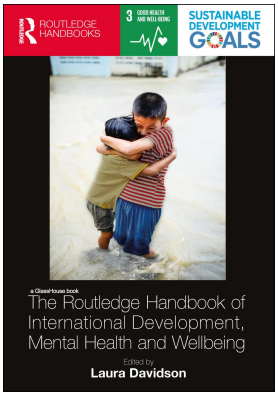
This article was downloaded by: *10.3.98.104*
On: 17 May 2021
Access details: *subscription number*
Publisher: *Routledge*
Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: 5 Howick Place, London SW1P 1WG, UK



The Routledge Handbook of International Development, Mental Health and Wellbeing

Laura Davidson

Mental Health, Disability Rights, and Equal Access to Employment

Publication details
https://www.routledgehandbooks.com/doi/10.4324/9780429397844-14
Aart Hendriks
Published online on: 25 Jun 2019

How to cite :- Aart Hendriks. 25 Jun 2019, *Mental Health, Disability Rights, and Equal Access to Employment from:* The Routledge Handbook of International Development, Mental Health and Wellbeing Routledge
Accessed on: 17 May 2021
https://www.routledgehandbooks.com/doi/10.4324/9780429397844-14

PLEASE SCROLL DOWN FOR DOCUMENT

Full terms and conditions of use: https://www.routledgehandbooks.com/legal-notices/terms

This Document PDF may be used for research, teaching and private study purposes. Any substantial or systematic reproductions, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The publisher shall not be liable for an loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

Downloaded By: 10.3.98.104 At: 22:26 17 May 2021; For: 9780429397844, chapter14, 10.4324/9780429397844-14

14

MENTAL HEALTH, DISABILITY RIGHTS, AND EQUAL ACCESS TO EMPLOYMENT

Global challenges in light of the Sustainable Development Goals

Aart Hendriks⋆

Introduction

The relationship between medicine and disability rights is everything but unproblematic.[1] This particularly holds true with respect to persons with mental illness and persons with mental disabilities (henceforth, persons with mental health disabilities). Traditionally, they are assumed (wrongly) to be unable to participate as equals in society, particularly in the labour market. In fact, their legal capacity is regularly taken away arbitrarily, leading to a high degree of dependency and vulnerability.[2] These prejudices and practices affect persons with mental health disabilities even more in low- and middle-income countries (LMICs); countries that cannot provide basic facilities in various aspects of life. In such countries, people with mental health disabilities often have no access to evidence-based health care and may, for a number of reasons, experience even more exclusion and physical and social violence than in other parts in the world.[3] People with mental health disabilities often experience additional hardships in LMICs—not merely economic

⋆ Aart Hendriks is a health and human rights lawyer and Professor in Health Law at Leiden University, The Netherlands.

1 Hendriks, A. C. & Lewis, O. (2015), 'Disability', in Y. Joly & B. M. Knoppers (eds), *Routledge Handbook of Medical Law and Ethics* (Abingdon: Routledge), pp.78–97.

2 Lewis, O. (2015), *Legal Capacity in International Human Rights Law* (Leiden: Leiden University). See also the Committee on the Rights of Persons with Disabilities (CRPD), 9 Sept 2013, Communication No.4/2011 (*Zsolt Bujdosó, et al.*), UN Doc.CRPD/C/10/D/4/2011. In this case, the authors of the complaint successfully contended that their automatic disenfranchisement, regardless of the nature of their disability and their individual abilities, was discriminatory and unjustified.

3 Humphrey, M. (2016), 'The intersectionality of poverty, disability, and gender as a framework to understand violence against women with disabilities: a case study of South Africa', International Development, Community and Environment (IDCE), Paper 36; Kirakosyan, L. (2014), An Examination of Violence Practiced against Disabled Brazilians in Relation to Sustainable Development, *Disabilities Studies Quarterly*, 34(4). Available at: dx.doi.org/10.18061/dsq.v34i4.3989. See also Patel, V. (2007), Mental health in low- and

Downloaded By: 10.3.98.104 At: 22:26 17 May 2021; For: 9780429397844, chapter14, 10.4324/9780429397844-14

poverty, but regular and severe physical, emotional and psychological abuse, often by their own families.[4] These practices most certainly have a negative impact on their overall health and well-being.[5] Unfortunately, mental health legislation, often aimed at protecting society against persons with mental health disabilities rather than the opposite, may contribute to the segregation of people with mental health disabilities from others in society.[6]

From an economic perspective, unemployment and segregation are a waste of economic resources; people with the potential to generate an income for themselves independently, be it with or without workplace adaptations, are made dependent on benefits, welfare and health care.[7] The economic situation of persons with mental health disabilities is often much worse in countries that cannot afford to support them financially, as is the case in many LMICs. In these countries, people with mental health disabilities are completely dependent on family, friends and charity. From a human and human rights perspective this is catastrophic; a large group of persons who may be highly motivated to participate in the labour market[8] is forced to live in economic deprivation. It is important to realise that the unemployment rate of people with mental health disabilities is, in all parts of the world, sometimes as high as 90%.[9] Whilst it should be stressed that mental health issues can be both a root cause and the result of poverty and social exclusion,[10] unnecessary unemployment deprives those with mental health disabilities of status within their community—thus also adversely affecting their wellbeing.

The adoption of the United Nations (UN) Sustainable Development Goals (SDGs) in 2015 provides an excellent opportunity to reflect upon health and health care as human rights. It is also a good reason to examine the way these rights can contribute to rights-based disability policies that—in the words of target 3.4 of SDG3—'promote mental health and well-being'. In doing so, this chapter will focus particularly on the importance of enhancing equal access

middle-income countries, *British Medical Bulletin*, 81–82(1): 81–96. Available at: doi.org/10.1093/bmb/ldm010.

