

Submission to Expert Meeting of the Special Rapporteur on Torture  
Torture in Health Care Settings  
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## **What Next?**

### **Recommendations for the Special Rapporteur on Torture to Promote the Abolition of Forced Psychiatric Interventions and Comprehensive Reparation**

The 2008 report of former Special Rapporteur on Torture Manfred Nowak made significant strides in the development of norms for the abolition of forced psychiatry interventions as a form of torture and ill-treatment.<sup>1</sup> Since that time, the Committee on the Rights of Persons with Disabilities and other treaty bodies have issued their own jurisprudence calling for abolition of forced psychiatric interventions.<sup>2</sup> This expert meeting on torture in healthcare settings offers a welcome opportunity to reflect on normative standards and to consider how best to promote and enforce states' obligations to change their laws, policy and practices to prevent forced psychiatric interventions, which are a form of inhuman and degrading treatment and torture.

There are four areas in which the Special Rapporteur on Torture could take steps beyond Mr Nowak's report of 2008.

#### **I. Eliminate Impunity and Take Positive Measures for Social Accessibility**

The first step in prevention is to eliminate impunity, and the first step in eliminating impunity is repeal or derogation of laws that permit, authorize and require state officials or others to commit the prohibited acts of torture and ill-treatment, in this case the laws that authorize forced psychiatric interventions and psychiatric detention (civil commitment or involuntary admission to psychiatric facilities). Beyond this first and crucial step of repealing laws that authorize violations, states need to promote a positive outlook welcoming persons with psychosocial disabilities as contributing members of communities (as per CRPD Article 8), to create services and supports that meet the expressed needs of persons with psychosocial disabilities (as per CRPD Article 19, see also CRPD Committee Concluding Observations on Article 25), and to create community peace-building programs incorporating a disability perspective and a gender perspective, to address conflicts and needs that families and communities met in the past by institutionalization or other means that violated the human rights of persons with psychosocial disabilities (as per CRPD Articles 13 and 14, also drawing on principles from restorative justice and critiques of restorative justice and proposals by the user/survivor movement).

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<sup>1</sup> A/63/175, paras 38, 40, 41, 44, 47, 61-65, 72-74.

<sup>2</sup> See Submission by European Network of Users and Survivors of Psychiatry, International Disability Alliance, Mental Disability Advocacy Center and the World Network of Users and Survivors of Psychiatry to the UN Special Rapporteur on Torture on his upcoming thematic paper on torture in the context of healthcare ("Joint ENUSP/IDA/MDAC/WNUSP Submission"), Annex II.

The Special Rapporteur should therefore:

1. Call for a complete ban on forced psychiatric interventions and for derogation of the laws that permit forced psychiatric interventions (including deprivation of liberty, restraint, solitary confinement, and administration of treatments such as electroshock, psychosurgery and mind-altering drugs such as neuroleptics).
2. Call for thorough revision of laws, policies, customs and practices to eliminate discrimination against persons with psychosocial disabilities, and for positive measures such as:
  - a. awareness-raising activities to foster respect for capabilities and rights of persons with psychosocial disabilities, in collaboration with their self-representative organizations;
  - b. a shift in resources to services that meet needs expressed by persons with psychosocial disabilities, and that respect individuals' autonomy, choices, dignity and privacy, including peer support and other alternatives to the medical model of mental health; and
  - c. community peacebuilding programs incorporating a disability perspective and a gender perspective so as to resolve conflicts without resort to either coercive mental health interventions or law enforcement interventions amounting to disability-based scapegoating or profiling.

## II. Take Measures to Make the Mandate Itself More Accessible

A second avenue for development of the work of the Special Rapporteur on Torture in relation to forced psychiatric interventions is to reflect on how to make the mandate more accessible and responsive to these widespread and systemic human rights violations. Persons with psychosocial disabilities and their self-representative organizations for the most part lack the resources and skilled personnel that could submit cases effectively for urgent appeals; furthermore the confidential process of the mandate can frustrate individuals who submit information and receive no response, especially when there is no indication of the factors weighed by the mandate in considering whether to take action. Human rights NGOs that are not user/survivor organizations still lack the requisite expertise in the subject matter particularly with regard to appreciating the severity of the harms and the requirement of abolition rather than safeguards on forced interventions. A further obstacle to effective monitoring is the systemic nature of these human rights violations, which warrant systemic rather than individual examination and redress for effective prevention. It would be helpful to improve communication and collaboration between the Special Rapporteur and organizations of users and survivors of survivors at the global, regional and national levels, and to take proactive measures aimed at promoting the abolition of forced psychiatric interventions and the establishment of community-based supports and services including peer support and other alternatives to the medical model of mental health.

