

**Third-party intervention in Communication No. 36/2016 under CRPD  
Optional Protocol (Daniels v Australia)**

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## **Third-party Intervention in Communication No. 36/2016 under CRPD Optional Protocol (Daniels v Australia)**

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### **1. Information about third-party intervener**

The Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP) is a human rights organization run by and for persons with psychosocial disabilities/users and survivors of psychiatry. CHRUSP provides strategic leadership in working for legal capacity for all, an end to forced interventions and deprivation of liberty in the context of mental health services, and the availability of support that respects the person's autonomy, will and preferences. For more information, please see [www.chrusp.org](http://www.chrusp.org).

Tina Minkowitz, CHRUSP president and author of the third-party intervention, is a lawyer and survivor of psychiatry who worked on the drafting and negotiation of the CRPD on behalf of the World Network of Users and Survivors of Psychiatry, and coordinated the work of civil society in the drafting and negotiations of Articles 12, 14, and 15, among others. She has contributed to the work of the CRPD Committee and to other human rights mechanisms including the Special Rapporteur on Torture, the Working Group on Arbitrary Detention, the Special Rapporteur on the Rights of Persons with Disabilities, the Special Rapporteur on the Right to Health, the Special Rapporteur on Violence Against Women, the Office of the High Commissioner for Human Rights, the Organization of American States, and UNESCAP.

### **2. Exhaustion of remedies**

In addressing exhaustion of domestic remedies in relation to involuntary commitment and forced or coerced treatment in mental health services, we urge the Committee to take account of:

- 1) the unequivocal prohibition of these practices under Articles 12, 14, and 15, and their seriousness as violations against personal security and integrity;

- 2) the conflict between states' obligations under CRPD to abolish and prohibit these practices, and provisions in domestic legislation that directly authorize and regulate them. These provisions manifest a discriminatory intent and policy to target persons with psychosocial disabilities for acts of arbitrary detention, torture and other ill-treatment;
- 3) the harm caused by the existence of these provisions, and by the failure to unequivocally abolish and prohibit the practices of commitment and forced/coerced treatment, which creates a state of permanent insecurity for persons with psychosocial disabilities, and marks such individuals for social degradation and discrimination in all aspects of life;<sup>1</sup>
- 4) the potential existence of circumstances that pose obstacles to individuals vigorously pursuing remedies to enforce their rights under domestic legislation regulating mental health commitment and forced treatment, such as the strong incentive to cooperate with unwanted treatment in the hope of minimizing the extent of forced intervention, the risk of retaliation, and the individual's diminished cognitive abilities and isolation from potential support and other resources as a result of being subjected to a regime of commitment and forced treatment;
- 5) the inability of domestic proceedings that determine on a case-by-case basis the lawfulness of mental health detention and forced treatment within the framework of regulatory legislation to serve as an effective remedy in the long run, since these proceedings leave the individual at risk of repeated violations and marked for social degradation;<sup>2</sup>
- 6) the high barriers to accessing the potential remedy of judicial nullification of legislation authorizing commitment and forced treatment through domestic courts. While theoretically available, such remedies do not offer a reasonable likelihood of success to the individual who remains in a state of extreme vulnerability and is being actively subjected to harm.<sup>3</sup>

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<sup>1</sup> See as analogous situations in other areas of law, *Dudgeon v UK*, ECtHR No. 7525/76, Judgment (1981), paras 14, 29-31, 34-35, 40-41, 63; and *Brown v Board of Education*, 347 U.S. 483 (1954) (U.S. Supreme Court) (holding that segregation by race even if "tangible" factors were equal violates individual rights, reasoning that "to separate them from others of similar age and qualifications solely because of their race generates a feeling of inferiority as to their status in the community that may affect their hearts and minds in a way unlikely ever to be undone.")

<sup>2</sup> See further below sections 3a and 4.