4 See, *e.g.*, Ssengooba, M. (2012), *'Like a Death Sentence': Abuses against Persons with Mental Disabilities in Ghana*, Human Rights Watch, Kwesi Kassah, A., Lind Kassah, B. L., & Kobla Agbota, T. (2012), Abuse of disabled children in Ghana, *Disability & Society*, 27(5): 689–701. Available at: dx.doi.org/10.1080/09687599.2012.673079. See also Kheswa, J. G. (2014), Mentally Challenged Children in Africa: Victims of Sexual Abuse, *Mediterranean Journal of Social Sciences*, 5(27): 959–965.

5 See, *e.g.*, Kirk, D. S. & Hardy, M. (2012), The Acute and Enduring Consequences of Exposure to Violence on Youth Mental Health and Aggression, *Justice Quarterly*, 31(3): 539–567. Available at: dx.doi.org/10.1080/07418825.2012.737471. See also Hecker, T., Hermenau, K., Maedl, A., *et al.* (2013), Does Perpetrating Violence Damage Mental Health? Differences Between Forcibly Recruited and Voluntary Combatants in DR Congo, *Journal of Traumatic Stress*, 26(10): 142–148. Available at: doi.org/10.1002/jts.21770.

6 WHO (2005), *WHO Resource Book on Mental Health, Human Rights and Legislation. Stop Exclusion, Dare to Care* (Geneva: WHO), Publication No. WHO/MSD/MER/06.2.

7 WHO (2006), *Economic Aspects of Mental Health: Key Messages to Health Planners and Policy-makers* (Geneva: WHO).

8 Saunders, S. L. & Nedelec, B. (2014), What Work Means to People with Work Disability: A Scoping Review, *Journal of Occupational Rehabilitation*, 24(1): 100–110. Available at: doi.org/10.1007/s10926-013-9436-y.

9 Harnois, G. & Gabriel, P. (2000), *Mental Health and Work: Impact Issues and Good Practices* (Geneva: WHO and International Labour Organisation), p.9.

10 Weich, S. & Lewis, G. (1998), Material standard of living, social class and the prevalence of common mental disorders, *Journal of Epidemiology and Community Health*, 52: 8–14. Available at: doi.org/10.1136/jech.52.1.8.

Downloaded By: 10.3.98.104 At: 22:26 17 May 2021; For: 9780429397844, chapter14, 10.4324/9780429397844-14

to employment, probably one of the most important means to reduce poverty and isolation, whilst at the same time promoting mental health and wellbeing. In discussing this relationship, SDG3 will be examined (relating to good health and wellbeing) and SDG8 (which requires a healthy work environment and economic growth), as well as the Convention on the Rights of Persons with Disabilities (CRPD). The ultimate aim of this chapter is to examine the changes that are needed to enable the full and effective participation and inclusion in society of persons with mental health disabilities, notably through the enjoyment of equal employment opportunities in the spirit of the SDGs. In so doing, there will be a particular focus on LMICs, where access to, and the quality of, mental health care is most problematic, despite about 80% of the total number of people with mental health disabilities living in these countries.[11] Thus, these countries deserve special attention and support in terms of sustainable development, SDG3 and SDG8.

Health and health care rights

Terminology

Health is one of our most precious assets, often underestimated until it is compromised and affecting our wellbeing. Even though there is a general layman's understanding of the meaning of 'health', it is a concept that is extremely difficult to define. The world's leading description of health can be found in the Preamble to the Constitution of the World Health Organization (WHO), as adopted in 1946. According to its first principle, '[h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Admittedly, this definition is heavily contested. It is contended that it is obsolete, too vague, unachievable given the emphasis on 'complete wellbeing', and dependent on how individuals subjectively interpret their wellbeing, thus lacking operational value.[12] Despite this, the WHO's definition of health remains until today the most authoritative definition of health in the absence of a better alternative.

As a corollary, health care can be defined as the maintenance or improvement of the health of individuals and communities. In industrialised countries it is often taken for granted that specially trained medical and paramedical professionals, acting within the realm of their competence, play a crucial role in the provision of health care. In LMICs, access to these professionals is not uncommonly restricted to a selective number of citizens from the highest income groups.

Health is not merely dependent on access to health care and the quality of health care. Important as health care is, it should be noted that health—as well as a complete state of

11 De Boer, H. M., Mula, M., & Sander, J. W. (2008), The global burden and stigma of epilepsy, *Epilepsy & Behavior*, 12: 540–546. Available at: doi.org/10.1016/j.yebeh.2007.12.019.

12 Callahan, D. (1973), The WHO definition of health, *The Hastings Center Studies*, 1(3): 77–87. Available at: doi.org/10.2307/3527467. See also Jadad, A. R. & O'Grady, L. (2008), How should health be defined?, *British Medical Journal*, 337(a2900): 1363–1364. Available at: doi.org/10.1136/bmj.a2900. See also Huber, M., Knottnerus, J. A., Green, L., *et al.* (2011), How should we define health?, *British Medical Journal*, 343(d4163): 235–237. Available at: doi.org/10.1136/bmj.d4163.