1. The Mandate should seek clarification and revision of its constraints with regard to confidentiality, in particular so as to be able to communicate with individuals about actions taken on their own cases or about the reasons for no action being taken.
2. The Mandate should develop and publicize criteria for assessing information submitted, so that individuals and organizations can be better equipped to make appropriate submissions.
3. The Mandate should conduct public awareness-raising activities in conjunction with self-representative DPOs to address the need for systemic changes in law and policy to end forced psychiatric interventions and to recognize them appropriately as inhuman and degrading treatment and as torture.

### III. Utilize the Framework of Remedy and Reparations to Promote Comprehensive Justice

Finally, the General Comment recently issued by the Committee against Torture on the right to a remedy and reparation for acts of torture and ill-treatment can offer valuable guidance regarding proactive measures required to prevent forced psychiatric interventions. Significantly, the Committee considers that the duty to provide remedy and reparation extends to all acts of ill-treatment, so that it is immaterial for this purpose whether forced psychiatric interventions meet the criteria for torture *per se*.<sup>3</sup> As acts violating the physical and mental integrity of persons with disabilities, that are furthermore prohibited by international law under the CRPD, forced psychiatric interventions cannot be excluded from the category of torture and ill-treatment and as such give rise to the right to remedy and reparation.

This framework opens new possibilities for holistic social processes that could foster appreciation of the lived experiences of persons with psychosocial disabilities, including as measures of satisfaction and guarantees of non-repetition, the repeal or derogation of legal provisions that authorize forced psychiatric interventions and psychiatric detention. The reparation framework could also help to create both the social space and the social supports and services to bring the “recovery” perspective of the user/survivor movement into the wider communities we live in. “Recovery” as understood by many of us includes recovery from the destructive effects of forced psychiatric interventions, making free and informed decisions about mental health services including medications, and rejection of the life of a “mental patient” defined by one’s relationship to services.<sup>4</sup> Considering the forms of reparation available to individuals, such as compensation, rehabilitation and restitution, can help us to formulate innovative social policies and practices that can meet the needs of those who have been harmed by the current system, which include needs the system was unable to meet due to medical model limitations and needs created by its

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<sup>3</sup> CAT/C/GC/3 para 1.

<sup>4</sup> Shery Mead, David Hilton and Laurie Curtis, “Peer Support: A Theoretical Perspective” available at [http://www.peerzone.info/sites/default/files/resource\\_materials/Peer%20Support%20A%20Theoretical%20Perspective%20Mead.pdf](http://www.peerzone.info/sites/default/files/resource_materials/Peer%20Support%20A%20Theoretical%20Perspective%20Mead.pdf).

harmful practices, and that can also set a course for future directions in social policy, practices and supports including the role to be played by mental health services.

The Special Rapporteur on Torture can invoke the right to a remedy and reparation, including the varied forms of reparation, to call on states to immediately take action to stop forced psychiatric interventions, to assist victimized individuals and to comprehensively and holistically address the needs of all who are affected, making sure to not re-victimize persons with psychosocial disabilities and to ensure that all measures comply with the requirements and principles of the CRPD. In addition, the Special Rapporteur could lend his support to reparations initiatives by users and survivors of psychiatry, such as the petition for Truth and Reconciliation in Psychiatry, which seeks UN involvement as well as that of national governments in negotiating an apology and reparations.<sup>5</sup>

#### IV. Normative Updating

The Special Rapporteur should consider the following modest recommendations for re-affirmation and extension of the standards adopted by Mr Nowak during his term as Special Rapporteur on Torture. The suggestions made here are primarily based on jurisprudence of the Committee on the Rights of Persons with Disabilities adopted since Mr Nowak's report in 2008.

1. Re-affirm that intrusive and irreversible treatments aimed at correcting a disability, including electroshock, psychosurgery and mind-altering drugs such as neuroleptics, when enforced or administered without the free and informed consent of the person concerned, as well as the use of detention, solitary confinement and restraint in mental health settings, are forms of torture and ill-treatment committed against persons with disabilities.<sup>6</sup>
  - a. Clarify that such interventions always amount at least to inhuman and degrading treatment, that they arguably meet the criteria for torture, and that they are always prohibited.<sup>7</sup>
    - i. It would be welcome for the Special Rapporteur to affirm that forced psychiatric interventions meet the criteria for torture due to their discriminatory character as well as their interference with the consciousness, personality and will of an individual.<sup>8</sup>

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<sup>5</sup> [http://www.ipetitions.com/petition/truth\\_and\\_reconciliation\\_in\\_psychiatry/](http://www.ipetitions.com/petition/truth_and_reconciliation_in_psychiatry/).

<sup>6</sup> Nowak 2008 Report A/63/175 (SRT 2008), paras 38, 40, 41, 47.

