



Center for the Human Rights of  
Users and Survivors of Psychiatry

## **Submission on Report under HRC Resolution No. 32, 30 August 2016**

1. CHRUSP welcomes the concern expressed in Resolution A/HRC/32/L.26 about persons being subjected to human rights violations including unlawful or arbitrary institutionalization, overmedicalization, and treatment practices that fail to respect their autonomy, will and preferences, which may amount to torture or other ill-treatment, and the recognition that mental health services should integrate a human rights perspective so as to avoid any harm to those using them. CHRUSP further welcomes the recognition that states must take active steps to fully integrate a human rights perspective into mental health services, and the request to OHCHR to produce this report, dealing with realization of the human rights of persons with psychosocial disabilities/mental health conditions as well as the integration of human rights perspective into services. However, there are significant respects in which the resolution leaves an opening for the legitimization of practices that violate the CRPD, which is the legally binding human rights standard in 165 countries and the European Union, and by virtue of this overwhelming participation and its status as a legally binding, thematically specialized treaty monitored and interpreted by a Committee of experts in the specialized subject matter, has a valid claim to the greatest weight in determining customary law that should be applied by all international and regional human rights mechanisms, including with respect to those countries that have yet to ratify.

*A. Identical standard under CRPD for all persons with psychosocial disabilities/ persons with actual or perceived mental health conditions; CRPD applies to all mental health services and to services of any kind provided to such persons*

2. The resolution refers to persons with psychosocial disabilities and/or mental health conditions. It is unclear what reading is intended, whether there is an attempt to draw a distinction between these two categories or whether the terminology is used in the alternative to refer to the same group of persons. The resolution does not refer to those who are perceived by others as having mental health conditions or psychosocial disabilities, nor does it acknowledge the existence of persons on whom mental health interventions are imposed against their will, who cannot be legitimately regarded as users of services. All these individuals in addition to those who self-identify as persons with psychosocial disabilities or mental health conditions are protected by the non-discrimination guarantees of the CRPD, as defined in Article 2 and prescribed

under Articles 4 and 5 generally and throughout the text wherever the language and concept of non-discrimination or equal basis with others is referenced. It is implicit in the concept of discrimination that it does not require subjective identification with a concept that many of those so labeled consider to be pejorative not only in terminology but in substance. The report should follow the CRPD Committee's lead in making sure that no substantive distinction is made between persons with actual or perceived mental health conditions and persons with actual or perceived psychosocial disabilities, and that all such individuals are guaranteed the same protection of their rights as specified by the CRPD under international law.

3. Some states parties and medical stakeholders have used such distinctions to remove from CRPD coverage the category of persons with mental health conditions, as distinct from those with psychosocial disabilities, arguing that psychosocial disability only means those experiencing serious long term impairment. Contrary to incorrect readings of the text, CRPD Article 1 does not define persons with disabilities nor does it limit coverage of any provisions to those with long-term impairments. There are both positive and negative provisions of the CRPD that must be applied when it is not known if an impairment is long-term, including those mandating formal equality. Non-discrimination provisions such as those at issue in Articles 12.2, 14, and 15, which prohibit adverse treatment on the basis of disability or impairment, necessarily apply when an individual is perceived as having a disability or impairment as well as when she or he subjectively experiences disability or impairment. The CRPD Committee has correctly applied the text in this manner, as evidenced by its use of the phrase "actual or perceived impairment" (with variations) routinely in Concluding Observations and in General Comment No. 1 and the Guidelines on Article 14. The CRPD Committee has consistently applied Articles 12, 14 and 15 to require states parties to eliminate all forced and coercive practices in mental health services, and to ensure that all mental health services are based on the free and informed consent of the person concerned. This is the standard that must apply throughout mental health services, inpatient and outpatient, public and private, and irrespective of the nature or duration of a person's actual or perceived mental health condition.
4. We support the recognition of the need for states parties to fully integrate a human rights perspective into all community services. This obligation similarly requires states parties to refrain from violent, coercive, and discriminatory practices in social and community services in interactions with, and provision of services to, persons with actual or perceived psychosocial disabilities or mental health conditions. Sites of concern include social services, vocational training and placement, and health care, as well as interactions with law enforcement.

*B. All involuntary institutionalization and treatment is unlawful and arbitrary under CRPD*