Downloaded By: 10.3.98.104 At: 22:26 17 May 2021; For: 9780429397844, chapter14, 10.4324/9780429397844-14

wellbeing—is influenced by a large number of factors, including individual behaviour, biology and social and economic conditions.[13]

Health and health care as rights

The right to health is one of the most essential human rights,[14] and was first recognised as a human right in 1946. This occurred on the adoption of the Constitution of the WHO.[15] According to the Preamble of this document, '[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'. Thus seen, the right to health is closely interconnected with other individual and social human rights, including the right to employment.[16] It also transpires from the WHO provision on the right to health that this right is intimately connected to the principles of equality and non-discrimination, with states expected to take measures to enhance the health of all and guarantee access to health care services on the basis of non-discrimination.[17] Similar provisions on the right to health were included in 1965 in the International Convention on the Elimination of All forms of Racial Discrimination (ICERD);[18] the following year in the International Covenant on Economic, Social and Cultural Rights (ICESCR);[19] in 1979 in the Convention on the Elimination of All forms of Discrimination against Women (CEDAW);[20]

13 Kawachi, I. & Kennedy, B. P. (1997), Socioeconomic determinants of health: health and social cohesion: why care about income inequality?, *British Medical Journal*, 314: 1037–1040. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC2126438/. See also von Rueden, U., Gosch, A., Rajmil, L., *et al*. (2006), Socioeconomic determinants of health related quality of life in childhood and adolescence: results from a European study, *Journal of Epidemiology and Community Health*, 60(2): 130–135. Available at: doi.org/10.1136/jech.2005.039792.

14 B. C. A. Toebes (1999), *The Right to Health as a Human Right in International Law* (Antwerp/Oxford: Intersentia/Hart); Hendriks, A. C. (1998), The Right to Health in National and International Jurisprudence, *European Journal of Health Law*, 5: 389–408; A. Clapham & M. Robinson (eds) (2009), *Realizing the Right to Health* (Zurich: Rüffer & Rub); B. C. A. Toebes, R. Ferguson, M. Markovic & O. Nnamuchi (eds) (2014), *The Right to Health—A Multi-country Study of Law, Policy and Practice* (The Hague: T.M.C. Asser Press/Springer).

15 Grad, F. P. (2002), The Preamble of the Constitution of the World Health Organization, *Bulletin of the World Health Organization*, 80(12): 981–982.

16 Toebes, B. C. A. (2012), 'The Right to Health and Other Health-related Rights', in B. C. A. Toebes, M. Hartlev, A. Hendriks, & J. Rothmar Herrmann (eds), *Health and Human Rights in Europe* (Cambridge, Antwerp and Portland: Intersentia), pp.83–110.

17 M. San Giorgi (2012), *The Human Right to Equal Access to Health Care* (Antwerp/Oxford: Intersentia/Hart).

18 Art.5 of the ICERD states:

> In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: . . . (e) Economic, social and cultural rights, in particular: . . . (iv) The right to public health, medical care, social security and social services; . . .

19 Art.12(1) of the ICESCR states that 'States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.

20 Art.12 of the CEDAW states that

> States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

Downloaded By: 10.3.98.104 At: 22:26 17 May 2021; For: 9780429397844, chapter14, 10.4324/9780429397844-14

in 1989 in the Convention on the Rights of the Child (CRC);[21] and more recently in 2006 within the CRPD,[22] as well as in national constitutions.[23]

All these international provisions, in addition to those under national law, build on the broad definition of health, as defined by the WHO in 1946. This implies that state obligations in relation to respecting, protecting and promoting health should not be confined to guaranteeing access to health care, but should be extended to improving the underlying determinants of health gradually, such as access to water, sanitation and food, housing, healthy occupational and environmental conditions, and access to education and information.[24] Thus, the right to health should be interpreted as an inclusive right, covering both health care and the underlying determinants to health.[25]

This comprehensive view of health is also reflected in targets listed under SDG3 on good health and wellbeing which require UN member states (*inter alia*) to strive towards a reduction of the maternal mortality ratio, end a number of communicable diseases, and reduce global deaths for road accidents. These targets cannot be achieved merely by improving health care, but require policies to enhance income-raising opportunities with the participation not only of individuals, but also civil society groups and organisations. This will require the promotion and enforcement of equal employment opportunities (as required by SDG8), and thus increase the participation of people with mental health disabilities and all others in the labour market.

Interim conclusions

The importance of health for one's wellbeing (which states must ensure under SDG3) and one's societal opportunities is reflected in the fact that health has been acknowledged universally as a human right. Even though the right to health should not be understood as a right to be healthy,[26] it imposes an obligation upon states to take a range of measures to meet it, and to respect relevant essential freedoms, in order to enable individuals to enjoy the highest attainable level of health and allow economic growth as required by SDG8.

Although health care may play an important role with respect to an individual's health, it has been acknowledged that health and wellbeing are dependent on many more determinants than the accessibility and quality of health services. Not all of these factors fall within the scope of the roles and duties of health professionals, to the extent that they are available and accessible

21 Art.24(1) of the CRC states that

> States parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

22 Art.25 of the CRPD states that

> 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.

23 Heymann, J., Cassola, A., Raub. A., & Mishra, L. (2013), Constitutional rights to health, public health and medical care: the status of health protections in 191 countries, *Global Public Health*, 8(6): 639–653. Available at: dx.doi.org/10.1080/17441692.2013.810765.

24 UN CESCR, General Comment No.14: *The Right to the Highest Attainable Standard of Health*, UN Doc.E/C.12/2000/4, 11 Aug 2000, para.11.

25 *Ibid*.

26 *Ibid*., para.8.

Downloaded By: 10.3.98.104 At: 22:26 17 May 2021; For: 9780429397844, chapter14, 10.4324/9780429397844-14

to individuals and society at large. Moreover, not all determinants of health can be properly addressed by state policies (such as biological factors). Furthermore, certain state interventions might be inappropriate, as they might lead to unacceptable interferences with individual freedoms associated with health rights (such as the right to choose one's own lifestyle). Nonetheless, to comply with SDG8 states can develop and enforce occupational health laws to protect the health of employees and to promote decent work conditions. In addition, to ensure non-discrimination states ought to take measures to protect individuals from harassment and violence by others. States must recognise, therefore, not only the need to create policies to meet their obligations to ensure good health, but also of necessary restrictions on such obligations due to competing rights.

