

Mandate of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

REFERENCE:
AL OTH 3/2020

11 March 2020

Ms. Van der Leyen,

I have the honour to address you in my capacity as Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, pursuant to Human Rights Council resolutions 42/16.

I am sending this letter under the communications procedure of the Special Procedures of the United Nations Human Rights Council. Special Procedures mechanisms can intervene directly with governments and other stakeholders on human rights issues of concern that come within their mandates by means of letters, which include urgent appeals, allegation letters, and other communications. The process involves sending a letter to the concerned actors identifying the human rights issues of concern, applicable international human rights norms and standards, the concerns and questions of the mandate-holder(s), and a request for follow-up action. Communications may deal with individual cases, general patterns and trends of human rights violations, cases affecting a particular group or community, or the content of draft or existing legislation, policy or practice considered not to be fully compatible with international human rights standards.

In this connection, I would like to bring to your attention, in your capacity as the President of the European Commission, information I have received concerning **the use of the European Structural and Investment Funds to replace large institutions for persons with disabilities and older persons with smaller institutions, without addressing the deeply ingrained discrimination, social exclusion and segregation of these groups.**

According to the information received:

Funds of the European Structural and Investment Funds have been granted to the Government of Bulgaria through the Call for Proposals BG16RFOP001-5.002 “Support for the deinstitutionalisation of services for elderly people and people with disabilities” under Priority Axis 5 “Regional social infrastructure” of Operational Programme “Regions in Growth.” These funds are allegedly not being used to deinstitutionalize persons with disabilities and older persons currently placed in large institutions, but to replacing these institutions with smaller ones without addressing the deeply ingrained discrimination, social exclusion and segregation of these groups.

While I do not wish to prejudge the accuracy of the information made available to me, I wish to express my serious concern about these allegations. I am deeply concerned

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that European Structural and Investment Funds are being used to continue the outdated practice of institutionalization, albeit in smaller facilities, with services that fail to address the deeply ingrained discrimination, social exclusion and segregation of persons with disabilities and older persons. Health services delivered in smaller institutions do not include a balanced health approach that includes psychosocial interventions and that, most importantly, supports independent living, effectively safeguarding persons with disabilities and older persons from discrimination and from arbitrary, excessive, inappropriate and ineffective clinical care. These type of services are neither delivered at the community level.

In connection with these allegations, I would like to remind you that the European Union is party to the Convention on the Rights of Persons with Disabilities (CRPD) since 22 January 2011. Moreover, all the 28 Member States of the European Union, including Bulgaria, have ratified the CRPD. Article 5 of the CRPD requires States to, inter alia, prohibit all discrimination on the basis of disability and to take all appropriate steps to ensure reasonable accommodation. In interpreting article 5 of the CRPD, the Committee on the Rights of Persons with Disabilities has established that segregation, separate treatment and institutionalization constitute a *prima facie* form of discrimination and thus a breach of article 5 (CRPD/C/GC/6). The provision has in mind practices of segregation and exclusions that persons with disabilities have experienced as a result of laws, policies and practices in the past.

Under article 25 of the CRPD, the European Union is obliged to, inter alia, i) take all appropriate measures to ensure access for persons with disabilities to health services as close as possible to their own communities; of the same quality 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; ii) prohibit discrimination against persons with disabilities, and iii) foster respect for the rights and dignity of persons with disabilities, combating stereotypes, prejudices and harmful practices, including those based on age, in all areas of life.

I would like to further remind that as a duty-bearer under CRPD article 4, but also under the Charter of Fundamental Rights of the European Union, the European Commission has a clear responsibility as a donor not to finance initiatives that are contrary to human rights, including to its obligations under the CRPD. I therefore call on the European Commission to immediately stop the funding to Bulgaria that is being used to build a large number of smaller institutions for persons with disabilities and older persons and to ensure that its funding is used in line with human rights principles and standards.

In addition, I wish to draw your attention to article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) which establishes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The Committee on Economic, Social and Cultural Rights (CESCR) in its General Comment 14 indicates that, while the right to physical and mental health is of progressive realisation, the obligation not to discriminate (ICESCR art. 2.2) is of immediate effect and it is not subject to considerations of resource availability.

Health care services must therefore ensure that persons with disabilities and older persons get the same level of medical care within the same system as other members of society and do not face discrimination on the basis of presumptions of their quality of life and potential. The obligation of non-discrimination in relation to the right to health requires that persons with disabilities and older persons enjoy their right to physical and mental health in the communities as persons without disabilities or younger persons do.