<sup>3</sup> CEDAW has addressed comparable situations in which victims were placed in situations of extreme vulnerability by the state's acts or omissions in *LC v Peru*, CEDAW/C/50/D/22/2009, paras 8.1-8.5 (withholding of abortion from woman for whom it was medically necessary and who was suffering serious distress from the pregnancy that drove her to attempt suicide), and *Goekce v Austria*, CEDAW/C/39/D/5/2005 paras 7.1-7.6 (failure of police to respond adequately to domestic violence). The victims' vulnerable circumstances and the serious

### **3. Applicable standards**

We urge the Committee to consistently apply the standard established under CRPD Articles 12, 14 and 15, as explained by the Committee's jurisprudence, to find that each instance of deprivation of liberty in any mental health facility<sup>4</sup> and each instance of forced treatment<sup>5</sup> in mental health services violates the rights of the individual concerned, irrespective of any case-specific circumstances.

#### **a. Deprivation of liberty**

Deprivation of liberty in a mental health facility is both arbitrary, as it is a regime of detention applied only against individuals who are alleged to have a mental health condition, and unlawful, as it is contrary to international law obligations in force for the state, whether or not it meets the standards established by domestic law.<sup>6</sup> The Committee should examine the domestic regulatory framework in order to ascertain whether and in what ways that framework permits involuntary commitment and/or involuntary treatment in mental health services, and if so must find that its application to any individual violates the Convention. The existence and outcome of proceedings under a domestic regulatory framework to challenge the lawfulness of mental health commitment or forced treatment is of no consequence to finding a violation of Article 14. It should be noted that access to justice, as protected by Article 13, with respect to human rights guaranteed by the CRPD, cannot be satisfied by domestic procedures that subject the individual to demeaning standards and inquiries contrary to the CRPD.<sup>7</sup>

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and irreparable nature of the harm facing them were factors in the Committee's finding that exhaustion of lengthy procedures unlikely to offer effective relief was not required.

<sup>4</sup> I use the term "mental health facility" to include any place under the control of mental health service personnel where a person is deprived of liberty, including mental health clinics, psychiatric wards in general hospitals, stand-alone psychiatric institutions, mental health units in jails and prisons, and any similar place.

<sup>5</sup> I use the term "forced treatment" as equivalent and shorthand for treatment that is enforced against the person's will and/or is administered without the free and informed consent of the person concerned. Consent obtained under threat of force, in coercive circumstances, or based on deception, must be considered forced.

<sup>6</sup> CRPD Guidelines on Article 14 paras 6-8, 10, 13-15; see also Working Group on Arbitrary Detention Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court (WGAD Guidelines), A/HRC/30/37, paras 10(e) (on arbitrary detention as encompassing discrimination based on disability) and 12 (on unlawful detention as encompassing violations of international law).

<sup>7</sup> To illustrate, a mental health review proceeding that requires the individual to debate his or her mental health condition, predictions of harm to self and others, the advisability of mental health treatment, etc., is demeaning and

If domestic commitment and forced treatment laws were not applied to the complainant, the Committee should consider whether factual circumstances existed from which the individual would reasonably consider him or herself to be deprived of liberty and/or under compulsion to undergo unwanted treatment.

As the Committee has pointed out, the prediction that a person will endanger self or others cannot legitimize discriminatory detention.<sup>8</sup> Non-discrimination in law enforcement and criminal proceedings is complementary to the prohibition of impairment-based detention, and provides balance as a second pillar of Article 14. Endangerment of self similarly cannot justify measures that discriminate in law or in fact; legal capacity includes the right to take risks on an equal basis with others.

Article 14 makes no exceptions for duration of the detention.<sup>9</sup> Since the regime of involuntary commitment to mental health facilities is linked to the aim of providing care and treatment, it is an impermissible violation of the right to legal capacity under Article 12, which includes the right to make decisions about whether, where, how, and under what circumstances to receive health care and services, including mental health services. Detaining a person for any period of time in the context of health care and services, whether for observation, care or treatment, violates the autonomy rights guaranteed by Article 12 and the integrity rights guaranteed by Articles 15, 16, and 17. As there is no legitimate basis for forced treatment under the CRPD, there is no legitimate reason to detain an individual for any evaluative process that would form the basis for continued detention or forced treatment.