Mental health and disability rights

Terminology

Following the WHO's 1946 definition of health, mental health was subsequently defined by the WHO in 2005 as 'a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'.[27] A temporary mental health problem does not necessarily equate to a long-term mental disability.[28] Both conditions, however, have in common that they are generally perceived as unhealthy, and sufferers are thought to be in need of medical assistance to solve their so-called 'medical problems' and to lack the capacity to take decisions for themselves. As a result of the latter assumption, their legal capacity is often partially or even totally denied,[29] making it difficult for persons whose mental health is impaired to exercise such rights as the right to be free from unwanted medical treatment (the right to physical and mental integrity), the right to freedom from unwanted institutionalisation (the right to freedom) and the right to decide where to live and with whom.[30] In other words, mental health problems and mental health disabilities are commonly seen as medical conditions that are inherent to an individual and that need to be addressed by treatment and rehabilitation provided by medical professionals.[31] In the traditional medical model on mental health disability, it is commonly taken for granted that health care and medical professionals are accessible and available. This, however, is far from the reality in LMICs.

27 WHO (2001), Strengthening Mental Health Promotion (fact sheet No.220) (Geneva: WHO), p.1.

28 The CPRD and other legal instruments differentiate between short and long-term impairments now that individuals are commonly only eligible to benefits in case of long term or lasting inhibitions. *Cf.* ECJ, 1 Dec 2016, Case C-395/15 *(Mohamed Daouidi*), ECLI:EU:C:2016:917. In this judgment the European Court of Justice emphasised the importance of distinguishing between a temporary incapacity and a long-term limitation that constitutes a disability.

29 For a consideration of the legal provisions permitting psychiatric treatment on the basis of the assumed mental incapacity of psychiatric patients in the UK and South Africa, see Davidson, L. (2017), Capacity to consent to or refuse psychiatric treatment: an analysis of South African and British law, *South African Journal on Human Rights*, 32(3): 457–489. See further Lewis (2015), *op. cit.*, nt.2.

30 Robertson, G. B. (2015), 'Mental Health', in Joly & Knoppers, *op. cit.*, nt.1, pp.98–111. See also ECtHR 23 Mar 2017, *AM-V v. Finland*, Application No. 53251/13.

31 Hendriks & Lewis (2015), *op. cit.*, nt.1, p.79.

Downloaded By: 10.3.98.104 At: 22:26 17 May 2021; For: 9780429397844, chapter14, 10.4324/9780429397844-14

A rights-based perspective

Mental health and disability rights emerged in response to the massive violations of the rights of persons with mental health disabilities, notably in the context of psychiatry.[32] The recognition of persons with mental health disabilities as subjects of rights instead of recipients of care and charity, and subjects of coercion, required a fundamental change in the thinking surrounding mental health. In the traditional, 'individual' or 'medical model' of disability, a health disability essentially denoted an individual's inability to function in a conventional way due to a health impairment.[33] Scholars in favour of the 'social model' of disability[34] argue that the solution to problems relating to disability should not be centred on individuals, but that attention should be paid to the interaction between individuals and their environment. It is argued by the proponents of the social model of disability that many obstacles faced by persons with mental health disabilities are erected, imposed and exacerbated by their physical and social environment, often designed by able-minded persons who fail to take into account the needs of differently abled persons. In addition, mental health problems may be the effect of or exacerbated by such factors as unemployment, work-related stress, and uncertainty about one's income.[35] Therefore, it is contended, mental health disabilities are not merely individual characteristics, but a social construct that partially reflects the systematic denial of human rights to a group of individuals deemed less able to function in our society, or at least who do not function in a conventional way, due to individual health impairments.

This shift from the individual towards the social model of disability has been reflected in the definition of disability in the CRPD adopted in 2006. According to Article 1 of this human rights Convention, '[p]ersons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which *in interaction with various barriers* may hinder their full and effective participation in society on an equal basis with others'.[36] A similar shift towards

32 P. Bartlett, O. Lewis, & O. Thorold (2007), *Mental Disability and the European Convention on Human Rights* (Leiden and Boston: Martinus Nijhoff), pp.5–7. See also M. Perlin (2012), *International Human Rights and Mental Disability Law. When the silenced are heard* (Oxford: Oxford University Press); Dudley, M., Silove, D. M., & Gale, F. (2012), 'Mental health, human rights and their relationship: an introduction', in M. Dudley, D. Silove, & F. Gale (eds), *Human Rights and Mental Health: Vision, Praxis and Courage* (Oxford: Oxford University Press), pp.1–50; Slobogin, C. (2015), Eliminating mental disability as legal criterion in the deprivation of liberty cases: the impact of the Convention on the Rights of Persons with Disabilities on the insanity defence, civil commitment and competency law, *International Journal of Law and Psychiatry*, 40: 36–42.

33 Oliver, M. & Barnes, C. (2010), Disability studies, disabled people and the struggle for inclusion, *British Journal of Sociology of Education*, 31(5): 547–560. Available at: dx.doi.org/10.1080/01425692.2010.500088. See also Meekosha, H. & Soldatic, K. (2011), Human Rights and the Global South: the case of disability, *Third World Quarterly*, 32(8): 1383–1397. Available at: dx.doi.org/10.1080/01436597.2011.614800.

34 See, *e.g.*, C. Barnes & G. Mercer (2005), *The Social Model of Disability* (Leeds: Disability Press); S. French & J. Swain (2012), *Working with Disabled People in Policy and Practice. A Social Model* (Basingstoke: Palgrave Macmillan); and Oliver, M. (2013), The social model of disability: thirty years on, *Disability and Society*, 28(7): 1024–1026.