In connection with the above alleged facts and concerns, please refer to the **Annex on Reference to international human rights law** attached to this letter which cites international human rights instruments and standards relevant to these allegations.

As it is my responsibility, under the mandate provided to me by the Human Rights Council, to seek to clarify all cases brought to my attention, I would be grateful for your observations on the following matters:

1. Please provide any additional information and/or comment(s) you may have on the above-mentioned allegations.
2. Please explain how European Structural and Investment Funds prevents the replacement of larger institutions with smaller institutions.
3. Please explain how European Structural and Investment Funds enable the delivery of health care for persons with disabilities and older persons in their communities and how they enable the provision of supports for them to live independently while effectively safeguarding them from discrimination and from arbitrary, excessive, inappropriate and ineffective clinical care.
4. Please provide information on steps taken by the European Commission to protect the rights of persons with disabilities and older persons while addressing the deeply ingrained discrimination, social exclusion and segregation of these groups.
5. Please provide information about measures or strategies by the European Commission, including through the means of the European Structural and Investment Funds or others, to raise awareness and prevent stigmatization and prejudice of persons with disabilities and of older persons.

This communication and any response received from the European Commission will be made public via the communications reporting [website](#) within 60 days. They will also subsequently be made available in the usual report to be presented to the Human Rights Council.

While awaiting a reply, I urge that all necessary interim measures be taken to halt the alleged violations and prevent their re-occurrence and in the event that the

investigations support or suggest the allegations to be correct, to ensure the accountability of any person(s) responsible for the alleged violations.

I may publicly express my concerns in the near future as, in my view, the information upon which the press release will be based is sufficiently reliable to indicate a matter warranting immediate attention. I also believe that the wider public should be alerted to the potential implications of the above-mentioned allegations. The press release will indicate that I have been in contact with the European Commission to clarify the issues in question.

Please note that a letter with a similar content has been sent to the Government of Bulgaria.

Please accept, Ms. Van der Leyen, the assurances of my highest consideration.

Dainius Puras

Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Annex
Reference to international human rights law

In connection with above alleged facts and concerns, and without prejudice to the accuracy of these allegations, I would like to draw the attention of your Excellency's Government to the relevant international norms and standards.

The right to health for persons with disabilities and older persons

I would like to draw your attention to article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) which establishes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The Committee on Economic, Social and Cultural Rights (CESCR) in its General Comment 14 indicates that, while the right to physical and mental health is of progressive realisation, the obligation not to discriminate (ICESCR art. 2.2) is of immediate effect and it is not subject to considerations of resource availability.

Health care services must therefore ensure that persons with disabilities and older persons get the same level of medical care within the same system as other members of society and do not face discrimination on the basis of presumptions of their quality of life and potential. The obligation of non-discrimination in relation to the right to health requires that persons with disabilities and older persons enjoy their right to physical and mental health in the communities as persons without disabilities or younger persons do.

In this context, I wish to refer to my report on the right to mental health (A/HRC/35/21), where I stress that the right to health requires that mental health care be brought closer to primary care and general medicine, integrating mental with physical health, professionally, politically and geographically. The right to mental health not only integrates mental health services into mainstream health care so they can be accessible for everyone, it ensures that entire groups of people who are traditionally isolated from mainstream health care, including persons with disabilities, receive care and support on an equal basis with others.

In its General Comment 14, the CESCR also states that the right to health is an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to water, food, nutrition and housing, among others. (E/C.12/2000/4, para.11). In this connection, I would like to refer to my report on the role of the determinants of health in advancing the right to mental health (A/HRC/41/34) where I highlight that one of the social determinants of the right to health is access to healthy and positive relationships between individuals based on trust, respect and tolerance.

The quality of social relationships is a crucial determinant, including affiliations and connections between individuals, families and communities but also, for example, between Government and people, and between mankind and nature. Respectful, non-violent relationships, and opportunities for solidarity, mutual support and trust are the

foundation of well-being and resilience and offer strong protection in times of adversity. Quality of relationships is determined by factors such as social connectedness, a sense of belonging and opportunities to collaborate for health and social gain, such as improving living conditions, protecting the environment, gaining equitable access to resources and preventing displacement. The promotion of the right to mental health therefore requires action to support healthy and positive relationships in society.