<sup>7</sup> Minkowitz Expert Submission to this meeting; WNUSP/ENUSP/IDA/MDAC Joint Submission; WNUSP/ENUSP/IDA/EDF Third Party Intervention in *Milhailovs v. Latvia* (in European Court of Human Rights); Minkowitz, *The UN CRPD and the Right to be Free from Nonconsensual Psychiatric Interventions*, *Syr J of Intl L & Commerce* 34:2 (2007); Minkowitz, *IDC Advocacy Note on Forced Interventions as Torture* (2005).

<sup>8</sup> *Id.*

2. Re-affirm that there is no therapeutic justification for restraint or solitary confinement.<sup>9</sup>
  - a. Clarify that this applies to both long- and short-term application, and that these measures are always prohibited in healthcare settings and amount to inhuman or degrading treatment or torture.<sup>10</sup>
3. Re-affirm that discrimination based on disability satisfies both the intent and purpose requirements for torture under CAT Article 1, notwithstanding that such discrimination may be masked by “good intentions” of medical professionals.<sup>11</sup>
4. Re-affirm that governments must recognize the legal capacity of persons with disabilities and provide support for the exercise of legal capacity.<sup>12</sup>
  - a. Clarify that substituted decision-making is prohibited and that all measures of support must respect the person’s autonomy, will and preferences.<sup>13</sup>
5. Re-affirm that the CRPD provides authoritative guidance complementing other instruments on the prohibition of torture and ill-treatment, and that the CRPD prohibits involuntary treatment and involuntary confinement contrary to earlier non-binding declarations such as the MI Principles.<sup>14</sup>
6. Affirm that provision of mental health services must always be based on the free and informed consent of the person concerned, and that any legal provisions to the contrary, such as provisions allowing detention or compulsory treatment in mental health settings, must be repealed.<sup>15</sup>
7. Affirm that governments must institute community-based services that respect the autonomy, choices, privacy and dignity of individuals and that meet needs expressed by persons with disabilities, including peer support and other alternatives to the medical model of mental health.<sup>16</sup>
8. Affirm that children have the right to be free from coercive psychiatric interventions and from treatments that risk interfering with the development of the child’s mind and brain.<sup>17</sup>

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<sup>9</sup> SRT 2008 paras 55, 56.

<sup>10</sup> Joint Submission.

<sup>11</sup> SRT 2008 para 49.

<sup>12</sup> SRT 2008 paras 44, 50 and 73.

<sup>13</sup> CRPD Committee Concluding Observations on Spain (CRPD/C/ESP/CO/1), Peru (CRPD/C/PER/CO/1), Hungary (CRPD/C/HUN/CO/1) and China (CRPD/C/CHN/CO/1) under Article 12.

<sup>14</sup> SRT 2008 para 44.

<sup>15</sup> CRPD Committee Concluding Observations on Spain, Hungary and China, under Articles 14 and 25.

<sup>16</sup> CRPD Committee Concluding Observations on China under Articles 19 and 25.

<sup>17</sup> SRT 2008 para 59; CRC Concluding Observations on Costa Rica (CRC/C/CRI/CO/4), Australia (CRC/C/AUS/CO/4), Belgium (CRC/C/BEL/CO/3-4), Norway (CRC/C/NOR/CO/4) and Spain (CRC/C/ESP/CO/3-4).

9. Affirm that persons with psychosocial disabilities have the right to personally exercise free and informed consent with respect to all health and mental health services, and the right to not be segregated based on their disability, and that these rights apply to health and mental health services provided within prisons.<sup>18</sup>
10. Affirm that the obligation to end forced psychiatric interventions is of immediate application and that scarce financial resources cannot justify postponement of its implementation.<sup>19</sup>
11. Affirm that the right to a remedy and reparation applies to individuals and groups victimized by forced psychiatric interventions, and that governments must undertake holistic and comprehensive measures of reparation, including satisfaction and guarantees of non-repetition as well as restitution, compensation and rehabilitation. This entails the immediate cessation of forced interventions in public and private institutions, provision of assistance to individuals leaving institutions to re-build their lives and to access desired services while avoiding unwanted ones, and implementation of awareness-raising programs and practical assistance for communities including training led by persons with psychosocial disabilities so as to break with discrimination and move towards creation of inclusive social practices and customs, along with other appropriate measures to be devised by governments in collaboration with persons with psychosocial disabilities and their self-representative organizations.

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<sup>18</sup> CRPD Articles 14.2 and 19; ENUSP/IDA/MDAC/WNUSP Joint Submission; WNUSP Discussion Paper on Prison and Mental Health Systems and submissions to the review of the Standard Minimum Rules on the Treatment of Prisoners, available at [www.chrusp.org/home/resources](http://www.chrusp.org/home/resources).

<sup>19</sup> CRPD Article 4.2; civil and political rights are not subject to progressive realization.