35 Barr, B., Taylor-Robinson, D., Stuckler, D., *et al.* (2015), First, do no harm: are disability assessments associated with adverse trends in mental health? A longitudinal ecological study, *Journal of Epidemiology & Community Health*, 70(4). Available at: dx.doi.org/10.1136/jech-2015-206209. See also Milfort, R., Bond, G. R., McGurk, S. R., & Drake, R. E. (2015), Barriers to Employment Among Social Security Disability Insurance Beneficiaries in the Mental Health Treatment Study, *Psychiatric Services*, 66(12): 1350–1352. Available at: dx.doi.org/10.1176/appi.ps.201400502.

36 Emphasis added. The Committee on the Rights of Persons with Disabilities (CRPD) is very critical of states parties embracing the medical model of disability. See, *e.g.*, CRPD, 4 Apr 2014, Communication No.2/2010 (Liliane Gröninger), UN Doc.CRPD/C/D/2/2010:

Downloaded By: 10.3.98.104 At: 22:26 17 May 2021; For: 9780429397844, chapter14, 10.4324/9780429397844-14

the recognition of the environmental components impacting upon an individual's functional opportunities underlies the decision by the WHO to replace the 1980 International Classification of Impairments, Disabilities, and Handicaps (ICIDH) by the International Classification of Functioning, Disability and Health (ICF) in 2001. It was maintained by the drafters of the ICF that a diagnosis reveals little about a person's functional abilities. Whereas the ICIDH was a framework for classifying the (individual) health components of functioning and disability, the ICF looks into factors of relevance for functional abilities more generally. Therefore, the ICF takes into account all aspects of a person's life (development, participation and environment), instead of solely focusing on the person's diagnosis.

The SDGs tacitly build upon the social model of disability, now that SDG3 sets as a goal the need to ensure 'healthy lives' and the promotion of 'well-being for all at all ages'. However, this approach in no way suggests that the achievement of good health and wellbeing is dependent upon access to and the quality of health care services. The 2030 Agenda for Sustainable Development largely leaves it to UN member states to decide on the measures to be taken which they deem most appropriate to achieve the goals to which they must commit. In so doing, they must abide by the principles to which they have committed in General Assembly Resolution 70/1 (2015),[37] including the eradication of poverty, the fostering of social inclusion and the combatting of inequality.[38] SDG8 is closely related to these principles, requiring member states to promote 'full and productive employment and decent work for all'. There are other targets attached to SDG8 (with which SDG3 is interrelated) which are likely to be instrumental in eradicating poverty, fostering social inclusion and combatting inequality.[39]

Interim conclusions

Important as (mental) health care is, increasingly over the course of the last few decades it has been acknowledged that mental health disabilities cannot be equated to mere medical conditions in need of treatment and rehabilitation. In fact, for there to be full participation in society of individuals with mental health disabilities on an equal basis with others—goals which underpin the CRPD and the SDGs—states must take an array of measures not confined to the field of health care, and not restricted to individuals. Such measures are aimed instead at the interaction between individuals and their environment. This idea underlies the recognition of persons with mental health problems and intellectual disabilities as holders of rights, and not mere objects of care and treatment.

> Provision of an integration subsidy that only applies to persons with disabilities whose full working capacity may be restored within 36 months [. . .], according to the Committee, seemed to respond to the medical model of disability, because it tends to consider disability as something that is transitional and that, in consequence, can be 'surpassed or cured' with time.

For a critique of the biomedical model of recovery for those with mental disability, see Chapter 17 of this book by Peter Lehmann. See also Chapter 15 by Dainius Pūras and Julie Hannah.

37 See A/RES/70/1, *Transforming our World: The 2030 Agenda for Sustainable Development*, 25 Sept 2015. Available at: www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E.

38 *Ibid.*, para.13.

39 Such as achieving full and productive employment and decent work for persons with disabilities, reducing unemployment in young people, and increasing the number in education or training.

Downloaded By: 10.3.98.104 At: 22:26 17 May 2021; For: 9780429397844, chapter14, 10.4324/9780429397844-14

From mental health problems to equal employment opportunities

Introduction

Like the CRPD and its underlying general principles,[40] the SDGs acknowledge the importance of societal participation and equal opportunities for persons with mental health disabilities. They uphold the view that health care can contribute to equal opportunities[41] and that full and productive employment for all is not merely a way to achieve sustainable economic growth, but an important means to enable people with mental health disabilities fully and effectively to participate in society, respecting their dignity and inherent human rights. It must, however, also be acknowledged that mental health disabilities frequently obstruct the integration in the workforce of persons who have them, not least because of societal prejudices and discriminatory stereotypes. Disability policies may improve the equal employment opportunities of persons with mental health disabilities.[42] These are discussed below.

Policies promoting inclusion and preventing exclusion

Article 27 of the CRPD recognises the right of those with disabilities to work on an equal basis with others, including the opportunity to gain a living by work freely chosen, or to be accepted in the labour market and in a work environment that is open, inclusive and accessible to those with disabilities. Education as well as vocational training are probably the strongest tools to promote equal employment opportunities for all and to prevent the exclusion of individuals and groups from the labour market. Given that unemployment, poverty and other forms of exclusion may themselves lead to mental illness,[43] measures aimed at promoting equal employment opportunities also contribute to mental health and wellbeing. It is therefore crucial that persons with mental health disabilities are offered equal educational and vocational training opportunities which adequately cater for their needs. This will help to enable persons with mental health disabilities to compete on an equal basis with others in the labour market and prevent their exclusion.