In the same report, I underscore that the right to health further includes a right to conditions that are conducive to a life of dignity and equality. It therefore includes an obligation to create and sustain specific conditions that promote a life of dignity and well-being for all and a requirement that no one be denied access to a healthy psychosocial environment to sustain their well-being. This is in line with the increasing understanding that not just the physical environment but the emotional and psychosocial environments are crucial to the attainment of the highest standard of mental and physical health.

Community inclusion is one component of a psychosocial environment that is conducive to health and well-being. The right to health is thus intimately connected with the right to live independently in the community. In this connection, I would like to refer to article 25 of the Convention on the Rights of Persons with Disabilities (CRPD), which establishes the right to health of persons with disabilities. Accordingly, health services should be provided as close as possible to people's own communities. The obligation to secure the right to health should be read in conjunction with CRPD article 19 that secures the right of persons with disabilities to "choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangements." This article provides for the Parties of the Convention the duty to ensure "access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation and segregation from the community."

However, the right to health, particularly for persons with intellectual, cognitive or psychosocial disabilities, has too often been interpreted through a limited biomedical lens. This focuses on neurobiological processes and aspects but is no longer defensible in light of the evolving understanding of the determinants of health, well-being and, especially, since adoption of the Convention on the Rights of Persons with Disabilities. Rather, the human rights-based models and approaches offers a balanced model of care that locates disability and well-being in people's broader personal, social, political and economic lives. This model allows us to take into consideration the range of obstacles to the full and effective exercise of the right to health and to understand that discriminatory funding of segregated care facilities is one such obstacle.

Seen through this lens, the right to health for persons with these disabilities and older persons includes not just the right to access to relevant medical services such as psychotherapy or general practitioners who are informed about mental health and emotional wellbeing, but also to access to social and other support services necessary to achieve and maintain the highest attainable physical and mental health. For all persons with disabilities and for older persons, the same as for other persons, the exercise of the right to health requires full inclusion in society, an adequate standard of living, access to

inclusive education, access to employment, and access to community services. It includes, a right to integration and treatment in the community with appropriate support to both live independently and to exercise legal capacity.

Closed, segregating facilities are, per se, incompatible with international human rights law, the rights of persons with disabilities and the right to health

The continued use of institutions to house and provide services to persons with disabilities and older persons follows a reductive, biomedical approach that does not adequately address contexts and relationships and that is not compatible with the right to health. Institutionalization and institutionalized living arrangements, whether in large facilities or smaller group homes, amount to segregation and are inconsistent with inclusion in the community. The Committee on the Rights of Persons with Disabilities has repeatedly expressed concern about the institutionalization of persons with disabilities and the lack of support services in the community, and has recommended implementing support services and effective deinstitutionalization strategies in consultation with organizations of persons with disabilities.

Confining persons with disabilities in closed, segregated care facilities violates the right to be included in the community as set out in CRPD article 19 and as a component of the right to health. It ignores the importance of the social environment and the freedom to develop inter-personal relationships for mental and emotional health and well-being. It ignores the obligation to create a supportive and enabling environment that fosters mental health and well-being.

In addition, institutions are a form of discrimination against persons with disabilities that actually undermine their right to health, including by failing to ensure equality. In a number of my reports I have stressed that investment in long-term institutional care and psychiatric hospitals has resulted in a near total policy failure to promote mental health holistically for all (see in particular A/HRC/35/21).

The right to health requires that available mental health services must be adequate and must not provide inappropriate care. Services that segregate people with intellectual, cognitive and psychosocial disabilities and autism into separate care facilities or institutions do not support their rights to live independently and be included in the community, do not comply with their right to health and are therefore neither adequate nor appropriate. Moreover, the services and supports provided in segregated social care settings are often compromised by managerial procurement decisions and accessibility of available services is often dependent on negotiations with staff tasked with control and containment.

Without trust and mutual respect there cannot be a real or lasting therapeutic benefit to mental health interventions. Yet institutional environments where control lies outside the individual with staff who have the power to direct and coerce the individual's movements and daily life are anathema to the development of this trust and mutual respect. In several of my reports, I have highlighted the importance of empowerment as a basic precondition for recovery for people with psychosocial disabilities. I would like to

particularly draw your attention to my report on deprivation of liberty and the right to health (A/HRC/38/36) where I emphasise that empowerment and recovery cannot happen in closed settings as these are fundamentally not therapeutic environments. This is true even where efforts are made to establish a strong culture of respect and care and where violence and humiliation usually prevail.

