Nº Registro Mº Interior: F-456 • Declarada de Utilidad Pública (O.M. 18-XII-1996) • C.I.F.: G-46245247

**CONTRIBUTIONS OF THE SPAIN MENTAL HEALTH CONFEDERATION SPANISH COMMITTEE OF REPRESENTATIVES OF PERSONS WITH DISABILITIES (CERMI) TO THE REPORT OF THE SPECIAL RAPPORTEUR ON TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENTS OR PENALTIES**

**June 2020**

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**Introduction**

In the case of people with psychosocial disabilities (mental health problems), stigma permeates all social layers, so that both those who approve the regulations and those who interpret and apply them are affected by it. This produces the violation of human rights of the group of people with psychosocial disabilities who, due to the effect of myths and prejudices, are considered especially "conflictive", "difficult" or "dangerous". The lack of knowledge and awareness causes these people to suffer from violence that is insufficiently treated in public policies, normalizing situations that are incompatible with international human rights conventions and standards. For this reason, people with psychosocial disabilities form a group especially susceptible to situations of exclusion, discrimination, exploitation and inequality.

**2**

In this regard, on July 28, 2008, the Special Rapporteur against torture and other cruel, inhuman or degrading treatment or punishment prepared a revealing report pursuant to resolution 62/148 of the United Nations General Assembly. It highlights that, after the entry into force of the Convention on the Rights of Persons with Disabilities and its Optional Protocol (hereinafter, referred to as the 'Convention'), it would be appropriate to examine the framework against torture in relation to persons with disabilities, which connects with article 15 of the text of the Convention. Notes that many States allow, with or without a legal basis, the detention in institutions of people with mental disabilities without their free and informed consent, based on the existence of a diagnosis of mental disability, often together with other criteria such as' being a danger to himself and others' or 'need for treatment': “*This is particularly relevant in the context of medical treatment of persons with disabilities, where serious violations and discrimination against persons with disabilities may be masked as “good intentions” on the part of health professionals. Purely negligent conduct lacks the intent required under article 1, and may constitute ill-treatment if it leads to severe pain and suffering*” 1.

Subsequently, in 2013, this Rapporteur issued a new report in which it recalled that the Convention provides authoritative guidance on the rights of persons with disabilities and prohibits treatment and involuntary confinement for reasons of disability. In addition, he noted that serious abuses such as neglect, mental and physical abuse and sexual violence were being committed in health care settings. Therefore, he reaffirmed that there can be no therapeutic justification for the use of solitary confinement of persons with disabilities in psychiatric institutions. So “*it is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions*”. In fact, “*the environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-consensual treatment, such as forced medication and electroshock procedures*”2.

However, as the Rapporteur highlighted in this same report, such forced medical interventions, for the sake of "incapacity" and "therapeutic need" have their support in national laws, which may come to enjoy broad public support by for the sake of the alleged 'best interest' of the affected person.

From this starting point, a psychosocial dynamic is generated in which the affected person is vulnerable to suffering behaviors that may constitute torture and ill-treatment.

1 UN, General Assembly, The interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, A/63/175, 28 July 2008:

[https://documents-dds-ny.un.org/doc/UNDOC/GEN/N08/440/75/PDF/N0844075.pdf](https://amsm.es/2013/03/28/colaboraciones-sigue-siendo-necesario-incluir-la-perspectiva-de-genero-ensalud-mental-y-en-derechos-humanos-a-proposito-de-las-consideraciones-despectivas-sobre-la-llamada-ideologia-de-gene/)

2 UN, General Assembly, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, A/HRC/22/53, 1 February 2013: <https://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf>

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# An important aspect to consider: Capacity

As the Rapporteur pointed out in the aforementioned 2013 report, full respect for the legal capacity of each person is a first step in the prevention of torture and ill-treatment.

However, this aspiration has not yet been achieved, despite the fact that according to General General comment No. 1 (2014) of the Committee on the Rights of Persons with Disabilities, article 12, paragraph 2, recognizes the legal capacity of persons with disabilities on an equal basis with others in all aspects of life and, therefore, the States Parties have the obligation to take all pertinent and effective measures to guarantee this right. The Committee emphasized that equality before the law is a general basic principle of the protection of human rights, indispensable for the exercise of other human rights and a right guaranteed by various international instruments, the most prominent being the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights3.

**3**

In this document, the Committee highlights the following: “*All persons with disabilities, including those with physical, mental, intellectual or sensory impairments, can be affected by denial of legal capacity and substitute decisionmaking. However, persons with cognitive or psychosocial disabilities have been, and still are, disproportionately affected by substitute decision-making regimes and denial of legal capacity. The Committee reaffirms that a person’s status as a person with a disability or the existence of an impairment (including a physical or sensory impairment) must never be CRPD/C/GC/1 3 grounds for denying legal capacity or any of the rights provided for in article 12. All practices that in purpose or effect violate article 12 must be abolished in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others*”4.

However, in some sectors of society, the idea that people with mental health problems “are not people with disabilities” has taken root and, therefore, they do not deserve the respect and protection of their rights, which, among other norms , the Convention grants them. What is involved with this type of approach is to exclude this group from the umbrella of human rights that the Convention implies and place it in a kind of legal limbo in which their rights can be suspended, based on a diagnosis and the effects that are considered derived from it. However, although this affirmation does not have any support from a human rights perspective, it makes it difficult to design or establish supports or measures to guarantee this right to people with psychosocial disabilities, promoting the deprivation of their freedom compared to promoting their autonomy.

# Uncontrolled Environments

In 2017, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health issued a Report specifically focused on the right of everyone to mental health, claiming that it has been frequently neglected and that when resources are allocated to it, ineffective and harmful models, attitudes and imbalances prevail.

This Report, which is the result of extensive consultations carried out with representatives of movements related to disability, users of mental health services, professionals in this field or members of the United Nations human rights mechanisms, among others, puts black and white the fact that in the current context human rights violations that occur in mental health care systems are not addressed. According to the document, people with mental health problems find in the exercise of their rights barriers derived from a real or supposed deficiency and, therefore, they are extremely exposed to human rights violations in mental health centers5.

3 UN, General comment No. 1 (2014), Article 12: Equal recognition before the law, Committee on the Rights of Persons with Disabilities, CRPD/C/GC/1, 19 May 2014: [https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement](http://aen.es/wp-content/uploads/2016/06/MANIFIESTO-DE-CARTAGENA-LOGOS-2-1.pdf?OpenElement)

4 *Ibid.*

5 UN, General Assembly, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/35/21, 28 March 2017:

[https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/076/04/PDF/G1707604.pdf?OpenElement](http://www.inmujer.gob.es/areasTematicas/salud/publicaciones/Seriesdebartedocumentos/docs/Saludmentalygenero.pdf?OpenElement)

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Furthermore, the Rapporteur estimates that “*globally, it is estimated that less than 7 per cent of health budgets is allocated to address mental health. In lower-income countries, less than $2 per person is spent annually on it*” and “*most investment is focused on long-term institutional care and psychiatric hospitals, resulting in a near total policy failure to promote mental health holistically for all*”. He adds: “*The arbitrary division of physical and mental health and the subsequent isolation and abandonment of mental health has contributed to an untenable situation of unmet needs and human rights violations (see A/HRC/34/32, paras. 11-21), including of the right to the highest attainable standard of mental and physical health*”. “*Forgotten issues beget forgotten people*” and this is so, as published, because “*for decades, mental health services have been governed by a reductionist biomedical paradigm that has contributed to the exclusion, neglect, coercion and abuse of people with intellectual, cognitive and psychosocial disabilities, persons with autism and those who deviate from prevailing cultural, social and political norms. Notably, the political abuse of psychiatry remains an issue of serious concern. While mental health services are starved of resources, any scaled-up investment must be shaped by the experiences of the past to ensure that history does not repeat itself*”.

**4**

Thus, people with psychosocial disabilities frequently suffer serious abuses and violations of their right to physical and mental integrity (articles 16 and 17 of the Convention). Specifically, this occurs, in addition to the aforementioned involuntary admission measure, through treatments in principle aimed at correcting and alleviating your situation: forced treatments, medication administered without their free and informed consent or against their will and that they can have side effects such as tremors, contractions, apathy, etc., the so-called "electroconvulsive therapy" and other forms of treatment for this purpose.

People with psychosocial disabilities in health care centers depend on the health professionals who provide services to them and in this type of strongly hierarchical structures, the person is under the absolute control of one or more others and is placed in a position of impotence, which increases with the deprivation, where appropriate, of the legal capacity, in the sense of deprivation of their ability to make decisions and assignment of that power to third parties.

These structures can be reproduced, in addition to informal care, mainly in health centers, residences or other places of deprivation of liberty.

According to the Spanish National Mechanism for the Prevention of Torture (MNP), places where people are deprived of liberty, whether it is short, medium or long-term, must meet minimum criteria or preventive safeguards in accordance with international regulations and internal on the matter that, in addition to helping to guarantee fundamental rights, favor an improvement in the situation and correct any deficiencies that may be observed6.

In light of the Convention, the regulatory framework in this matter must be reviewed, providing the most appropriate means to address the health, empowerment and rehabilitation of the person from a human rights perspective, also taking into account the gender impact.

In this sense, the MENTAL HEALTH SPAIN Confederation (under the name then FEAFES) has presented two important documents in which therapeutic measures are proposed to avoid having to resort to interventions that force the will of the person:

1. “Therapeutic measures to avoid having to resort to coercive measures” (2013)7;
2. “Proposal for Therapeutic Intervention. Alternative to Involuntary Outpatient Treatment (TAI)” (2009)8.