Similarly, Article 14 requires that a person have the legal right to refuse to enter a mental health facility and to leave at will, and that exercise of this right not be impeded or interfered with in any way. Providing services in a locked ward is inconsistent with the right to liberty and the right to exercise free and informed consent. It is similarly inconsistent with these rights to threaten or carry out any legal process to detain an individual who wishes to leave, even in an open ward. Both the right and the opportunity to exercise it must be guaranteed and readily enforceable.

#### **b. Forced treatment amounts to torture/other ill-treatment**

Acts of forced treatment violate the right to legal capacity in Article 12, the right to security of the person in Article 14, the prohibition of torture and other ill-treatment in Article 15, as well as the right to be free from all forms of violence, exploitation and abuse in Article 16 and the right to respect for physical and

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discriminatory, and is entirely unnecessary and counterproductive to fulfill the unequivocal right under Article 14 to not be deprived of liberty or forcibly treated in mental health services.

<sup>8</sup> Guidelines on Article 14, paras 13-15.

<sup>9</sup> Id., see also para 22.

mental integrity in Article 17.<sup>10</sup> The Committee should first examine the domestic legal framework as indicated in the first paragraph of section 3a above, and find a violation if the individual concerned has been subjected to forced treatment under those laws, or if circumstances existed from which she or he would reasonably consider her or himself under compulsion to undergo unwanted treatment.<sup>11</sup> The Committee should further address the harm caused by forced treatment so as to provide guidance to the state party regarding the nature of its obligations under Article 15 to eliminate and effectively prevent this practice.<sup>12</sup>

As the Committee has explained numerous times, consent must be by the person concerned and cannot be substituted.<sup>13</sup> Persons with actual or perceived mental health conditions retain at all times, including in crisis situations, the right to exercise free and informed consent in their own behalf and to refuse any unwanted services or mental health interventions.<sup>14</sup>

Consent must be both free and informed. Coercive circumstances in mental health services and facilities, especially when the person is involuntarily committed or threatened with involuntary commitment or with the use of physical force, often pressure individuals into giving nominal consent to the administration of psychiatric drugs or electroshock when they do not wish to receive it. Such consent cannot be said to be free. Consent should also be scrutinized for whether it is adequately informed about all known risks and adverse effects, the actual likelihood of any benefit, and the existence of alternatives, including the alternative of going through an experience of distress on one's own or with willing supporters.

The harm done by forced psychiatric interventions can be understood in relation to three kinds of discrimination that make this practice a disability-specific form of violence enacted against persons with psychosocial disabilities:

- Deliberate use of methods of punishment, intimidation, and coercion that are recognized as torture when done to non-disabled persons,<sup>15</sup> such as neuroleptic drugs and electroshock;<sup>16</sup>

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<sup>10</sup> GC1 para 42; Guidelines on Article 14, paras 11-12.

<sup>11</sup> Deprivation of liberty in a mental health facility is one such coercive circumstance that creates an incentive to comply with treatment in an attempt to minimize the extent of forced interventions by appearing to cooperate.

<sup>12</sup> Guidelines on Article 14 para 12.

<sup>13</sup> GC1 paras 40-41.

<sup>14</sup> GC1 paras 15, 18, and 42; Guidelines on Article 14 para 22.

<sup>15</sup> See Convention against Torture Article 1, and Special Rapporteur on Torture, E/CN.4/1986/15 para 119, and A/63/175 paras 37-41, 45, 62-63.