Whilst the UN Principles for the Protection of those with Mental Illness (the MI Principles)[44] prohibit forced labour of psychiatric patients under Principles 13.3 and 13.4, outside the confines of the hospital, there have been many documented instances of the abuse of those with mental and physical disabilities in employment. Such abuse may involve financial exploitation—underpaid or unpaid work (sometimes due to human trafficking)—or excessive working hours, often in poor or inhumane workplace conditions.[45] Whilst the criminal law may apply in such circumstances, an important means of promoting inclusion in the labour

40 Art.3 of the CRPD.

41 Art.25 of the CRPD and SDG3.

42 See OECD (2015), *Fit Mind, Fit Job. From Evidence to Practice in Mental Health and Work* (Paris: OECD Publishing). Available at: www.oecd.org/els/fit-mind-fit-job-9789264228283-en.htm. See also Koslowski, N., Klein, K., Arnold, K., *et al.* (2016), Effectiveness of interventions for adults with mild to moderate intellectual disabilities and mental health problems: systematic review and meta-analysis, *The British Journal of Psychiatry*, 209(6): 469–474. Available at: doi.org/10.1192/bjp.bp.114.162313.

43 See, *e.g.*, Funk, M., Drew, N., & Knapp, M. (2012), Mental health, poverty and development, *Journal of Public Mental Health*, 11(4): 166–185. Available at: doi.org/10.1108/17465721211289356.

44 UN GA A/RES/46/119), 17 Dec 1991. The MI Principles are now outdated.

45 See, *e.g.*, Balderian, N. (1991), Sexual abuse of people with developmental disabilities, *Sexuality and Disability*, 9(4): 323–335; Poreddi, V., Ramachandra, R. K., & Math, S. B. (2013), People with mental illness and human rights: a developing countries perspective, *Indian J Psychiatry*, Apr–June, 55(2): 117–124.

Downloaded By: 10.3.98.104 At: 22:26 17 May 2021; For: 9780429397844, chapter14, 10.4324/9780429397844-14

market is the adoption of comprehensive non-discrimination legislation. However, such laws are meaningless if they are not enforced. Therefore there should be effective dissuasive penalties that deter employers, employees, occupational health professionals and all others in the labour market from discriminating against a person with mental health disabilities. In this respect, it is crucial that non-discrimination laws should not confine themselves to promoting equal treatment (formal equality), but instead focus on equally favourable treatment for all (material equality). The latter implies that individual and group differences, like mental health disabilities, are taken into account and may imply that individuals are treated differently to the extent that they are different to ensure that they are eventually equally well-off. Non-discrimination laws based on material equality, like the CRPD, thus embrace a broad concept of discrimination that stipulates that the denial of a 'reasonable accommodation' is also seen as a form of discrimination.[46] 'Reasonable accommodations' are defined in the CRPD as 'necessary and appropriate modifications and adjustments, not imposing a disproportionate or undue burden on others, where needed in a particular case, to ensure persons with disabilities can enjoy or exercise their rights on an equal basis with others'.[47] Reasonable accommodations for persons with mental health disabilities in the labour market might be the modification of a regular work schedule or more flexibility in working hours to avoid stress or to take into account the effects of medication. Similarly, a job might be restructured by reallocating marginal job functions an individual is unable to do due to an anxiety disorder, or adjusting supervisory methods to allow an otherwise qualified individual who experiences problems in concentration to receive more detailed day-to-day guidance than others.[48] Such accommodations might be essential in various situations to enable persons with mental health disabilities to access the labour market.[49] States and employers have a certain degree of liberty to decide on the adjustment to be made.[50] However, it remains of the utmost importance in all cases to ensure that a reasonable accommodation meets an individual's needs. In other words, reasonable accommodations should be tailor-made.[51]

Inclusion and equal opportunities can also be promoted by the provision of information on mental health disabilities to employers, employees, occupational health professionals and others in the labour market, to address concerns and reduce negative stereotypes. Measures such as these are not focused upon individuals with mental health disabilities, but upon their environment; an approach fully in line with the social model of disability according to which there should

46 Waddington, L. & Hendriks, A. (2002), The Expanding Concept of Employment Discrimination in Europe: From Direct and Indirect Discrimination to Reasonable Accommodation Discrimination, *International Journal of Comparative Labour Law and Industrial Relations*, 18(4): 403–428.

47 Art.2 of the CRPD.

48 Center, C. (2010), 'Law and Job Accommodation in Mental Health Disability', in I. Z. Schulz & E. S. Rogers (eds), *Work Accommodation and Retention in Mental Health* (New York: Springer), pp.17–18.

49 See further on this topic Bell, M. (2015), Mental Health at Work and the Duty to Make Reasonable Adjustments, *Industrial Law Journal*, 44(2): 194–221. Available at: doi.org/10.1093/indlaw/dwv009.

50 See CRPD, Communication No. 5/2011 (*Marie-Louise Jungelin*), 2 Oct 2014, UN Doc.CRPD/C/12/D/5/2011:

> 10.5 The Committee considers that, when assessing the reasonableness and proportionality of accommodation measures, State parties enjoy a certain margin of appreciation. It further considers that it is generally for the courts of States parties to the Convention to evaluate facts and evidence in a particular case, unless it is found that the evaluation was clearly arbitrary or amounted to a denial of justice.

51 See Bond, G. R. & Drake, R. E. (2014), Making the case for IPS supported employment, *Administration and Policy in Mental Health and Mental Health Services Research*, 41(1): 69–73. Available at: doi.org/10.1192/bjp.bp.114.162313. See also Ellison, M. L., Klodnick, V. V., Bond, G. R., *et al.* (2015), Adapting Supported Employment for Emerging Adults with Serious Mental Health Conditions, *The Journal of Behavioral Health Services & Research*, 42(2): 206–222.