6 MNP, Mecanismo Nacional de Prevención de la Tortura, “Informe Anual 2014. Madrid: Defensor del Pueblo”, 2015: [https://www.defensordelpueblo.es/informe-mnp/mecanismo-nacional-de-prevencion-de-la-tortura-informe-anual-2014/](https://consaludmental.org/centro-documentacion/propuesta-intervencion-terapeutica-alternativa-al-tai/)

7FEAFES, “Therapeutic measures to avoid having to resort to coercive measures” (2013): [https://consaludmental.org/publicaciones/Medidasterapeuticas-mayo2013.pdf](https://consaludmental.org/centro-documentacion/propuesta-intervencion-terapeutica-alternativa-al-tai/)



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## Health centers

* **Involuntary admission**

As the United Nations High Commissioner for Human Rights has stated in a 2009 report, the doctrine of medical necessity continues to hinder protection against arbitrary abuse in health care settings. It is, therefore, important to clarify that treatment provided contrary to the provisions of the CRPD, whether through coercion or discrimination, cannot be legitimate or justified under the doctrine of medical necessity9.

According to this same report, community life, with support, is an internationally recognized right, so the norms that authorize persons with disabilities to be held in an institution without their free and informed consent must be abolished. This should include the repeal of the provisions that authorize such detention for their care and treatment without their free and informed consent, as well as those that authorize the preventive deprivation of liberty of persons with disabilities for reasons such as the possibility that they may be placed in detention, danger to themselves or others, in all cases in which the reasons for care, treatment and public safety are linked in law to an apparent or diagnosed mental illness.

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**3.2 Prisons and psychiatric correctional facilities**

In the prison environment, serious violations have been detected that hinder and impede access to justice for these people and guarantee their right to freedom and security in accordance with international human rights law, including the provision of support.

In the report of RED2RED CONSULTORES "Mental health and social inclusion: current situation and recommendations against stigma", promoted by MENTAL HEALTH SPAIN, it is highlighted that the inadequate application of the law results in a prevalence of mental health problems among people female inmates five times greater than that of the general population (Grupo PRECA, 2011)10.

According to this same report, another fundamental problem lies in the difficulty of providing continuity of care once people leave prison, which contributes to what is called “recidivism” when it is most likely that we are facing a worsening of the person's state of health. The prison population living with a mental disorder carries a double stigma: on the one hand, that associated with their mental disorder and, on the other, that linked to the prison environment. Thus, they have no place and are not well received either in the services for the prison population or in the services for people with mental health problems, since they are seen as criminals11.

According to a study carried out on people sentenced to custodial security measures at the Alicante Penitentiary Hospital, almost 30% of the inmates who were part of the sample should not have any custodial measure whatsoever since their clinical situation had changed and they were able to live in freedom. However, they remained in the center due to the lack of open resources appropriate to their circumstances (Ortiz, 2013; Ministry of Health, 2012).

In this sense, according to this analysis, the following problems should be highlighted:

8 FEAFES, “Proposal for Therapeutic Intervention. Alternative to Involuntary Outpatient Treatment (TAI)” (2009) https: //consaludmental.org/centro-documentacion/propuesta-intervencion-terapeutica-alternativa-al-tai/

9 ONU, Asamblea General, “Informe anual del Alto Comisionado de las Naciones Unidas para los Derechos Humanos e Informes de la Oficina del Alto Comisionado y del Secretario General”, Estudio temático preparado por la Oficina del Alto Comisionado de las Naciones Unidas para los Derechos Humanos para mejorar el conocimiento y la comprensión de la Convención sobre los derechos de las personas con discapacidad, A/HRC/10/48, 26 de enero de 2009: [https://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/a.hrc.10.48\_sp.pdf](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/076/04/PDF/G1707604.pdf)

10 Red2red Consultores. (2015). Salud mental e inclusión social: situación actual y recomendaciones contra el estigma. Madrid: Confederación SALUD MENTAL ESPAÑA: [https://consaludmental.org/publicaciones/Salud-Mental-inclusion-socialestigma.pdf](http://www.diariodenavarra.es/noticias/navarra/2016/01/25/3600_adolescentes_ninos_tratamiento_por_enfermedades_mentales%20_391513_300.html) 11 *Ibid.*



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1. Primacy of the legal-penitentiary perspective over the medical one when applying the law: this refers to the still unmet need to provide people in prison with socio-sanitary care of characteristics equivalent to those received by the general population; as well as a standard treatment in the mental health network when they are subjected to a security measure.
2. Lack of guarantees to detect mental health problems in legal proceedings. According to recent research, the reason why so many people with mental disorders end up serving sentences in an ordinary prison is due to various circumstances such as: Failure to detect the existence of a mental disorder during the processing of the criminal case; the increasing number of fast trials; or the confirmation of a situation of mental disorder, but without being able to prove the imputability.

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1. Discrimination in the application of security measures. On few occasions these measures are modified, on the one hand due to cumbersome procedures (it is the surveillance court that must issue a positive report to the sentencing court and the latter must propose a change to the measure previously imposed) and, on the other, because of poor coordination between the socio-sanitary care system and the criminal legal system (Ministry of Health, 2012).
2. Lack of referral protocols to coordinate this type of measures between the judicial bodies and the health and social care network, as well as the social entities that carry out support activities is also a problem.
3. Little compliance with security measures in therapeutic spaces to the detriment of penalties in ordinary penitentiary centers (ARARTEKO, 2014).
4. Existence of paternalistic attitudes between socio-health professionals that distort the internal functioning in the prison environment. In other words, there is a primacy of criteria of beneficence and justice over criteria of autonomy, which goes in the opposite direction to the model of psychosocial rehabilitation that fosters personal autonomy and empowerment of the patient.
5. There is a lack of mechanisms that favor the psychosocial rehabilitation of inmates with mental health problems through individual and group intervention both outside and inside the penitentiary centers. It is necessary to support and advise family members to alleviate this situation and meet the training and counseling needs of officials and inmates about people with mental disorders. In addition, personality disorders seem to be particularly relevant in the analysis since there is no shared diagnosis regarding their incidence in the commission of the criminal act. Some personality disorders are in a fine line between mental disorder and deviant personality, so that for the purposes of imputability in many cases it is understood that the people who have them are fully aware of their actions (Esbec et al, 2010 ).
   1. **Forced psychiatric interventions**

As expressed in the Cartagena Manifesto by Mental Health Services respectful of Human Rights and Free of Coercion, the range of coercion in psychiatric care is broad and includes the use of power, force or threat to achieve that a person being cared for does or stops doing something against their will. Referring especially to the use of restraints or isolation and other forms of coercion, the signatory entities, including MENTAL HEALTH SPAIN, strongly affirm that it is time to advance awareness of these practices that do not guarantee rights of people; to work for their elimination and for the eradication of the deficiencies that make them possible12.

Among other proposals, this document advocates promoting transparency; redesign spaces and organization, promote a work culture oriented to non-coercion; train professionals in person-centered therapeutic relationship practices; propose creative alternatives; create real channels for user

12 AEN et alt., “Manifiesto de Cartagena por unos Servicios de Salud Mental respetuosos con los Derechos Humanos y Libres de Coerción”, 2016: [http://aen.es/wp-content/uploads/2016/06/MANIFIESTO-DE-CARTAGENA-LOGOS-2-1.pdf](https://www.consaludmental.org/publicaciones/Informe-Derechos-Humanos-Salud-Mental-2019.pdf)



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participation or urge the commitment of the social and health administrations in prioritizing the necessary investments in resources that favor the inclusion, belonging and permanence of people in their environments, thus avoiding exclusion practices.

## Access to justice

For those with mental health problems, access to justice on an equal basis with other people is still not guaranteed, facing many barriers. For example, in theory, each person has the right to appeal when they are involuntarily admitted, but, most of the time, neither information is provided nor is it answered to requests for legal assistance, which may be requested. The contact of the court with the person is translated many times more in a formalism than an effective guarantee.

**7**

This legal regime that also allows the institutionalization of people with mental health problems in residential centers or psychiatric hospitals, favors abuse and only contains post-factual safeguards. Thus, on many occasions, claiming their rights is identified with "rebellion" and encourages the increase of coercive or pharmacological measures.

These difficulties of access to justice also extend to the prison environment, adding the double stigma when it comes to social reintegration that a person has having a psychosocial disability and having been subjected to the prison regime.

This lack of awareness also results in the absence of studies that allow a quantitative and qualitative assessment of the situation (including the consideration of the combination of gender, age and disability as a risk factor for multiple discrimination), which impedes the design of the corresponding actions to guarantee such rights, increases their invisibility and favors the creation of wide spaces of impunity. Thus, for example, it is common that the complaints of the people affected can be interpreted as mere symptoms of their "mental illness".

## Recommendations

1. Review the norms that regulate the declaration of incapacity procedure, guardianship and conservatorship, to adopt norms and policies that replace the regimes of substitution in the adoption of decisions-making by assistance in making decisions that respect the autonomy, will and preferences of the person;
2. Provide training on this issue to all public officials and legal operators in general;
3. Guarantee access to justice on equal terms with other people, creating protocols and support figures for this purpose. Regarding the problem of legal aid *ab initio* in the process of involuntary admission, for the effective compliance of Article 13 of the Convention, the legal aid to persons with disabilities against whom the procedure is directed must be assumed. Unfortunately, given the circumstances in which the person admitted is usually found, most of the files are processed without naming a representative or defense (which are optional under the current regulation). For this reason, it would be advisable to establish the obligation of legal aid and these assumptions were covered by free justice, so that they do not have to pay the corresponding expenses for their defense and representation through a lawyer and attorney, unless expressly designated lawyer of your choice. Ultimately, adequate and effective safeguards must be established to guarantee rights.
4. Advocate for the adoption of measures to fight impunity, establishing measures to prevent torture and ill-treatment against people with psychosocial disabilities in the context of involuntary admissions, through the corresponding regulations and coordination of actions in accordance with the Convention.
5. Take into account the double aspect of this matter: social and health. In her two circumstances of the person converge: age (older people or children) and mental health problems, among others.