<sup>16</sup> Evidence of the use of drugs and electroshock for purposes of punishment, intimidation, and coercion may be found in statements contained in official records, but can also be inferred from circumstances. Use of drugs as chemical restraint and use of electroshock with the aim of controlling behavior are examples of this.

- Deliberate administration of these same methods as a purported therapeutic treatment without securing the free and informed consent of the person concerned, manifesting callous disregard for the personal autonomy and integrity of persons with psychosocial disabilities;<sup>17</sup>
- Failure to appreciate and respect the right of persons with psychosocial disabilities to be different than others and to enjoy and defend their personalities and minds as part of human diversity and humanity.<sup>18</sup>

Forced treatment always violates a person's physical and mental integrity, which includes bodily autonomy and the right to exclude unwanted touch and unwanted substances from one's person. Harm is caused by this violation of personal boundaries and the experience of having unwanted bodily sensations and alterations created by others' interventions, an experience of intimate subjection and control by others. The right to preserve and defend one's bodily autonomy is preserved by the requirement of free and informed consent for all health care and treatment, including psychiatric interventions. Harm is also caused by the specific nature of the intervention, e.g. the signature adverse effects of neuroleptic drugs such as akathisia, tardive dyskinesia, metabolic disturbances, neuroleptic dysphoria, and cognitive impairment,<sup>19</sup> and those of electroshock including cognitive impairment and loss of short- and long-term memory.<sup>20</sup> Such harm includes both immediate suffering and damage that persists long afterwards and may be permanent.<sup>21</sup> All these aspects of harm, and collateral effects on the person's life project, relationships, and sense of self,

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<sup>17</sup> See CAT Article 1 and Special Rapporteur on Torture, A/63/175, paras 44, 47-50, 57-65.

<sup>18</sup> See Minkowitz, *The UN CRPD and the Right to be Free from Non-consensual Psychiatric Interventions*, 34 *Syracuse J Intl L & Commerce* 405 (2007).

<sup>19</sup> See Gøtzsche, *Forced admission and forced treatment in psychiatry causes more harm than good*, <http://www.deadlymedicines.dk/wp-content/uploads/2016/03/Abolishing-forced-treatment-in-psychiatry-short-version.pdf>; Whitaker, *Medical Science Argues Against Forced Treatment Too*, <https://absoluteprohibition.wordpress.com/2016/03/26/robert-whitaker-medical-science-argues-against-forced-treatment-too/>; sources cited in Minkowitz (2007); and CHRUSP et al., *Joint Submission to Human Rights Committee for its review of the United States in October 2013 on nonconsensual psychiatric medication*, part II, <http://www.chrusp.org/file/294433/CHRUSPUSICCPRshadowreportFINAL.docx>.

<sup>20</sup> See Read and Bentall, *The Effectiveness of Electroconvulsive Therapy: A Literature Review*, *Epidemiologia e Psichiatria Sociale*, 19, 4, 2010, <https://www.power2u.org/downloads/1012-ReadBentallECT.pdf>.

<sup>21</sup> See Minkowitz, *Forced interventions and forced institutionalization as torture/CIDT*, Annex III to Final Report of the OHCHR expert seminar on freedom from torture and persons with disabilities, <http://www2.ohchr.org/english/issues/disability/docs/torture/AnnexIII.ppt>.

should be taken into consideration when assessing the severity of the violation and the reparations required.

#### **4. Remedies for violations**

We urge the Committee to recommend both systemic and individual measures to correct the violations found under Articles 12, 14 and 15, and to consider applying the framework of the right to a remedy and reparation for serious human rights violations, as set out in the UN Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law.<sup>22</sup>

First and foremost, the state must immediately direct the cessation of violations against that individual, including by release from the place of deprivation of liberty, an end to forced interventions including restraints and confinement as well as forced treatment, and notification that henceforth all desired services will be made available based on the person's free and informed consent, and no detention, treatment, or other interventions will be imposed against the person's will.