The right to health can only be safeguarded by ensuring a broad package of integrated and coordinated services for promotion, prevention, treatment, rehabilitation, care and recovery. This includes mental health services integrated into primary and general health care, which support early identification and intervention, and are designed to support a diverse community.

While the process towards de-institutionalization is encouraged, I would like to recall that any such effort must be guided by article 19 of the CRPD and the principle of autonomy and freedom of choice and control. Progressive realization of the obligations under article 19 of the CRPD is not compatible with other forms of institutions. The support to building larger or smaller institutions therefore contradicts the previously expressed de-institutionalization policy of your Excellency's Government.

For a comprehensive guidance on phasing out institutions and transitioning to community based support, I encourage your Excellency's Government to peruse the General Comment on living independently and being included in the community, adopted by the Committee on the Rights of Persons with Disabilities and the report of the Special Rapporteur on the Rights of Persons with Disabilities on how to ensure the provision of different forms of rights-based support and assistance for persons with disabilities.¹

In particular, I would like to highlight the general obligations of State Parties to the CRPD as set out in article 4, which point to a dynamic of change that requires State Parties, inter alia, to enact new laws and policies where needed to give effect to the CRPD; to refrain from engaging in any act or practice that is inconsistent with the CRPD; and to ensure that public authorities and institutions act in conformity with the CRPD. This also entails that expenditures must reflect these obligations. Finally, I would like to underline the obligation in article 4(3) of the CRPD to closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organization, in decision-making processes concerning issues related to persons with disabilities.

Closed, segregating facilities damage the right to health and foster rights violations

Institutionalisation damages the right to health in many ways, including by the psychological and emotional burden of segregation, isolation, control and collective treatment. In this connection, I would like to bring your attention to the report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (A/HRC/34/26) where he acknowledges that the severe emotional pain and

¹ Ie, A/HRC/34/58.

suffering caused by segregation may rise to the level of ill-treatment or torture. I wish to further refer to Human Rights Council Resolution 32/18 on Mental Health and Human rights which recognizes that social exclusion, segregation and institutionalisation may constitute or lead to violations of the human rights and fundamental freedoms of persons with mental health conditions or psychosocial disabilities, sometimes amounting to torture or ill-treatment.

Forced institutionalisation on the basis of psychosocial, intellectual or other disability, including confining people in residential settings against their will or with the consent only of their guardian amounts to a violation of the right to liberty and security of the person. Depriving people with disabilities of their liberty in closed institutions is a misuse of science and practice of medicine.

In addition, due to their closed nature, the restriction of choice, the need for control by staff, the group nature of their management practices and policies, and the power imbalance between residents and staff, institutions cannot but, by their very nature foster ill-treatment and other rights violations. Institutionalization reinforces a vicious cycle of stigmatization, discrimination and social exclusion and may be more detrimental than the mental health conditions it is supposed to treat. Institutions breed cultures of violence and helplessness. People in segregated service systems and residential settings are particularly vulnerable to violations of their human rights.

I wish to further bring your attention to my report on the role of the determinants of health in advancing the right to mental health (A/HRC/41/34) where I highlight that violence is common in large and small institutions alike. In my work as Special Rapporteur and during many of my country visits, I have collected testimony and observed cases of abuses of people with mental disabilities in institutions, including: forced sterilisations; being chained to beds; being held in cages; violence and torture; unmodified use of electro-convulsive therapy (i.e. without anaesthesia or muscle relaxants); grossly inadequate sanitation; and a lack of food. I have also noted that in settings of confinement it is common for people to experience physical abuse by staff and peers, the use of physical and chemical restraints, forced and non-consensual medical treatment and solitary confinement. In this context, I would like to refer again to my report on deprivation of liberty and the right to health (A/HRC/38/36) where I stress that the most silent forms of adverse conditions of detention and confinement, including boredom and powerlessness, can often prove to be the most severe, notably affecting mental health while giving rise to feelings of hopelessness and despair and suicide attempts.