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1. Collect data on the inmate population with mental disorders. It is important to have information in this regard to measure the incidence of the problem and correct it until there are no people with mental disorders in these centers;
2. Control forced psychiatric interventions. In this sense, it is important to keep in mind the proposals incorporated in the aforementioned Cartagena Manifesto by Mental Health Services respectful of Human Rights and Free of Coercion;
3. Prevent the entry of people with mental health problems into prison. No person with mental health problems should remain in a correctional facility, so that their care would have to occur specifically in the National Health System. For this reason, the necessary procedures must be carried out to enable them to enter centers of the National Health System, so that they may fulfill the possible sentence in a therapeutic context;

**8**

1. Control of the performance of multidisciplinary teams. In all centers where people with mental health problems are cared for, effective monitoring of the performance of multidisciplinary teams will be carried out, in order to control the quality of their interventions, the effective achievement of objectives and the rationale of their decisions from a human rights perspective;
2. Coordination and training of staff. In all the centers where people with mental health problems are kept, the personnel in contact with them will work in a coordinated manner, promoting the creation of mechanisms for the continuous control of individualized care plans and their effective impact on life and health of the people to whom they are intended. In addition, personnel in contact with people with mental health problems must be specialized and mechanisms will be established to control their capacities and actions;
3. Take care of the design of the space. The spaces must be oriented to the well-being of the person, so that the creation of warm and pleasant environments will be sought. This implies adequate equipment, in accordance with their dignity and needs, that favors respect for their privacy, freedom of movement, opportunities for leisure and interaction, etc. Recourse to containment, punishment or isolation will be avoided13.
4. Design of individualized care plans. In all centers where people with mental health problems are cared for, there should be support protocols to prevent worsening of the state of health, grading the intensity of the support according to the specific situation of the person;
5. Review the resources dedicated to the care and protection of minors deprived of liberty;
6. Professionals who intervene in the judicial procedure and who are in contact with the person with mental health problems in the prison context must guarantee their rights on an equal basis with others. This implies attending to essential aspects such as the way in which information is provided, the characteristics of the environment, the way in which communication occurs and all those others that contribute to the identification and elimination of obstacles and barriers. For this, they will take into account the way in which the information is provided.

The information and communications must be adapted to the specific circumstances of the person, respecting their diversity and avoiding those risk factors that may make them vulnerable. For this reason, the language used must be clear, simple, colloquial and concrete, taking into account its cultural, socioeconomic or other characteristics.

Thus, in general, the information provided must have at least the following contents:

13 Poder Judicial de Costa Rica, Comisión de Acceso a la Justicia, Programa EUROsociAL. (2013). Protocolo de atención para el efectivo acceso a la justicia de personas con discapacidad psicosocial. Madrid: Programa EUROsociAL: [https://consaludmental.org/publicaciones/Protocolo-justicia-discapacidad-psicosocial.pdf](http://aen.es/wp-content/uploads/2016/06/MANIFIESTO-DE-CARTAGENA-LOGOS-2-1.pdf)



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1. The nature of the judicial action in which they will participate;
2. Their role in said action, their rights and their procedural position, whether as a victim, witness or accused;
3. The meaning of her intervention;
4. The type of support that can be received in the context of said intervention, and what organization or institution can offer it;

Regarding the form, the following criteria will be followed:

1. Address the person directly;

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1. Recognize the person as someone capable of contributing; and not as a mere recipient;
2. Use a simple language and adapted to its characteristics, checking the person's understanding;
3. Communicate naturally;
4. Treat the person according to their age, avoiding "infantilization" and avoiding attitudes of superiority;
5. Adapt the times to the particular circumstances;
6. Create a warm, structured and stable environment that avoids conflict;
7. Adopt an attitude of active listening, which includes the perception of non-verbal language;
8. Answer the questions, making sure they have been understood;
9. Ask clearly and precisely, taking into account their preferences or interests;
10. Take advantage of new technologies as appropriate14.
11. Investigation of complaints and denunciations. In all the Centers, a file or book should be established in which the complaints presented by the inmates are registered, as well as the complaints or judicial procedures that are known, related to incorrect actions or mistreatment by the officials, in order to monitor and supervise them. It is important that the investigation as a result of complaints or allegations of torture or ill-treatment, even when there is no formal complaint but there are indications that an act of this nature may have been committed, an investigation be initiated that is in accordance with the provisions of the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishmen, known as the “Istanbul Protocol”.
12. Establishment of control mechanisms on the number and motivation of the contentions;
13. Training of professionals in verbal deactivation techniques and especially in empathy and investment of the necessary time to, through the word, reduce eventual situations of violence of the person against himself or against other people.
14. **Groups especially vulnerable to psychosocial dynamics conducive to torture and other forms of ill-treatment**

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has already highlighted in a 2015 report that the history of psychiatry shows that the good intentions of service providers can turn into violations of the human rights of users. In addition, he showed that these groups are subject to social exclusion, stigmatization or humiliation, which negatively affects their health. Too often what prevents the implementation of basic principles are not financial obstacles, but certain attitudes that persist among stakeholders and that are not in line with human rights and public health principles. Starting from the premises that "all persons with disabilities have the right to health" and that "without mental health there is no health", the Rapporteur advocates a modern conception of mental health that goes beyond the absence of

14 *Ibid.*

relationships between groups and individuals, in which there is a mutual bond of trust, tolerance and respect for the dignity of each15.

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Likewise, during the 36th session of the Human Rights Council of the United Nations (UN) and under item 3 of the agenda "Promotion and protection of all human, civil, political, economic, social and cultural rights, including the right to development ”, this council approved on September 28 a specific resolution on mental health. This session of the UN Human Rights Council, which took place in Geneva from September 11 to 29, closed with the adoption of more than 30 resolutions, including resolution A / HRC / 36 / L.25 “Mental health and human rights”.

**10**

In this resolution, the Council is deeply concerned that people with mental health problems around the world may be subject, in general, to discrimination, stigma, prejudice, violence, abuse, social exclusion and segregation, illegal or arbitrary internment, excessive medicalization and treatments that do not respect their autonomy, will and preferences. Thus, recognizing the need to protect, promote and respect all human rights in the global response to issues related to mental health, this document emphasizes that States must ensure that people with mental health problems can live independently, be included in the community, exercise their autonomy and capacity to act, participate meaningfully in all matters that affect them and make decisions in this regard, as well as ensuring that their dignity is respected, on equal terms with the other people16.

In the case of people with psychosocial disabilities, stigma permeates all social layers, so that both those who approve the rules and those who interpret and apply them are affected by it, which means that it is in violation of human rights. a group that, due to the effect of myths and prejudices, is considered especially "conflictive", "difficult" or "dangerous". From these premises, a social acceptance and widespread support of abuses are generated that are generally perceived as “necessary” or “for the good” of the person. These patterns of collective psychosocial behavior are based on a distorted perception of reality that is the germ of prejudice and the consequent discriminatory behavior.

The reality is that individuals have multiple identities, not a single one, and therefore they can face multiple discriminations as well. This situation is based on positions of power and privilege that cannot be ignored when designing norms, policies or any other measure that affects the group. The absence of protocols to promote their participation with all the guarantees leads to a permanent violation of the rights recognized in the Convention. Therefore, the ultimate goal of all actions should be to create environments that facilitate the optimal development of people with psychosocial disabilities from inclusion, promotion of autonomy, participation in decision-making, respect and adequate support.

In short, it is necessary to adopt measures that promote models of care centered on the person and their life project according to the needs and expectations of each one.

## Gender perspective: inequality between men and women

Gender is a symbolic construction referring to the sociocultural attributes assigned to people from a biological category such as sex. The concept of gender, therefore, is an artificial category historically elaborated from myths, stereotypes or false beliefs that generate imposed dichotomous models with which people identify. Thus, an unequal social position between women and men is revealed, and the ideological assumption that equates biological differences with ascription to certain social roles is made visible, which has an important impact on mental health17. In this way, sex determines from birth

15 ONU, Naciones Unidas, Asamblea General. “Informe del Relator Especial sobre el derecho de toda persona al disfrute del más alto nivel posible de salud física y mental”, A/HRC/29/33, 2 de abril de 2015: <http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session29/Documents/A_HRC_29_33_SPA.DOCX>

16 UN, General Assembly, “Mental health and human rights”, Report of the United Nations High Commissioner for Human Rights, A/HRC/34/32, 31 January 2017: [https://digitallibrary.un.org/record/861008](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf)

17 MINISTERIO DE CULTURA. “Género y cultura”, AGETECA, Base de datos/Gestión cultural:

socialization) that, together with gender violence, contribute to the perpetuation of much more marked inequalities if one has a disability, even more so if it is associated with a mental health problem, with what it entails in terms of stigma18.

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For the analysis of the specificities inherent in the diversity of the human condition, the adoption of the 'Theory of Intersectionality' is essential and enriching. In this sense, if we analyze the stigmatization processes related to mental health problems and those that are associated with people's sex (such as the cultural construction of gender), we find that they occur in a similar way19. However, there is still much to do when addressing mental health problems with a gender perspective and, in this way, analyze the person's situation in a comprehensive way, attending to each of their particularities and barriers to you are facing.

**11**

As Silvia Tubert expresses, although the social networks in which women are immersed are very decisive when considering their mental health, it is not possible to make “*a sociological generalization that relates the possibility of becoming ill with a certain situation of frustration objective* ”. This is so, because “*mental disorders are, essentially, a precipitate of problems related to different dimensions of human life: psychic suffering, social failure, inappropriate behaviors, conflicts with life as a couple or family, helplessness, ruptures with the consensual reality, and they appear as the manifestations of a discomfort that cannot be reduced to an absolute determinism, be it biological, psychological or social*”. However, women cannot find answers to their questions or consideration of their suffering in health institutions that are organized solely to treat symptoms. Furthermore, he is vulnerable to different types of violence, which constitutes an additional risk factor for his mental health, “*whether it be visible violence (sexual abuse, rape, physical abuse, labor or affective exploitation, etc.) or invisible ( forms of relationship that place women in a position of inferiority, devaluation or inequality)*"20.