Downloaded By: 10.3.98.104 At: 22:26 17 May 2021; For: 9780429397844, chapter14, 10.4324/9780429397844-14

be concentration on the interaction between an individual and his or her environment. In this respect, research suggests that an integrated inclusion and equal opportunities approach is the best way successfully to address the impact of mental health disability upon work commitments and productivity.[52] This requires a combination of the improvement of knowledge and skills, the specification of responsibilities for the involved actors, financial incentives, and the rigorous implementation and policing of such policies.[53]

Although contested, inclusion in the labour market for persons with mental health disabilities can also be advanced by the introduction of a quota system.[54] Levying a quota means requiring employers to employ a certain number or percentage of employees with health problems or disabilities. However, equal rights and disability rights scholars often deem quota systems to be incompatible with the principles of equality and non-discrimination,[55] because they may, unintentionally, reinforce the incorrect assumption that persons with mental health disabilities would otherwise not be eligible for employment due to their lack of competencies or productivity.[56]

Last but not least, another way to promote the integration and prevent the exclusion of persons with mental health disabilities from the labour market is by integrating mental health into primary health care to prevent mental health problems being neglected by primary health providers, and enable early and effective treatment where possible.[57]

Interim conclusions

Policies enhancing equal employment opportunities for persons with mental health disabilities are largely human rights-based. This reflects the idea that human rights violations arising from poverty or discrimination negatively impact upon mental health. Conversely, respecting human rights can improve mental health, and promote wellbeing.[58] Enhancing equal employment opportunities for persons with mental health disabilities requires states and other actors to take a range of measures. Some of these measures are health and health care rights-related (such as occupational health strategies), whilst others are not (such as non-discrimination laws and

52 LaMontagne, A. D., Martin, A., Page, K. M., *et al.* (2014), Workplace mental health: developing an integrated intervention approach, *BMC Psychiatry*, 14(1): 1–11. Available at: doi.org/10.1186/1471-244X-14-131. See also OECD (2015), *op. cit.*, nt.42.

53 See also Lockwood, G., Henderson, C., & Thornicroft, G. (2014), Mental health disability discrimination: law, policy and practice, *International Journal of Discrimination and the Law*, 14(3): 168–182.

54 Waddington, L. (1996), Reassessing the employment of people with disabilities in Europe: from quotas to antidiscrimination laws, *Comparative Labor Law & Policy Journal*, 18: 62–101.

55 See further C. Barnes (1991), *Disabled People in Britain and Discrimination: A Case for Anti-discriminatory Legislation* (London: Hurst and Co./University of Calgary Press); Waddington, L. (1996), Reassessing the employment of people with disabilities: from quotas to anti-discrimination laws, *Comparative Labor Law & Policy Journal*, 18: 61–101; and Waddington, L. (2016), Positive Action Measures and the UN Convention on the Rights of Persons with Disabilities, *International Labor Rights Case Law*, 2: 396–401.

56 For discussion of case studies which challenge this notion, see, *e.g.*, WHO (2009), 'Mental health, poverty and development', discussion paper, July; ECOSOC meeting, 'Addressing noncommunicable disease and mental health: major challenges to sustainable development in the 21st century', para.6.3 (Interventions for poverty reduction and income generation).

57 Daar, A. S., Jacobs, M., Wall, S., *et al.* (2017), Declaration on mental health in Africa: moving to implementation and mental disability, *Global Health Action*, 7: 24589. Available at: dx.doi.org/10.3402/gha.v7.24589.

58 Mann, S. B., Bradley, V. J., & Sahakian, B. J. (2016), Human Rights-based Approaches to Mental Health: A Review of Programs, *Health and Human Rights* [online], 18(1). Available at: www.hhrjournal.org/2016/05/human-rights-based-approaches-to-mental-health-a-review-of-programs/.

Downloaded By: 10.3.98.104 At: 22:26 17 May 2021; For: 9780429397844, chapter14, 10.4324/9780429397844-14

enforcement measures). Also, it must be emphasised that some such measures should be aimed at individuals with mental health disabilities themselves (such as the provision of reasonable accommodation), but efforts should also be made to influence the environment of these persons to promote equal employment opportunities effectively.

Conclusions and agenda for policy and research

In this chapter it has been maintained that promoting equal employment opportunities for persons with mental health disabilities is a human rights requirement which underlies several of the SDGs (notably SDG3 and SDG8) as well as the CRPD. Promoting equal employment opportunities is also related to health and health care. Employment enhances the health and wellbeing of individuals, whilst (mental) health care can lead to an improvement in job opportunities. The latter principle illustrates the importance for LMICs of promoting mental health and strengthening mental health care programmes,[59] particularly in view of disproportionately high numbers of persons with mental health disabilities in these countries who have been excluded from the labour market, and who frequently are exposed to many forms of inhuman and degrading treatment.[60] The deprivation of employment can impact upon mental health detrimentally, and may eventually lead to social isolation and poverty. Thus, it is in the economic interest of all individuals as well as all states to ensure that nobody is excluded from the labour market. Indeed, the costs of mental ill-health are enormous, for the individuals concerned, for employers (due to job absenteeism and loss of productivity), and for society at large.[61] Equal employment opportunities and mental health thus need to be promoted in tandem. It is also well known that employment may cause or exacerbate mental health problems such as stress, anxiety, depression, bipolar disorder, and attention deficit hyperactivity disorder (ADHD), affecting wellbeing and productivity.[62] It is therefore important that more research is done on the interrelationship between mental health and employment, including in LMICs, and that employers appropriately consider this issue. Investing in occupational health care will assist in this regard.[63]

In this chapter a range of measures have been described that are likely to promote the integration and prevent the exclusion of persons with mental health disabilities from the labour market. Such strategies will contribute to the achievement of the SDGs and their targets. It is, therefore, most regrettable that to date very few countries have comprehensive employment policies and laws in place with respect to persons with mental health disabilities. In fact, knowledge about how best to promote equal employment opportunities for this group is still relatively limited.[64]

59 Semrau, M., Evans-Lacko, S., Alem, A., *et al.* (2015), Strengthening mental health systems in low- and middle-income countries: the Emerald programme, *BMC Medicine*, 13(79): 1–9. Available at: doi.org/10.1186/s12916-015-0309-4.