In the same report, I elaborate on the issue of women who are confined in segregated institutions due to structural inequalities and discrimination, harmful gender stereotypes and deep disadvantage. This leads to failure to secure their appropriate access to social and underlying determinants of health and to services and support in the community. The effects of such institutionalization on women and the gendered and challenging environment of detention and confinement compounds their immediate and long-term health risks, reproduces past violence and trauma, and undermines the full and

effective realization of the right to health. Rape and sexual violence against women has been shown in multiple cases pertaining to this context, to be systematic and widespread. *Closed, segregating facilities make for bad policy and are not financially efficient*

I wish to refer to my predecessor's report on the effective and full implementation of the right to health framework (A/69/299), where he states that good public policy, but also progressive realisation of the right to health, requires that available resources are allocated efficiently. Efficiency means that funding allocations should reduce barriers to non-discriminatory access to available and acceptable-quality health facilities, goods and services. Ignoring human rights obligations by financing institutions that cause social exclusion, discrimination and violence has, in the longer run, a negative impact on the health of the people concerned and our societies. It is at best an inefficient use of funds and, ultimately, an ineffective, even harmful, health policy and health-care practice in addition to being a violation of the right to health. The surveillance, diagnostic overshadowing, and enormous psychosocial pain and hopelessness of confinement when health care is provided in institutions become themselves determinants of poor mental and physical health. In my report on deprivation of liberty and the right to health (A/HRC/38/36) I underline that the enjoyment of the right to health in the context of confinement and deprivation of liberty is conspicuous by its absence.

Yet, confinement as a public-health strategy is routinely the policy instrument of choice, despite mounting evidence that health outcomes for individuals and the communities in which they live are better with health care and support in community settings. The imbalance in financing that prioritises investment for mental health care in biomedical interventions and institutionalisation and not for the development of psychosocial interventions and community-based services. This does not reflect sound policy. Rather, as I stress in my report to the Human Rights Council (A/HRC/29/33), it is driven and motivated by power asymmetries between interest groups behind different forms of services and interventions, and a lack of transparency, monitoring and accountability in mental health-care systems.

Where institutions are prioritised for financing, one of the effects is that people end up being placed there regardless of their support needs, because there is no real alternative. It is a convenient alternative to developing genuinely effective services. This places the entire health care system at risk of poor management, generating negative public health outcomes. Relying on confinement as a public health response has led in many countries, including Bulgaria, to a monopolisation of resources that should be supporting the progressive development of a robust health-care system, programmes to support healthy relationships, and access to development opportunities, among other things. Eliminating discrimination and inequalities in access to health facilities, goods and services is associated with better health outcomes overall and more effective health systems.

Moreover, adults are often institutionalised in segregated social care settings as a direct result of the failure of the health and social systems to respect their rights as children: children with disabilities in particular are disproportionately represented in institutions for children and do not therefore have the opportunity for healthy

development, including development of skills necessary for independent living. As a result, where funding is provided for segregated adult institutions, these children are the first to be placed there when they grow up. Funding for segregated children's institutions fuels the isolation of people with disabilities and the perceived need for continued segregation.

In addition, segregation and isolation of persons with disabilities in institutions entrenches stigma, prejudice and fear, especially concerning persons with psychosocial disabilities and persons with intellectual disabilities, making the possibility of eventual inclusion in the community even more remote due to the discriminatory and uninformed reactions of society at large to those they perceive as different or in need of confinement and control.

The importance of investing in community-based services and accessibility of general services

I would like to recall that persons with disabilities should not be placed in segregated facilities for the purpose of receiving support services and social protection. All support services must be designed to be supporting living included within the community and preventing isolation and segregation from others. Therefore, any institutional form of support services, which segregates and limits personal autonomy, is not permitted under article 19(b) of the CRPD (CRPD/C/GC/5). Segregation and institutionalization would demonstrate a failure to create support and services in the community for persons with disabilities.

As provided for by article 19(b), services and facilities cover a wide range of services, such as housing, schools, transport, hospitals, and must be available, universally accessible, acceptable and adaptable for all persons with disabilities within the community. The State should put in place comprehensive service and community development programs and structural reforms to improve overall accessibility within the community, which may also reduce the demand for disability-specific services.