For this reason, the clinical psychologist Rebeca González recommends adopting a clear position in this regard. Thus, he affirms that: “*Positioning ourselves is something complicated, something that generates doubts, something that can bring us that our path is less easy than was intended, but much more coherent, healthy and responsible towards us and, above all, towards the patient. It is about putting the focus where it should, not where it is more comfortable for us*.21 ”

Unfortunately, as can be seen, the gender perspective continues to be a pending issue in the field of mental health, despite the multiplicity of facets and identities of the person and, therefore, despite the possibility of being the victim of multiple discrimination, sustained in positions of power and privilege22. Following the psychiatrist Cristina Polo, therapeutic interventions should not be excluded from this, since they can also "*be a space for the visibility of invisible symbolic violence*"23. It must always be

[http://www.agetec.org/ageteca/genero.htm](https://consaludmental.org/publicaciones/Salud-Mental-inclusion-socialestigma.pdf)

18 BUSTAMANTE MUÑOZ, C., CABALLERO PÉREZ, I., CASTELLANO DOMÍNGUEZ, I., VALES HIDALGO, A. “Niñas con discapacidad”, en la obra colectiva Transversalidad de Género en las Políticas Públicas de discapacidad-Manual, Capítulo II, ed. CINCA, Madrid, diciembre de 2013, pp. 47-48

19 TUBERT COTLIER, S., “La construcción cultural de la feminidad”, en la obra colectiva Salud Mental y Género, Aspectos psicosociales diferenciales en la salud de las mujeres, ed. Instituto de la Mujer (Ministerio de Trabajo y Asuntos Sociales), Madrid, 19 y 20 de octubre de 1999, pp.66-71: [http://www.inmujer.gob.es/areasTematicas/salud/publicaciones/Seriesdebartedocumentos/docs/Saludmentalygenero.pdf](https://www.defensordelpueblo.es/informe-mnp/mecanismo-nacional-de-prevencion-de-la-tortura-informe-anual-2014/)

20 TUBERT COTLIER, S. “La construcción cultural de la feminidad”, en la obra colectiva Salud Mental y Género, Aspectos psicosociales diferenciales en la salud de las mujeres, ed. Instituto de la Mujer (Ministerio de Trabajo y Asuntos Sociales), Madrid, 19 y 20 de octubre de 1999, pp.66-71: [http://www.inmujer.gob.es/areasTematicas/salud/publicaciones/Seriesdebartedocumentos/docs/Saludmentalygenero.pdf](https://consaludmental.org/publicaciones/Medidasterapeuticas-mayo2013.pdf)

21 GONZÁLEZ IBÁÑEZ, R., “Trastorno límite de personalidad y violencia de género”, Diagonal, 25 de noviembre de 2014: [https://www.diagonalperiodico.net/cuerpo/24807-transtorno-limite-personalidad-y-violencia-genero.html](https://digitallibrary.un.org/record/861008)

22 POLO USAOLA, C. ‘¿Sigue siendo necesario incluir la perspectiva de género en salud mental y en derechos humanos? A propósito de las consideraciones despectivas sobre la llamada “Ideología de género”’, Asociación Madrileña de Salud Mental, 28 de marzo de 2013: [https://amsm.es/2013/03/28/colaboraciones-sigue-siendo-necesario-incluir-la-perspectiva-de-genero-](https://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/a.hrc.10.48_sp.pdf) [ensalud-mental-y-en-derechos-humanos-a-proposito-de-las-consideraciones-despectivas-sobre-la-llamada-ideologia-de-gene/](https://www.consaludmental.org/publicaciones/Informe-Derechos-Humanos-Salud-Mental-2016.pdf) Asimismo, POLO USAOLA, C. “Deconstruyendo mandatos de género en narrativas terapéuticas”, Boletín nº 42 de la Asociación Madrileña de Salud Mental (AMSM), 12 de febrero de 2018: [https://amsm.es/2018/02/12/deconstruyendomandatos-](https://digitallibrary.un.org/record/861008) [de-genero-en-narrativas-terapeuticas-boletin-no-42-de-la-amsm/](https://amsm.es/2018/02/12/deconstruyendomandatos-de-genero-en-narrativas-terapeuticas-boletin-no-42-de-la-amsm/)

23 *Ibid.*

systems and far from the public eye24.

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According to the study ‘Public health from the perspective of gender and social class’”, women, the population with a lower socioeconomic level or areas with greater material deprivation, present health indicators that denote a worse situation. However, the health system suffers from the same androcentric approach of the society in which it is inserted and generates a bias in health professionals, when it is women who come to their medical consultations and, if it is also mental health, the problem multiplies in a context of coercion where gender takes on a larger dimension. This is so because the paradigm of the social model of disability and the human rights approach of the Convention on the Rights of Persons with Disabilities and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) have not permeated the legislation and in policies that affect people with mental health problems, so harmful stereotypes and all forms of discrimination against women prevail. Dr. Aurora Rovira, in her article 'Science and medical practice, a reflection of patriarchal society', affirms that, despite the predominance of women in the practice of Medicine, medical practice is still androcentric and patriarchal because the people who are part of this profession are socialized and trained in this context. At the end of the day, "*medicine is a reflection of the culture and beliefs that support it and therefore has its same characteristics*", adding: "*Now that we begin to recognize patriarchal power structures in other areas of the life, it is important to reflect on how these have shaped science and medical practice and what impact they have on women's health*” (Carme VallsLlobet, 2009). Women, in general, suffer different forms of violence in this context, which have to do with overmedication of pregnancy, childbirth or menopause, among other life circumstances, neglect of health problems whose symptoms are attributed to "*issues nerves and multiple mismatches between the needs of patients and the resources provided. On the other hand, an overdiagnosis of mental disorders occurs in women, identifying discomforts with pathologies that in most cases have to do with the burdens associated with gender stereotypes and different types of violence, such as male violence. In this way, the structural violence of society takes the form of diagnosis, generating a label that hides, not solving the true background of the problem and relegating women to a passive role or victims*”25. As this doctor points out, a critical and feminist view is needed in this area that questions science and medical practice from a gender perspective and denounces the conditions that harm the health of women and, in some cases, that of men26.

**12**

For all these reasons, it is essential to demand the incorporation of the principle of equality between women and men in public policies on mental health and to incorporate it into the practice of mental health professionals, in order to achieve an effective guarantee of human rights.

## Gender violence

A serious problem of invisibilization of the psychological effects of gender violence persists, which also affects very seriously the minor sons and daughters of the women affected. According to the WHO, mistreatment is one of the risk factors to be taken into account when addressing suicide prevention, and to this must be added the serious impediments faced by women with psychosocial disabilities when accessing reception resources, which also affects the minors in their care27.

24 FEDERACIÓN VIDA INDEPENDIENTE. “La institucionalización aumenta el riesgo de explotación, violencia y abuso”, páginas 25 y 26 del informe CommDH/IssuePaper(2012) 3 sobre el artículo 19 de la Convención sobre los Derechos de las Personas con Discapacidad por el Consejo de Europa, traducción de César Giménez: [https://federacionvi.org/la-](http://acnudh.org/wpcontent/uploads/2013/11/orentaci%C3%B3n-sexual-e-identidad-de-g%C3%A9nero2.pdf) [institucionalizacion-aumenta-el-riesgo-de-explotacion-violencia-y-abuso/](https://amsm.es/2013/03/28/colaboraciones-sigue-siendo-necesario-incluir-la-perspectiva-de-genero-ensalud-mental-y-en-derechos-humanos-a-proposito-de-las-consideraciones-despectivas-sobre-la-llamada-ideologia-de-gene/)

25 ROVIRA, A., “La ciencia y la práctica médica, un reflejo de la sociedad patriarcal”, Catalunya Plural, 4 de abril de 2018. Asimismo, Fundación Cermi Mujeres, “Violaciones de derechos humanos de las mujeres con discapacidad psicosocial”, 1 mayo de 2019 [Artículo en web] y Borrell, C., García-Calvete, M. M., Martí-Boscà, J. V. (2004). La salud pública desde la perspectiva de género y clase social. Gaceta Sanitaria, 18(6), pp. 2-6. 13.

26 *Ibid.*

27 FEDEAFES. Guía “Investigación sobre la violencia contra las mujeres con enfermedad mental”, Llodio (Álava), 2017.

and boys by their parents, compromises early mental health, by becoming involuntary witnesses. Various studies have revealed psychological disturbances in minors exposed to gender violence, warning of chronic stress that, in addition, can trigger or accelerate any other mental problem: anxiety, depression, withdrawal, somatic problems, social problems, attention problems, disruptive behavior, aggressive behavior, etc.28

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In addition, boys and girls reproduce patterns, both to mistreat and to be mistreated. According to the 'Reina Sofía Center Report on Violence, 2010', four out of ten abusers have been mistreated as children, and children who witness (or even suffer first-hand) male violence, can also accept this mode as normal behavior29.

**13**

Therefore, it is not possible to continue perpetuating the myths that minors recover “spontaneously”, “do not remember” or “do not understand”. If this occurs, the diagnosis of trauma and Post Traumatic Stress Disorder is difficult at these ages, as insufficient and adequate preventive and care measures are not taken. It is essential to make girls and boys visible in the context of violence against women30.

Furthermore, women with mental health problems face serious impediments to accessing shelter resources designed for women who experience gender-based violence. This reality has been included in the Guide “Research on violence against women with mental illness” published by the Basque Federation of associations of relatives and people with mental illness (FEDEAFES) in 2017 and by the report of the paper for a Pact of State against Gender Violence approved in the Senate that claims to modify the regulations of the shelters so that no victim with a disability can be rejected for this reason, as is the case today. The report calls for ensuring the accessibility of all resources (health, social, judicial and reception) to victims with disabilities, and CERMI MUJERES Foundation (an Spanish non- profit organization whose main objective is to favor the conditions for women and girls with disabilities to enjoy fully and on equal terms all the human rights and fundamental freedoms) has participated in its preparation, which stresses: All this must be regulated in close collaboration with the autonomous communities (first-level political and administrative division in Spain), which are the ones that have the power in this field. This requires, among other important aspects, specific campaigns aimed at this group, as well as specialized training on gender violence for all agents who work with people with disabilities (health personnel, social workers, psychologists, educators and agents of the bodies State Security); so that they are able to identify when these women may be experiencing gender violence.

