” North American Congress on Latin America (June 23, 2020). Available at <https://nacla.org/news/2020/06/23/guatemala-mental-health-hospital-covid> [↑](#footnote-ref-56)
57. E. Pendo, “Covid-19 and disability-based discrimination in health care,” American Bar Association (May 22, 2020). Available at <https://www.americanbar.org/groups/diversity/disabilityrights/resources/covid19-disability-discrimination> . [↑](#footnote-ref-57)
58. European Network on Independent Living, the Validity Foundation, the International Disability Alliance, et al., *COVID-19 disability rights monitor*(2020). Available at <https://covid-drm.org> . [↑](#footnote-ref-58)
59. S. Fink, “U.S. civil rights office rejects rationing medical care based on disability, age,” *New York Times*(March 28, 2020). Available at <https://www.nytimes.com/2020/03/28/us/coronavirus-disabilities-rationing-ventilators-triage.html> [↑](#footnote-ref-59)
60. <https://commonwealthdpf.org/covid-19/> [↑](#footnote-ref-60)
61. <https://covid-drm.org/en/statements/covid-19-disability-rights-monitor-report-highlights-catastrophic-global-failure-to-protect-the-rights-of-persons-with-disabilities> [↑](#footnote-ref-61)