While segregated treatment in some cases may be warranted, it would have to be shown that the voice of the persons affected has been genuinely sought and respected, that the treatment is genuinely part of a broader inclusion strategy and that institutions or segregated communities that effectively deny any meaningful connection with the broader community are not permitted.²

Moreover, I wish to refer to Human Rights Council Resolution 36/13 on Mental Health and Human Rights which underscores the importance of "access to a range of support services that are based on respect for human rights in order to live independently, be included in the community, exercise their autonomy and agency, participate meaningfully in and decide upon all matters affecting them and have their dignity

² Committee on the Rights of Persons with Disabilities, General Comment No. 5 (2017) on living independently and being included in the community (CRPD/C/GC/5). See also Committee on Economic and Cultural Rights, highlighting that "segregation and isolation achieved through the imposition of social barriers" count as discrimination. General Comment no. 5, para. 15 and paras. 48-49.

respected, on an equal basis with others” and urged for the development of community-based, people-centred services and supports.

Respect for the right to health, including the requirements of availability, accessibility and non-discrimination among others, requires that mental health services and supports be integrated more closely into primary care and general medicine. Access to primary health care is the crucial cornerstone of modern medicine and public health for persons with disabilities. The right to health requires an efficient balance in the allocation of funds between primary, secondary and tertiary care sectors, with an emphasis on primary health care, as I have highlighted in many of my reports, including on country visits. Primary health care is provided in the community in clinics or in homes, making it more geographically adaptable and less costly, which increases its availability and accessibility.

Health care services for persons with disabilities and financing of such services need a strong focus on human rights, experiences and relationships. This requires basing disability-related health services, including support services, in the community and integrating them into general health services, including primary health care. In this context I would like to bring your attention to the report of the High Commissioner for Human Rights (A/HRC/34/32) which underlines the importance of evidence in showing that the provision of interdisciplinary and demedicalized services in the community enables users to remain connected with their families, to maintain employment and generally to remain close to the support networks which facilitate early treatment and recovery.

In this context, I refer to the report of the first Special Rapporteur on the right to health on mental disability and the right to health (E/CN.4/2005/51) which elaborates on steps that should be taken to ensure a full package of community-based mental health and support services conducive to health, dignity, and inclusion. Some of these services include: psychotherapy; ambulatory services; programmes to maximise independence and skills of persons with intellectual disabilities; inclusive education; and respite care for families. The right to community living requires access to social supports, including supported and assisted housing, health care, crisis response systems, income support, support for social networks and access to education and work.

The right to health requires that services for persons with disabilities be of good quality. Prioritising community-based psychosocial services and mobilising social resources to support people with disabilities is necessary to ensure that the services provided are of such quality. Psychosocial interventions and support are not luxuries for persons with disabilities; they are an essential service for ensuring their right to the highest attainable standard of physical and mental health and can often be provided in the community by nurses, general practitioners, midwives, social workers and community health workers if they are adequately trained. Priority should be given to community-based services that empower and promote recovery and healthy relationships, while eliminating institutionalisation.

I would like to further refer to my predecessor report on health financing in the context of the right to health (A/67/302) where he highlights that, as a secondary consideration to the human rights imperative, prioritising specialised health-care services over primary care is ultimately more expensive for health systems. It ignores the crucial role of primary care in preventing the exacerbation of impairments and the need for more costly specialised interventions. It also prevents illness and promotes general health, thereby reducing the need for advanced levels of most costly curative care. Prioritising specialised health-care services may also reinforce the power asymmetries and funding imbalances referred to above that favour powerful groups with vested interests in the health industry.

Financing institutions and failing to integrate interdisciplinary mental health services into primary care is a challenge that makes a “whole person” approach extremely difficult. Resources should be directed towards community-based mental health services with a “do no harm” approach in the investment of resources that avoid human rights violations. This should be an overarching principle informing policy in the area of mental health.

The role of the European Commission in combatting stereotyping and prejudicial attitudes against persons with disabilities

The European Commission has a particular role in ensuring that its acts and decisions are not based on stereotypes about persons with disabilities but rather contribute to visibly combatting prejudicial attitudes and promoting equality.

In this connection, I would like to refer again to my first report to the Human Rights Council (A/HRC/29/33) where I emphasize that all too often it is not financial obstacles that prevent respect for the right to health but rather prevailing attitudes among stakeholders that are not in line with human rights and public health principles. There is a common belief that people with disabilities are incapable of exercising agency over decisions that affect them or of contributing positively to society, as misconceptions that have been largely responsible for creating and perpetuating stigma and discrimination. In my report on corruption and the right to health (A/72/137), I note that evidence show that mental health policies and services are especially prone to ineffective practices, as well as the use of biased evidence. People frequently suffer more from discriminatory and inappropriate patterns of “care” than from the natural effects of mental health conditions.