## Sexual abuse and other forms of violence in places of custody of people with mental health problems

The WHO defines sexual violence as those acts that range from verbal harassment to forced penetration and a variety of types of coercion, from social pressure and intimidation to physical force.

The propensity to violence is greater in closed, hierarchical systems and away from the public eye. Silence is imposed or self-imposed in these contexts for fear of reprisals, the lack of protocols that guarantee access to justice and the barriers that arise due to the lack of adequate support resources One of the problems that they face at the time addressing this problem in the field of mental health is the paucity of studies that analyze the risk of victimization of people with mental health problems; this is due, among other factors, to the stigma that leads to not giving credibility to the testimony of the people of this group or to the self-stigma, which arises precisely from this foreseeable social rejection and leads to the devaluation of one's own experience. Given that violent victimization is a serious public health problem, it is urgent that a rigorous diagnosis be made of the situation of people with

28 EL IMPARCIAL. “¿Cómo afecta la violencia de género a los niños que la presencian?”, 1 de julio de 2017: [https://www.elimparcial.es/noticia/179144/sociedad/como-afecta-la-violencia-de-genero-a-los-ninos-que-la-presencian.html](https://documents-dds-ny.un.org/doc/UNDOC/GEN/N08/440/75/PDF/N0844075.pdf)

29 *Ibid.*

1. Atenciano, B. “Impacto de la violencia de género en los primeros años: Niñas y niños de 0 a 5 años”, Psicóloga infantojuvenil, Programa MIRA, 2015: [http://www.comunidad.madrid/sites/default/files/doc/justicia/exposicion\_0\_a\_5\_dgm\_2015.pdf](https://consaludmental.org/publicaciones/Protocolo-justicia-discapacidad-psicosocial.pdf)

assaults, gender violence, harassment school, neglect or neglect in boys and girls, robberies, etc.) in custody contexts that can go from reintegration centers to hospital and penitentiary centers.

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In many cases, women with psychosocial disabilities do not denounce because they are unaware that the situation they are experiencing is a crime or, even if they have this knowledge, they do not want to denounce for fear of retaliation, loss of affective ties or care provision, or because they think that they will not be believed, given that the type of disability they have is associated with a very intense level of social stigmatization31.

## Forced sterilizations

**14**

It is necessary to abolish the regulations that allow the practice of forced sterilizations and put in place means to avoid the application of coercive abortion.

## Ignored disorders associated with maternal mental health

It is essential to adopt a gender approach in the health system that questions medical science and practice in light of the determining factors that harm the health of women and, in some cases, that of men. For this, it is necessary to collect data on maternal mental health and promote social awareness and visibility and create resources that promote the prevention and adequate treatment of maternal mental health problems from primary care.

Situations such as postpartum depression (“baby blues”) or grief after the death of a baby (perinatal mortality) require specific resources and spaces where women can openly expose everything that affects and worries them in relation to maternity and mental health, in a setting of trust and free from prejudice.

## Recommendations

1. Adopt by the public powers a clear position around the recognition of the different impact of human rights violations in relation to being a man and a woman and the social constructions associated with being one. It is about incorporating gender mandates into the field of mental health in order to improve care and make invisible symbolic violence visible.
2. In light of the above, incorporate the principle of equality between women and men in public policies on mental health and in the practice of mental health professionals, in order to achieve an effective guarantee of human rights.
3. Execution of inter-institutional coordination and referral protocols, including the Mental Health Network and the associations of people with psychosocial disabilities;
4. Provide specialized training to all professionals who provide direct care to women with psychosocial disabilities;
5. Establish interdisciplinary teams that work in coordination;
6. Provide an immediate solution to the problem of exclusion of women with psychosocial disabilities from resources allocated to gender violence;
7. MILLÁN MADERA, S. “Mujeres con discapacidad y violencia sexual: guía para profesionales”, pp.13,14 y 21: [https://consaludmental.org/centro-documentacion/mujeres-discapacidad-violencia-sexual-8750](https://www.diagonalperiodico.net/cuerpo/24807-transtorno-limite-personalidad-y-violencia-genero.html)



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1. Advance towards a model of individualized and comprehensive care, which adapts the responses to the needs of each woman considered from an intersectional approach;
2. Include violence against women with psychosocial disabilities in social health commissions and agreements;
3. Incorporate in the detection and assessment tools of the different situations that the social services (dependency, lack of protection, risk of exclusion) attend to violence in the couple, differentiating it from violence coming from other family members and registering also the existence or suspicion of mental health problems.

**15**

1. Provide a response to women with psychosocial disabilities who are left out of foster care and psychological care specialized in violence;
2. Appoint reference psychiatrists to preferentially attend each of the shelter resources for women victims of violence;
3. Appoint reference psychiatrists to work with psychological care services specialized in violence;
4. Develop systems that allow violence data to be shared between different institutions.
5. Include violence against women with psychosocial disabilities in commissions and socio-health agreements;
6. Include violence against women with psychosocial disabilities in all resources for gender violence;
7. Create in the resources for gender-based violence that are appropriate an expert service on violence that provides clinical support to professional teams;
8. Include in the detection and assessment tools of the different situations that the social services attend –dependence, lack of protection, risk of exclusion- violence within the couple, differentiating it from violence originating from other family members. Also record the existence or suspicion of mental disorder;
9. Include associations in the field of mental health in the work on violence prevention and detection carried out with the associative movement.

# Boys and girls

## Structural violence against children

Observation 22 of the United Nations Committee on the Rights of the Child (2018) 44 has highlighted the right of girls and boys not to be subjected to any form of violence32.

32 ONU, Observaciones finales sobre los informes periódicos quinto y sexto combinados de España, Comité de los Derechos del Niño, CRC/C/ESP/CO/5-6, 5 de marzo de 2018.



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In contexts of violence, girls and boys can be seriously compromised with their mental health, which conditions their well-being. According to a January 2017 report by the United Nations High Commissioner for Human Rights, enjoying the highest possible level of physical and mental health is an essential human right for the exercise of other human rights, defining the latter, in the case of children and adolescents, as the ability to achieve and maintain optimal psychological function and well-being33. However, the psychological sufferings and ailments of boys and girls have traditionally been minimized to the point of becoming myths such as that of their "spontaneous" natural resistance and recovery, that of "do not remember" and "do not understand", or the that diagnosis of trauma and post-traumatic stress disorder (PTSD) is difficult at these ages34.

**16**

However, it is not only intentionally inflicted violence that has devastating consequences on the mental health of children and adolescents. There is also structural violence that prevents them from achieving and maintaining optimal psychological function and well-being. As Alice Miller expresses, "*unintentional cruelty also hurts*" and "*contrary to popular belief, the injustices, humiliations, ill- treatment and violence of those who have been victims of a human being, are not lost, but bring consequences*"35. Therefore, intentional or not, violence must be addressed in a comprehensive, transversal and interdisciplinary way in all its forms, with special emphasis on those who suffer higher rates of invisibility and, consequently, impunity. Among these invisibility factors are the childhood and adolescence-mental health binomial.

It is also important to highlight the need to incorporate the concept of diversity with a practical intention. In other words, establish provisions that define and delimit it as a guiding principle and an approach of established obligation together with that of gender. The objective is to design and implement policies, programs and measures to eradicate violence in all contexts where it proliferates, and to contribute to a broad and positive vision of mental health as an essential condition for girls, boys and adolescents to enjoy well-being.

## Institutional dimension of violence

The ANAR Foundation in its study 'Evolution of violence to childhood and adolescence in Spain according to victims (2009-2016)' highlights that there are violence that are always present (physical abuse, psychological abuse, abandonment, sexual abuse and extra-family attacks), all of them on a regrettable upward path. However, over the years there has been an alarming increase in other forms of violence, such as gender-based violence, bullying, children being thrown out of the home, and conduct disorders that, with the emergence of ICT(Information and Communications Technology). They have joined emerging problems such as 'sextorsion', grooming, cyberbullying and other forms of cyberbullying that affect and distort traditionally practiced violence. In addition, “*a growth in violence has been observed, with new, more sophisticated and aberrant violence appearing, such as: suicidal ideas and self-harm, group rapes, upward violence against parents and teachers, gender-based violence in the that the same parents or sentimental partners are the murderers of children and adolescents, or the sexual assault of adults on minors that ends with the murder of their victims*.36” At the base of all this, it is important to envision a favorable breeding ground that favors the systematic expansion of the different forms of violence, and this base is constituted by the institutions. It must be borne in mind that myths, prejudices and stereotypes are reproduced by these institutions, norms and policies, and have a high impact on individual behavior. Therefore, it is essential to place this

33 UN, General Assembly. “Mental health and human rights”, A/HRC/34/32 (31 de enero, 2017): <http://undocs.org/A/HRC/34/32> 34 Atenciano, B. “Impacto de la violencia de género en los primeros años: Niñas y niños de 0 a 5 años”, Programa MIRA. 2015: [http://www.comunidad.madrid/sites/default/files/doc/justicia/exposicion\_0\_a\_5\_dgm\_2015.pdf](https://consaludmental.org/publicaciones/Medidasterapeuticas-mayo2013.pdf)

35 MILLER, A. “Por tu propio bien. Raíces de la violencia en la educación del niño”, ed. Tusquets, Barcelona, 2006, p.239.

36 FUNDACIÓN ANAR. “Evolución de la violencia a la infancia y adolescencia en España según las víctimas (2009-2016)”,

p.26. Recuperado de [https://www.anar.org/wp-content/uploads/2018/06/Estudio\_Evoluci%C3%B3n-de-la-Violencia-a-la-](https://consaludmental.org/centro-documentacion/mujeres-discapacidad-violencia-sexual-8750) [Infancia-enEspa%C3%B1a-seg%C3%BAn-las-V%C3%ADctimas.pdf](http://www.agetec.org/ageteca/genero.htm)



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institutional dimension of violence in a very prominent place, due to the serious effects it has on the life and mental health of a group as invisible as that of girls, boys and adolescents.