In order to protect the right of all individuals with psychosocial disabilities to enjoy liberty and security of the person without any discrimination, states must take urgent action to end the application of domestic laws that authorize and regulate commitment and forced treatment. This should be done in the way most calculated to achieve the immediate result of removing all legal and physical obstacles from individuals who wish to leave mental health facilities and/or to stop receiving any undesired treatment.<sup>23</sup> All branches of the state are responsible for respecting and ensuring the rights guaranteed by Articles 12, 14, and 15, including the judicial branch; however, administrative and legislative branches cannot wait for the judicial branch to act and must assume their own responsibilities. In particular, they cannot rely on case-by-case determinations of individual cases in procedures established under legislation regulating commitment and forced treatment. These measures cannot meet states' obligations under Article 14, and perpetuate an incorrect standard of review that

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<sup>22</sup> A/RES/60/147 (2006). See also Special Rapporteur on Torture, A/HRC/22/53, paras 81-84, WGAD Guidelines Annex paras 25-26 and 106(f), CRPD Guidelines on Article 14 para 24 quoting WGAD Guidelines. For detailed recommendations see Orefellen, Torture and other ill-treatment in psychiatry – urgent need for effective remedies, redress and guarantees of non-repetition, side event to CRPD Committee (30 March 2015), [https://dk-media.s3.amazonaws.com/AA/AG/chrusp-biz/downloads/294485/Side event CRPD Art15 March2015 Hege.pdf](https://dk-media.s3.amazonaws.com/AA/AG/chrusp-biz/downloads/294485/Side%20event%20CRPD%20Art15%20March2015%20Hege.pdf).

<sup>23</sup> WGAD Guidelines para 126 (e) (old numbering), quoted in Guidelines on Article 14 para 24, offers a partial example of systemic remedies that could be ordered by a court having the requisite mandate to apply the CRPD and grant systemic as well as individual relief.



allows the perpetuation of commitment and forced treatment rather than ordering cessation in all cases.<sup>24</sup>

Measures should be taken to comprehensively review the state's legal framework as it pertains to persons with psychosocial disabilities, including legal capacity, penal law, family law, health law, mental health law, disability law, and social services law, and undertake reforms to repeal provisions that are inconsistent with the CRPD and where applicable replace such provisions by new material based on the standards established in General Comment No. 1 and the Guidelines on Article 14. It should be recalled that forced treatment cannot be legitimized under legislation in any of these fields. In particular, it is essential to reform legal capacity and health law so that persons with disabilities are not subjected to forced treatment by substitute decision-makers. It is also necessary to ensure that penal law, family law and social services law do not contain incentives for compliance with unwanted mental health treatment. In addition, all laws that discriminate against persons based on actual or perceived mental health condition contribute to political, social, and economic vulnerability of persons with psychosocial disabilities and leaves them at the mercy of mental health services as the only resource available to them to meet unrelated needs such as housing, livelihood, and community.

Measures should be undertaken as well as to comprehensively review the state's policy and services framework relevant to persons with psychosocial disabilities. Disability law, services, and policy must be equally relevant to persons with psychosocial disabilities as to other persons with disabilities, transversally reflecting their lived reality, promoting and protecting their rights against violations that have uniquely or disproportionately targeted this group, and responding to their expressed needs. Measures such as apology should be taken only as part of a transparent and accountable process of truth and reconciliation that acknowledges the violation of the human rights in each instance of mental health commitment and forced treatment and is accompanied by an end to the violations and redress for all victimized individuals.

In all matters of development, design, implementation, and review of measures responding to violations of Articles 12, 14, and 15, persons with psychosocial disabilities who have lived experience of the violations must be closely consulted and given the opportunity to provide leadership, including the provision of reasonable accommodation and support desired by the individual and respectful of his or her autonomy, will and preferences.

## 5. Conclusion

We thank the Committee for considering the information presented and remain at the Committee's disposal to answer any questions.

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<sup>24</sup> See above, sections 2 and 3a.