These factors divert mental health financing from the effective realisation of the right to health and include attitudes and biased evidence in favour of investment in institutional care rather than community-based services (such as reports, research and recommendations on the efficacy of institutional care formulated by institutions, State bodies and civil society that receive funding to run or manage institutions, or research that is tainted with a biomedical bias). When the European Commission makes millions of Euro available for health-related initiatives without accountability or oversight of the human rights implications, this is a prime example of how financing can encourage rather than discourage attitudes that are not in line with the right to health as a human right.

It is in the area of mental health therefore that the Commission has a particular obligation to exercise especial care to avoid relying on stigmatising attitudes and biased evidence when making decisions to allocate funds and in reviewing and evaluating whether such decisions are in line with fundamental rights norms. By continuing to provide very significant financial investments into projects that promote and entrench institutionalisation of persons with disabilities, the European Commission is endorsing, legitimising and actively contributing to the continuation of a bio-medical model approach in mental health systems, undermining the progress made by the adoption and ratification of the CRPD and encouraging States to maintain out-dated, ineffective frameworks that violate the rights of persons with disabilities, including their right to health. In this vein, I have expressed concern in several of my reports (see in particular A/HRC/35/21) about the worrying lag between emerging evidence and how it is used to inform policy development and practice. For decades now, an evidence base informed by experiential and scientific research has been accumulating in support of psychosocial, recovery-oriented services and support and non-coercive alternatives to existing services. Without promotion of and investment in such services and the stakeholders behind them, they will remain peripheral and will not be able to generate the changes they promise to bring.

It is crucial that the European Commission fully integrate a human rights-based approach across its funding using Structural and Investment Funds. Ensuring financial accountability is not sufficient. Ensuring that all of its financing decisions are grounded in the human rights based approach will prevent the tendency for financing to prop up health care systems that violate human rights and have a negative impact on the health of individuals and societies, such as the financing of institutions. The best way of “vaccinating” health-care systems and policy decisions against a departure from agreed principles and standards is to systematically apply a human rights approach in full accordance with universal principles.

The political will to apply human rights principles and standards to all policy and financial frameworks and implementation needs to be unequivocal and the European Commission must be held to the highest standards in this regard. This is true in both its own actions and decisions, such as decisions to finance particular projects, and in its supervisory role, ensuring that Member States partners to which it allocates financing carry out their initiatives with the highest respect for human rights.

The European Commission has a unique and important role to play in promoting consensus between European Union fundamental rights and the international human rights systems so as to strengthen mental health policies and services in Europe and globally. Ensuring that it provides funding without discrimination, stigmatisation or prejudice and only for human rights compliant projects is a basic requirement in this.

Accountability of the European Commission for its acts and decisions concerning development investment

As set out above, the right to health gives rise to obligations that provide a framework of reference for monitoring and accountability. Monitoring and accountability

are crucial to ensuring the right to health. This includes monitoring the human rights impact of policies and financing and ensuring that, where financing leads to violations of the right to health or other human rights, those responsible are held accountable.

When accountability for health system's and the right to health is weak or ineffective nationally, the role of supranational bodies such as the European Union takes an increasingly important role in ensuring human rights accountability through, inter alia, the role they play as development donors. The European Union monitoring and accountability system should avoid lacunas in the protection of the justice system for persons with disabilities and older persons who are adversely affected by Commission's decisions and financing.

Effective monitoring and accountability mechanisms are particularly essential for the European Commission in the allocation and disbursement of funds for health services to ensure that these funds do not obstruct the enjoyment of the right to health by financing initiatives that undermine human rights, principles of medical ethics, social justice, and effective and transparent health-care provision. Ineffective monitoring and accountability provides conditions in which practices contrary to these frameworks, including corruption, can thrive. As the first Special Rapporteur on the right to health pointed out "...accountability mechanisms that focus exclusively on the responsibilities of developing countries and do not also encompass the responsibilities of the donor community are unfair, flawed and lack credibility" (E/CN.4/2006/48, para. 46).

Finally, where financing is being provided directly by the European Commission, there is no excuse for decision-making that undermines human rights protections. The Commission must be fully competent to ensure that its decisions do not contribute to undermining the right to health, particularly for persons in vulnerable situations such as persons with disabilities and older persons in institutions.