Nor should we forget the nature of that violence as a generator of mental health problems. The main institutions for this purpose would be the following:

1. **Health centers and institutions**

For example, it is estimated that in Spain the prevalence of mental health problems in the child and adolescent population is between 10% and 20%, and more than 70% of all mental disorders begin before the age of 1837. However, despite this reality, it is more difficult to access psychology services than any other health specialty, which puts the mental health of young people at risk38.

**17**

1. **Judicial Institutions**

The gaps and barriers of access to justice for girls and boys who suffer violence constitute an additional form of violence that can be called secondary.

1. **Educational institutions**

As previously indicated, in Spain more than 70% of all mental disorders begin before the age of 18. For this reason, it is important to work on prevention as soon as possible, so that the youngest have guidelines and tools that allow them to recognize the appearance of the first signs of these disorders early, and also to learn not to stigmatize people for this reason. According to the UNICEF report 'An Everyday Lesson: #ENDviolence in Schools', all forms of violence at school have significant long-term consequences in the lives of girls, boys and adolescents and in the communities in which they live, affecting to your learning and well-being. The consequences of violence can be imprinted on their bodies and minds through physical injury, sexually transmitted diseases, anxiety, depression, suicidal thoughts, and unwanted pregnancies39.

Specifically, regarding bullying, this report argues that schools are places where friendship and peer relationships are cultivated, laying the bases for adult socialization. Bullying, precisely, undermines those bases and leads victims to loneliness and marginalization. Girls, boys and adolescents with disabilities or belonging to ethnic groups or minority groups are more likely to suffer violence. However, in many schools the violence persists because the lack of resources prevents the training of teachers and the development of curricula that address it. To this must be added the barrier to understand and respond appropriately to this scourge that involves the lack of data on its size and impact both individually and collectively and the lack of protective legislation. Furthermore, the important role of the media in the consolidation and perpetuation of different forms of violence cannot be ignored, while at the same time constituting an important tool to combat them. It is also important to note that this document reveals that although the risk of bullying affects both boys and girls, girls are more susceptible to psychological violence, while boys are more likely to face physical violence and threats.

37 SALUD MENTAL ESPAÑA. “#Descubre concienciará a jóvenes de toda España sobre el riesgo de adicción a las nuevas tecnologías y redes sociales”, 24 de enero de 2018: [https://consaludmental.org/sala-prensa/descubre-concienciara-](https://www.diagonalperiodico.net/cuerpo/24807-transtorno-limite-personalidad-y-violencia-genero.html) [jovenesadiccion-redes-sociales-35517/](https://federacionvi.org/la-institucionalizacion-aumenta-el-riesgo-de-explotacion-violencia-y-abuso/)

38 DIARIO DE NAVARRA, “3.600 adolescentes y niños, en tratamiento por enfermedades mentales”, 24 de enero de 2017: [http://www.diariodenavarra.es/noticias/navarra/2016/01/25/3600\_adolescentes\_ninos\_tratamiento\_por\_enfermedades\_mentale](http://www.inmujer.gob.es/areasTematicas/salud/publicaciones/Seriesdebartedocumentos/docs/Saludmentalygenero.pdf) [s \_391513\_300.html](https://amsm.es/2018/02/12/deconstruyendomandatos-de-genero-en-narrativas-terapeuticas-boletin-no-42-de-la-amsm/) Asimismo, SALUD MENTAL ESPAÑA. Informe sobre el Estado de los Derechos Humanos de las Personas con Trastornos Mentales en España 2015, pp.16-19: [https://www.consaludmental.org/publicaciones/Informe-DDHH-](https://www.consaludmental.org/publicaciones/Informe-DDHH-salud-mental-2015.pdf) [salud-mental-2015.pdf](http://www.comunidad.madrid/sites/default/files/doc/justicia/exposicion_0_a_5_dgm_2015.pdf)

39 Este punto se ha tomado como referencia SAVE THE CHILDREN, “Infancia y Justicia: Una cuestión de derechos. Los niños y las niñas ante la Administración de Justicia en España”, noviembre/2012: [http://www.cje.org/descargas/cje3143.pdf](https://consaludmental.org/sala-prensa/descubre-concienciara-jovenesadiccion-redes-sociales-35517/) Asimismo, UNICEF. “An Everyday Lesson: #ENDviolence in Schools, New York, September 2018, p.17, 21.



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According to various studies and a survey carried out in the United Kingdom, its effects on the mental health of victims are devastating. Experts reaffirm this idea when noting the increased risk of presenting long-term pathologies such as schizophrenia, psychotic disorders or depression, as well as a propensity for suicide, as a consequence of bullying by classmates40. In addition, girls, boys and adolescents who have a mental health problem are also prone to being the victims of mistreatment by their peers. It should also be borne in mind that, for example, in Spain suicide has become the leading cause of death among young people, with an increase in mental health problems41.

Since the problem of mental health in childhood and adolescence manifests itself in different areas of the person's environment (family, health, school or social), the variety of services and resources that serve children and adolescents or the diversity of contexts in which they participate can become promoters of positive mental health and detectors of problems that can be diagnosed and treated42.

**18**

Bullying is nothing other than the fruit of secondary violence exercised by the social on its members. As Ferrer González expresses: “*It is a kind of acting-out that shows the unsustainability of the current social situation. For the same reason, a solution to the problem of bullying must involve a process of encounter in which new ways of subjectivation appear to refute the insignificance to which the peer is reduced in said phenomenon. For this, it is essential to give freedom to the creative tools that those involved already own or know, since only they can definitively object to the places and circumstances that maintain the violence. It will be the creativity of a community, course, school, etc. empowered to promote the process of change that disarticulates inappropriate relationship guidelines, when it finds a significant node in its own resources, on which to reorder. Thus, the psychological task should take a more facilitating than directive stance: applying measures against this problem, as if it were prescriptions, would perpetuate the secondary violence already exerted and would incite a denial of the capacities to create that the individual has and the society that contains it. On the other hand, opening listening spaces to the own solutions and demands of an individual and its culture, would generate the necessary circumstances for new forms of meaning to appear. Therefore, about bullying, we can say that children would have the ability to solve their problems of aggression. They will only require a space to do it and psychology has the opportunity to provide it case by case*.43” In addition to the victimization that this type of violence generates, it is essential to also take into account the processes that make the victim adopt this role and address eventual disorders that have not been adequately treated.

## Gender identity, violence and mental health

As the Office of the United Nations High Commissioner indicates in its document 'Sexual Orientation and Gender Identity in International Human Rights Law', gender identity is the internal and individual experience of gender as each person experiences it deeply. This identity may or may not correspond to the sex assigned at the time of birth, including the personal experience of the body (which could involve the modification of the appearance or bodily function through medical, surgical or other techniques, provided that this is freely chosen) and other gender expressions, such as dress, manner of speaking, and manners. All persons, regardless of their sex, sexual orientation or gender identity, have the right to enjoy the protections provided by international human rights instruments. Now, since LGTBI people are a group vulnerable to discrimination and violence, especially if the conditions of being a minor, a woman or having a mental health problem are met, attention must be reinforced to prevent violations of your human rights. In 2011, Resolution 17/19 (A / HRC / RES / 17/19) of the

40 CADENA SER (20 de julio). El acoso escolar aumenta el riesgo de padecer trastornos mentales de adulto. Recuperado de: [http://cadenaser.com/ser/2016/07/20/sociedad/1469013479\_730248.html](https://www.elimparcial.es/noticia/179144/sociedad/como-afecta-la-violencia-de-genero-a-los-ninos-que-la-presencian.html)

41 EL MUNDO.es (29de julio). “El suicidio es la primera causa de muerte entre los jóvenes españoles”. Recuperado de: [http://www.elmundo.es/papel/lideres/2016/07/27/5797861746163f583d8b4583.html](https://www.consaludmental.org/publicaciones/Informe-DDHH-salud-mental-2015.pdf)

42 COSCOLLA AISA, R., MARTÍNEZ DOMINGO, S., y POLL BORRÀS, M., Atenció a la salut mental infantil i adolescent a Catalunya, comisión de revisión: Mònica Carrilero Ciprés, Wilan Kao Ventura, FUNDACIÓ PERE TARRÉS, FEDERACIÓ SALUT MENTAL CATALUNYA, 31de mayo de 2016.

43 FERRER GONZÁLEZ, P.A. “Psique: Bullying: ¿violencia primaria o secundaria?”, Boletín Científico Sapiens Research, Vol. 2(2)-2012, pp.22-23.

matter. Said report, called "Discriminatory laws and practices and acts of violence committed against people for their sexual orientation and gender identity," was prepared by the Office of the High Commissioner for Human Rights. It highlighted that the prevention of violence and discrimination based on sexual orientation and gender identity is an obligation of the States that comes from various international human rights instruments44.

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A study on mental health in the LGTBI community carried out in 2015, has corroborated previous research that revealed the existence of greater risk factors with respect to the general population due to a variety of factors that have to do substantially with lack of awareness and the repeated violation of their rights. The social and cultural environments play a fundamental role in discrimination and abuse in various contexts, constituting risk factors for the development of mental health problems. In fact, previous research suggests that risk appears to be greatly increased by exposure to external (i.e., social) factors, while resilience may stem from a combination of a supportive environment, self- acceptance, and attachment to the LGBTI community. This study reveals that there is strong evidence that associates suicide rates with negative experiences in various contexts, mostly materialized in struggles against homophobic or transphobic realities, generally experienced in the family network, schools (bullying) and the circle of peers. The feeling of misunderstanding about the way they were treated has led many people in this group to feel isolated and suffer from low self-esteem. To cope with these adverse scenarios, many people opted for harmful health behaviors such as drinking, truancy, smoking, self-harm, eating disorders, not talking to anyone, crying and trying to fit into the normative gender, pretending to be what they were not. The study warns of the lack of training of medical or health personnel when dealing with the autolytic attempts of people in this group and their specific needs. It is common to find inappropriate comments or inappropriate behaviors that do not favor the person's recovery and overcoming the trauma. Now this is just the tip of the mental health iceberg for the LGBTI community. As the Risk and Resilience Explored (RaRE) report indicates, full training and awareness of the lesbian, gay, bisexual and transgender community is essential for healthcare professionals45.