60 Daar *et al.* (2017), *op. cit.*, nt.57. See also Funk *et al.* (2012), *op. cit.*, nt.43; WHO (2003), *Investing in Mental Health* (Geneva: WHO).

61 OECD (2015), *op. cit.*, nt.42.

62 See, *e.g.*, Bilsker, D., Wiseman, S., & Gilbert, M. (2006), Managing depression-related occupational disability: a pragmatic approach, *Canadian Journal of Psychiatry*, 51(2): 76–83; Chopra, P. (2008), Mental health in the workplace: issues for developing countries, *International Journal of Mental Health Systems*, 3(4): 1–9.

63 Saunders, S. L. & Nedelec, B. (2014), What Work Means to People with Work Disability: A Scoping Review, *Journal of Occupational Rehabilitation*, 24(1): 100–110. Available at: doi.org/10.1007/s10926-013-9436-y.

64 Anderson, R., Wynne, R., & McDaid, D. (2007), 'Housing and employment', in M. Knapp, D. McDaid, E. Mossialos, & G. Thornicroft (eds), *Mental Health Policy and Practice across Europe* (Buckingham: Open University Press/McGraw-Hill Education), p.264.

Downloaded By: 10.3.98.104 At: 22:26 17 May 2021; For: 9780429397844, chapter14, 10.4324/9780429397844-14

Similarly, little research has been conducted on job adaptations ('reasonable accommodations') for persons with mental health disabilities. In fact, it appears that people with disabilities are reluctant to ask for a reasonable accommodation, fearing that this may affect their success adversely when applying for jobs, or result in their dismissal or redundancy.[65] This emphasises the importance of the enforcement of comprehensive non-discrimination legislation.

There are various reasons for the dearth of knowledge with respect to evidence-based employment strategies for those with mental health disabilities. As aforementioned, mental health disabilities have been viewed under the medical model as individual medical issues, and not as a focus for human rights efforts requiring steps to be taken to promote societal integration on the basis of dignity, autonomy and respect, taking into account the contextual factors that lead or contribute to exclusion (as under the social model). The traditional approach towards people with mental health disabilities has hampered research into the employment rights of these persons and the need to design integrated policies, the focus of attention having been upon individuals and their impairments, rather than the interaction between individuals and their environment.

Second, mental health disabilities are often considered intractable due to the diversity of mental health conditions and the lack of research and understanding of the aetiology (in relation to the brain) compared with other branches of medicine. Legislatures and policy-makers prefer to design laws and policies that offer solutions for groups, and are less likely to prescribe tailor-made solutions for 'deviant' individuals. The reality is, however, that a reasonable accommodation for one person within a group is not always useful to others, and vice versa. This also holds true with respect to persons with the same mental health disability; each person is unique and different. With regard to personalised medicine,[66] more research is needed on adaptations, prevention and rehabilitation, with a focus on individuals and their particular needs, instead of seeking to meet the needs of groups. This requires a new approach in the field of employment research; an approach that is still in its infancy. Whilst this may be very costly, particularly for LMICs, it should be a human rights goal to be achieved progressively.

From the above analysis it becomes clear that health and health care rights are important preconditions for the enhancement of equal employment opportunities for persons with mental health disabilities, and accordingly, their wellbeing. A broad range of measures will be needed to achieve the aspiration set down in SDG3, and these cannot be confined to the field of health care. Realising the goals laid down in SDG3 and SDG8, as well as meeting the obligations of the CRPD, requires not merely a set of policy measures, but above all research into the effectiveness of the measures described above in this chapter, with a focus on the interaction between individuals and their environment.

The lack of research evidence with respect to many relevant employment issues relating to those with mental health disabilities will hinder the systematic implementation of the SDGs through human rights and disabilities policies. However, such absence of knowledge must not deter states from taking further measures in pursuit of achieving the SDGs, whilst simultaneously undertaking much needed research in this area. All states must attempt to improve the mental wellbeing not only of groups, but also of individuals, in order to ensure the sustainable development of our societies. In view of the imbalance between the industrialised and developing worlds, the achievement of these goals—and particularly SDG8 in terms of decent workplace

65 Center, C. (2010), 'Law and Job Accommodation in Mental Health Disability', in Schulz & Rogers (2010), *op. cit.*, nt.48, pp.3–32.

66 Hamburg, M. A. & Collins, F. S. (2010), The Path to Personalized Medicine, *New England Journal of Medicine*, 363: 301–304. Available at: doi.org/10.1056/NEJMp1006304.

Downloaded By: 10.3.98.104 At: 22:26 17 May 2021; For: 9780429397844, chapter14, 10.4324/9780429397844-14

standards—will be an even greater challenge for LMICs.[67] At the same time, it should not be forgotten that international human rights law also requires states to assist one another and to cooperate in order to realise human rights worldwide.[68] This is another message to be taken from this chapter: the promotion of mental health and the integration of persons with mental health disabilities into the employment market requires the sharing of information, the definition of common goals and plans of action, and collaborative international efforts.

67 Chopra, P. (2009), Mental health and the workplace: issues for developing countries, *International Journal of Mental Health Systems*, 3(4). Available at: doi.org/10.1186/1752-4458-3-4.

68 Art.2(1) of the ICESCR and Art.32 of the CRPD.