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## Sexual abuse

According to Save the Children, sexual abuse is a manipulation of children and adolescents, their feelings, weaknesses or needs, based on an unequal power. It is understood as “*the participation of children or adolescents, dependent and immature, in sexual activities that they are not in a position to understand, that are inappropriate for their age and psychosexual development, for which they are unable to give their consent and that they violate taboos and family and social rules.46*”

In addition to physical injuries, it is important to highlight the importance of psychological injuries that abuse generates in the victim in the short and long term. According to teachers Cantón-Cortés and Cortés, in the short term there is a shortage of research on the psychological consequences of sexual abuse in the preschool stage. Even so, somatic problems (enuresis, encopresis, headaches and

44 ONU, “Orientación sexual e identidad de género en el Derecho Internacional de los Derechos Humanos”, Oficina del Alto Comisionado de las Naciones Unidas, América del Sur, Oficina Regional: [http://acnudh.org/wpcontent/uploads/2013/11/orentaci%C3%B3n-sexual-e-identidad-de-g%C3%A9nero2.pdf](https://amsm.es/2013/03/28/colaboraciones-sigue-siendo-necesario-incluir-la-perspectiva-de-genero-ensalud-mental-y-en-derechos-humanos-a-proposito-de-las-consideraciones-despectivas-sobre-la-llamada-ideologia-de-gene/)

ONU, “Leyes y prácticas discriminatorias y actos de violencia cometidos contra personas por su orientación sexual e identidad de género”, Informe del Alto Comisionado de las Naciones Unidas para los Derechos Humanos, A/HRC/19/41, 17 de noviembre de 2011, p.5.

45 NODIN, N., PEEL, E., TYLER, A., and RIVERS, I. “The RaRE Research Report: LGB&T Mental Health – Risk and Resilience Explored”, ed. PACE, London, 2015, pp.33, 66, 67 y 68: [http://www.queerfutures.co.uk/wpcontent/uploads/2015/04/RARE\_Research\_Report\_PACE\_2015.pdf](https://documents-dds-ny.un.org/doc/UNDOC/GEN/N08/440/75/PDF/N0844075.pdf) Asimismo, vid. VICE, “La salud mental LGBT: ¿Estamos haciendo lo suficiente?”, La Guía VICE de la Salud Mental, 29 de abril de 2015: <https://www.vice.com/es/article/nngnzm/la-salud-mental-lgbt-estamos-haciendo-lo-suficiente-877>

46 SAVE THE CHILDREN. “Abuso sexual. Niños desprotegidos por las Administraciones Públicas”, 23 de enero de 2018: [https://www.savethechildren.es/actualidad/abuso-sexual](http://www.comunidad.madrid/sites/default/files/doc/justicia/exposicion_0_a_5_dgm_2015.pdf)

and post-traumatic stress disorder and sexualized behavior are noted, among other effects. There are more data on school-age children and adolescents, being able to detect coincident symptoms in previous ages, along with new symptoms such as externalizing problems (for example, aggression and behavioral problems), dissociative disorders, problems in relations with peers, poor school performance and dysregulations in cortisol levels and other psychobiological disorders. Furthermore, adolescents are more likely to engage in criminal activities, suffer from eating disorders, physical health problems, use drugs, carry out more suicidal and self-injurious behaviors and early and risky sexual behaviors47.

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The researchers point out that, in the long term, especially if they are not treated, the symptoms can worsen and in some victims of childhood sexual abuse (ASI), what are known as sleeper effects are manifested. With this term they refer to the situation in which the child does not show significant problems immediately after the abuse, but over time, begins to manifest emotional or behavioral problems, even extending these effects during adulthood. "Adult victims of child sexual abuse are more likely to suffer emotional disorders such as depression, anxiety, low self-esteem or problems in sexual relationships" (Berliner and Elliot, 2002; Guerricaechevarría and Eheburúa, 2005). (…) Victims of sexual abuse are up to 5 times more likely than the rest of the population to be diagnosed with at least one anxiety disorder such as generalized anxiety disorder, phobias, panic disorder or obsessive compulsive disorder (Berliner and Elliott , 2002). Another common symptom among adults who were victims of ASI is low self-esteem. (...) In general, researchers have also found that women with a history of ASI are more likely than women without a history of engaging in unhealthy or poorly adaptive sexual practices (eg, avoidance of sex or sexual practices). risky). Furthermore, they have sex less frequently and experience more sexual problems and dysfunction (Randolph and Reddy, 2006). ASI can also affect their perception of themselves in relationships with others. Common interpersonal problems of victims include difficulties in initiating, maintaining, and developing interpersonal relationships, as well as difficulties in trusting others (Cortés and Cantón, 2008).

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Research has also found a relationship between a history of ASI and the development of dissociative and personality disorders, especially borderline personality disorder. But also other personality disorders such as antisocial, dependent, avoidant, and schizoid (eg, Katerndahl, Burge, and Kellogg, 2005). Numerous studies have also shown that Post Traumatic Stress Disorder (PET) is one of the most frequent long-term consequences of childhood sexual abuse, and that it often appears alongside other emotional problems (eg, Cantón-Cortés and Cantón, 2010; Sarasua, Zubizarreta, Corral and Echeburúa, 2013). (…) Studies have also found a relationship between ASI and drug and alcohol abuse during adulthood (Wilson and Widom, 2009) and criminal behavior, including property crimes, aggressive behavior and violence, as well as a more likely to abuse other children than the rest of the population (…). Another consequence that has been related to ASI has been the increased risk of re- victimization, understanding as such the subsequent sexual or physical abuse of the victim as an adult. (…) Finally, a causal relationship has been found between ASI and the appearance of serious physical health problems such as somatic disorders, chronic pain and gastrointestinal and eating disorders (Bonomi, Cannon, Anderson, Rivara and Thompson, 2008)48”

## Invisibility of the impact of gender violence on the mental health of girls, boys and adolescents

In our country, a serious problem of invisibility of the psychological effects of gender violence persists, which, in turn, also affects very seriously the minor sons and daughters of the affected women, despite the fact that Organic Law 1/2004, of December 28, Comprehensive Protection Measures against Gender Violence also recognizes them as victims of said violence. According to the WHO,

47 CANTÓN –CORTÉS, D., y CORTÉS, M.R. “Consecuencias del abuso sexual infantil: una revisión de las variables intervinientes”, Anales de Psicología, vol. 31, núm. 2, Universidad de Murcia, Murcia, mayo, 2015, pp. 552-554.

48 *Ibid.*

and to this must be added the serious impediments faced by women with psychosocial disabilities when accessing reception resources, which also affects the minors in their care49.

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In fact, exposure to gender-based violence, in addition to increasing the statistics of murders of girls and boys by their parents, compromises early mental health, by becoming involuntary witnesses. Various studies have revealed psychological disturbances in minors exposed to gender violence, noting chronic stress that, in addition, can trigger or accelerate any other mental problem (anxiety, depression, withdrawal, somatic problems, social problems, attention problems, disruptive behavior, aggressive behavior, etc.)50.

**21**

In addition, children reproduce patterns, both to mistreat and to be mistreated. According to the 'Report on Violence of the Reina Sofía Center, 2010', four out of ten abusers have been mistreated as children, and children who witness - or even suffer first-hand from male violence can also accept this way of behaving as normal51.

* 1. **Recommendations**

1. **Regarding preventive measures52**

* Invest in mental health in children and adolescents as a way of investing in the general well-being of people and of society as a whole, following the recommendations of the Pere Tarrés Foundation and the Mental Health Federation of Catalonia:
* Develop specific training plans for professionals working in the field of leisure time for children and adolescents, in order to recognize and understand the signs of mental health problems emerging; orient minors towards seeking help; and guarantee that these spaces are inclusive.
* Guarantee the existence of social support services for housing, training and pre-employment and labor insertion for adolescents.
* Generate leisure and free time services, as well as meeting and community participation spaces, that promote solidarity bonds and guarantee contexts for identifying the specific demands and needs of adolescents.
* Review the current model of care for children and adolescents with mental health problems linked to the social protection system, in order to guarantee care more tailored to their needs.
* Develop monitoring and individualized accompaniment programs for families with children and adolescents with mental health problems, who have associated serious social risk factors, promoting the figure of professionals in social work and social education.
* Promote policies to address social risk factors that have a clear impact on the mental health of families, such as, for example, the lack of reconciliation with family life, unemployment situations or the quality or instability of housing, among other.
* Guarantee the right of children with mental health problems to be cared for. A clear commitment from the National Health System (SNS) is lacking when it comes to providing resources and specifically trained professionals, sufficient and adequate for the care of this sector of the population from a multidisciplinary approach, including early care.

49 FEDEAFES. Guía “Investigación sobre la violencia contra las mujeres con enfermedad mental”, Llodio (Álava), 2017

50 EL IMPARCIAL. “¿Cómo afecta la violencia de género a los niños que la presencian?”, 1 de julio de 2017. Recuperado de [https://www.elimparcial.es/noticia/179144/sociedad/como-afecta-la-violencia-de-genero-a-los-ninos-que-la-presencian.html](http://www.queerfutures.co.uk/wpcontent/uploads/2015/04/RARE_Research_Report_PACE_2015.pdf)

51 *Ibid.*

52 CYRULNIK, B. “Los patitos feos. La resiliencia: una infancia infeliz no determina la vida”, ed. Gedisa, Col. Psicología, Barcelona, 2002, pp.46 y 215. Asociacíón Española de Neuropsiquiatría (AEN). “Informe sobre la salud mental de niños y adolescentes”, Cuadernos Técnicos 14, Madrid, 2009, p.71.

childhood through emotional ties and, when the time is right, through the expression of emotions. For this, it is necessary to build a social environment predisposed to contribute to the development of the boy or girl, which allows her to build links with the world around him or her. In this way, girls and boys who have suffered abuse and violence in all its forms, will have tools at the biopsychic level to repair the damage and develop from integration in their biography in a positive way.

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* Prepare training plans for pediatricians to detect the problem of Fetal Alcohol Syndrome (SAF), mental health teams, pedagogical advisory teams and teachers, as well as providing support resources to affected families.

**22**

* Creation of a specialized unit with comprehensive intervention teams to facilitate the child's psychic deployment and the relationship with their adoptive family. It is about going beyond diagnostic labels and medicalization to see what children and adolescents say with their symptoms.
* Develop coordinated actions by the Public Administrations to raise awareness, prevent, assist and protect against any form of child abuse, with special consideration to the mental health factor as a key element to guarantee its success.
* Incorporate the principle of equality in public policies in the field of mental health and in the practice of the personnel that serve this group.
* Develop systems that allow violence data to be shared between different institutions.
* Advance towards a model of individualized and comprehensive care, which adapts the responses to the needs of each girl, boy or adolescent, viewed from an intersectional approach.
* Promote specific training measures in mental health and violence for health, education, legal, social services and media personnel in order to eradicate stigma, discrimination and violence.
* Promote basic, translational and applied research in mental health, violence and the development of girls, boys and adolescents.
* Put in place specific information systems for mental disorders in children and adolescents, and therapeutic and healthcare resources with homogeneous indicators throughout the national territory.
* Favor good parenting habits from the beginning of pregnancy and early childhood, favoring protection factors and reducing risk factors.

1. **Regarding health and social care53**

* Guarantee the right of children to receive care from professionals specifically trained in child and youth mental health, while guaranteeing the training of primary care physicians so that they can adequately carry out detection and referral to the specialized service. Investment in mental health in childhood and adolescence affects the general well-being of people and of society as a whole.
* Develop a specific and specialized network of quality mental health for care from 0 to 18 years, ensuring accessibility and equity throughout the State. This network must follow the model of community care and have family and professional associations in the planning, development, control and management of healthcare resources.

53 *Ibid.*

coordinated with other disciplines in serious pathologies and high-risk situations at different stages of development.

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* Develop monitoring and individualized accompaniment programs for families with children and adolescents with mental health problems, who have associated serious social risk factors such as being or having been found in a context of violence.
* Develop the portfolio of services in the National Health System in the specific aspects of mental health care for girls, boys and adolescents who have lived or are living in contexts of violence.

**23**

* Agree on diagnostic criteria in mental health and clinical practice guidelines in order to reduce unjustified clinical variability and improve the quality of care.

1. **Regarding regulation and judicial actions**

* Promote a legal and judicial culture that favors the implementation of the various provisions, such as, for example, the protection order provided for in article 544 ter of the Spanish Criminal Procedure Law on the protection order "for victims of domestic violence" which includes, in addition to the woman, the minors in their care.
* Establish adapted mechanisms for the access of children to the courts for the exercise of their rights, including the human and material means to duly serve them in the judicial sphere, taking into account their mental health.
* Physically adapt the spaces in the courts where the interviews must take place and where the boys and girls must wait, as well as having the technical and audiovisual material that allows them to participate in the proceedings without having to see their aggressor or have to give a statement in a room full of unknown adults.
* Establish mechanisms to improve the guarantee of the right of children to be duly listened to during judicial and administrative proceedings, taking into account their mental health.
* Establish a team of support professionals specialized in mental health. In addition to preparing for direct care, it is essential that the psychological assessments of boys and girls have the expert intervention of psychology professionals in coordination with other areas of technical knowledge (social work, medicine, education), on whose assessment the decision made by the judicial body will depend to a great extent. The relevance of this intervention requires a greater specialization, regulation and definition of the competences, rights and obligations of professionals in the performance of their functions54.
* Regulate the right to information and legal assistance for children and adolescents during the processes, training professionals who attend them to learn to listen to them with special regard to their mental health55.
* Establish supervision and reporting mechanisms for the actions of legal operators, whose effectiveness is periodically evaluated56.
* Establish and regulate coordination between the departments of health, social services, education and justice.

54 SAVE THE CHILDREN, “Infancia y Justicia: Una cuestión de derechos. Los niños y las niñas ante la Administración de Justicia en España”, noviembre/2012: <http://www.cje.org/descargas/cje3143.pdf>

55 Ibid.

56 Ibid.

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1. **Regarding education and bullying**

* Approve and implement policies and regulations that protect minors from violence in classrooms, in addition to reinforcing prevention and response measures in schools.
* Creation of awareness campaigns and appropriate mechanisms for societies and individuals at the individual level to support students in reporting violence, working to change culture within classrooms and in societies and communities.

**24**

* Gather better information, disaggregated on violence against children at school and in the school environment, and share this data among all the actors involved.
* Promote policies for the prevention and promotion of coexistence in the school environment, with special emphasis on its consequences on the mental health of children and adolescents.

1. **Regarding sexual abuse**

* Promote continuous evaluation and good practice experiences of case detection mechanisms in order to improve the institutional response.
* Continuously review institutional protocols on this matter.
* Promote the continuous training of the professionals involved in order to guarantee better detection and prevention.
* Raise awareness in society to create a common conscience that mobilizes forceful action in favor of the rights of girls and boys victims of sexual abuse.

1. **Regarding gender violence**

* Provide training in violence and specialized resources to professionals who provide direct care to women with psychosocial disabilities, especially when they have minors in their care.
* Modify the regulations of the shelters so that no victim with a disability can be rejected for this reason, as is currently the case. Specifically, it is about eliminating the barriers that prevent access to resources for women victims of gender violence, when the condition of having a mental health problem occurs, especially when they have dependent sons and daughters.
* Appoint reference psychiatrists who preferentially attend each of the shelter resources for women victims of violence, including professionals specialized in child and juvenile psychiatry to attend to the minors who may be in their care.
* Design and implement measures to address the psychological effects of gender violence, establishing interdisciplinary teams that work in coordination.
* Carry out inter-institutional coordination and referral protocols, both at the regional and local levels, which include the mental health network and associations of people with psychosocial disabilities.
* Include violence against women with psychosocial disability in commissions and socio-sanitary agreements, incorporating the situation of their dependent daughters and sons.

provides clinical support to professional teams.

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* Include in the detection and assessment tools of the different situations that the social services (dependence, lack of protection, risk of exclusion) attend to violence in the couple, differentiating it from violence from other family members. Also record the existence or suspicion of mental disorder.
* Include associations in the field of mental health in the work on violence prevention and detection carried out with the associative movement.
* Promote the participation of men in programs related to care, as well as create groups of men who work, from the perspective of new masculinities, in the assumption of the values proper to the ethics of care.

**25**

1. **Regarding gender identity, violence and mental health**

Following the recommendations incorporated in the RaRE report cited in the body of this document:

* Train and educate health professionals to guarantee adequate attention to mental health and other health care needs of people with diverse sexual orientation or gender identity, with special consideration to the specialized professionals who will serve the child-youth population.
* Establish mechanisms for general and mental health services to be proactive, both physically and virtually, in assuring their users and users of sexual minorities that it is safe to reveal their sexual orientation or gender identity without risk of receiving an inappropriate treatment by staff members. Again, specific mechanisms must be provided to serve the child-youth population.
* Implement awareness and training measures on sexual diversity in all schools, for both staff and students, thus creating inclusive educational environments that do not tolerate homophobic, biphobic or transphobic discrimination or intimidation of any kind.
* Provide confidence and self-esteem support to LGBTI girls and boys at risk, in order to develop key skills to face adverse circumstances and prevent the development of mental health problems as they grow up.
* Promote inclusive environments through awareness campaigns that give visibility to sexual minorities.
* Promote family support as a key factor in the recovery of many mental health problems that affect LGBTI people, providing information, training and resources.

1. **Regarding control of the effectiveness of the Law**

* Develop a strategy that allows the effective application of the law, in which specific objectives are determined, the corresponding actions to achieve them, the indicators that allow the corresponding evaluations and mechanisms to monitor the performance of the different Administrations involved.

1. **Stigmatized identities**

Lesbian, gay, bisexual, transgender and intersex people (LGBTI) suffer multiple rights violations stemming from discriminatory attitudes, laws and practices. This vulnerability directly impacts the

the highest attainable standard of physical and mental health, in a report published in 2010, revealed that the impact on health of discrimination based on behavior and sexual orientation it is huge and prevents those affected from accessing other economic, social and cultural rights; as well as the full range of civil and political rights.57

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Added to this is the problem of stereotypes created around the sexuality of people with disabilities, based on negative stereotypes or directly ignored, coming to perceive the person as an asexual being. At the base of all this is a patriarchal system that promotes delimited and exclusive male and female roles; as well as a rehabilitating medical model of disability, which associates this circumstance with illness or physical, mental, intellectual or sensory limitation of the person conceived as a patient who needs to be rehabilitated, healed or, in short, “normalized” in order to be integrated into the society.

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The UN Convention on the Rights of Persons with Disabilities incorporates a social model of human rights that puts the focus of attention on the inability of society to include diversity. It is this incapacity that raises barriers and produces violations of rights that can range from a lack of respect for home and family (article 23) to protection against exploitation, violence and abuse (article 16) and personal integrity. (article 17) and health (article 25). Without prejudice to the importance of other related aspects, in this report we have paid attention to issues related to health, because according to a report published in 2014 in the Journal of General Internal Medicine58, sexual orientation can condition the level of health, not for being gay, lesbian, bisexual, transsexual or intersex, but for reasons purely related to the social context. In fact, discriminatory policies and practices and the lack of training of health professionals in sexual orientation, including the prejudice that all patients are heterosexual, profoundly affect people's physical and mental health. The study carried out in England reveals that these people are twice as likely to have had a negative experience with their GP and between two and three times more likely to have suffered psychological or emotional problems, and therefore concludes that it is essential to recognize the needs and improve the experiences of this group in their access to health care. This confirms previous studies carried out in the United States in which it was concluded that belonging to a sexual minority increases the risk of depression and anxiety59.

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