5. The resolution refers to unlawful or arbitrary institutionalization as a human rights violation, but does not mention the salient factor distinguishing the CRPD standard from earlier paradigms, consent by the person concerned. Under CRPD all involuntary institutionalization is arbitrary and unlawful, whereas earlier standards legitimized the practice of involuntary institutionalization subject to statutory criteria and procedural safeguards. CRPD wipes all that away, the compliance or noncompliance with domestic statutes and procedures is irrelevant to characterizing each instance of involuntary institutionalization as a human rights violation.
6. Furthermore, both long- and short-term deprivations of liberty in mental health services, whether intended as a residential placement or as a temporary measure to remove the person from his or her usual surroundings, are contrary to CRPD. Sometimes the term institutionalization is used to refer primarily to long-term residential placements; this is the subject of CRPD Article 19, which not only prohibits such involuntary placements but also prohibits the maintenance of a system of institutional placement even on a voluntary basis. In addition to Article 19 however, Article 14 on liberty and security of the person prohibits all involuntary institutionalization, hospitalization, commitment, or detention in the context of mental health services, however it may be referred to in domestic legislation, policy, or practice. All such deprivations of liberty are based on actual or perceived impairment as the threshold criterion, the sine qua non without which no other criteria could be applied; for this reason such deprivations of liberty are per se discriminatory and violate Article 14, whether the domestic basis is found in a mental health law, health law, incapacity law, family law, penal law, or any other area. The CRPD Committee has drawn particular attention to the fact that additional criteria or grounds such as alleged danger to the person or to others and alleged need for care and treatment cannot legitimize such detention (Guidelines on Article 14, section VII). Nor can alleged incapacity be invoked to justify deprivation of liberty in mental health services (GC1 paras 13-15, 40). Misguided reforms that do away with a stand-alone mental health law only to authorize deprivation of liberty in mental health services based on alleged incapacity to make a treatment decision do not comply with either Article 12 or Article 14.
7. It should be recalled, as recently emphasized by the Working Group on Arbitrary Detention, that detention is unlawful if it is contrary to international law, not only if it fails to comply with domestic provisions. The Working Group's Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court (A/HRC/30/37, Principle 20 and Guideline 20) follow CRPD in requiring courts to apply the prohibition of deprivation of liberty based on an actual or

perceived impairment, in particular an actual or perceived psychosocial disability, and taking measures to ensure that all health and support services, including all mental health-care services, are based on the free and informed consent of the person concerned. The WGAD's approach retains aspects of the old paradigm in emphasizing the role of courts adjudicating particular cases, and does not address the scope and extent of the meaning of deprivation of liberty based on disability, as the CRPD does in its Guidelines on Article 14. Nevertheless, the WGAD illustrates one avenue for states to move from the old paradigm to the new, by judicial enforcement of the CRPD absolute prohibition of mental health involuntary commitment and involuntary treatment, ordering release and cessation of the violative practice in an individual case and also using the judicial power to order systemic measures to end the practice and provide reparative measures to those who have been harmed. The CRPD Committee echoed these same recommendations in its Guidelines on Article 14, paragraph 24.

8. This submission emphasizes involuntary commitment in response to the language of the resolution, which raised doubts as to the standard being applied. As discussed further below, CRPD Articles 12, 14, 15, and 25 also prohibit involuntary treatment in both inpatient and outpatient mental health services, including community treatment orders.

*C. Medicalization or over-medicalization? How much medicalization is too much?*

9. The resolution mentions over-medicalization, but does not acknowledge the sharp critiques from both persons with disabilities and medical researchers that call into question any degree of medicalization of the experiences characterized as mental health conditions, nor does it mention the equally sharp critiques of the treatments offered by both medical professionals and non-medical mental health professionals (e.g. Peter Gøtzsche, Peter Breggin, David Cohen, Joanna Moncrieff, Robert Whitaker, Grace Jackson; for a sampling of critiques from multiple perspectives see <http://absoluteprohibition.wordpress.com>). It is clear to all concerned that there are phenomena in human experience of profound distress and disturbing thoughts, feelings and perceptions, and that these experiences can be so far out of the ordinary that the person is unable to continue life as usual for short or long periods of time. No one is denying that these experiences exist, or that society is obligated to offer support to people who are seeking relief, comfort, practical help, and ways to cope and navigate through the anguish and disturbance. The report should acknowledge the extent and scope of these critiques, and that they call into question not just "overmedicalization" or the exclusive reliance on a biomedical model, but the place of any reliance at all on biomedical diagnosis and treatment. Alternatives exist despite their marginalization in worldwide mental health services, and despite the hegemony exercised by mental health services themselves as the overarching framework in which to provide support to

individuals suffering from such experiences of distress and disturbance. Many of the alternatives exist somewhere on the spectrum from complete rejection of medicalization and professionalization to the biomedical model of mental illness diagnosis and treatment; alternatives as such need to be prioritized. The harms caused by psychiatric treatments like psychosurgery, electroshock, and neuroleptic and other drugs need to be considered as possible grounds for exercising regulatory power to ban them altogether as unsafe and without sufficient benefit to justify their use even on a noncoercive basis.

10. The report should start the important work of conceiving ways to fully integrate a human rights perspective not only *into* mental health and community services, but as a basis for alternative support mechanisms (that may differ substantially from traditional mental health and community services), which may be offered to individuals at all stages of experiences characterized as mental health conditions. Realizing the human rights of people with actual and perceived psychosocial disabilities/mental health conditions requires recognition of the limitations of the mental health paradigm and the diverse ways in which individuals understand their experiences. Alternative support mechanisms that individuals may choose to engage in order to live with, and through, their experiences should be bolstered, and people with disabilities or impairments should be consulted in order to develop new alternatives.
11. In addition to ordinary services and supports, alternatives must be implemented to deal with crises and emergent needs. Such alternatives must respect the person's continuous legal capacity and right to not be arbitrarily deprived of liberty or security of the person, which are violated by the practice of using detention and forced treatment as a response either to conflicts involving persons with alleged psychosocial disabilities or mental health conditions, or to meet pressing and intense needs for emotional support. We have framed CRPD-compliant alternatives as "support to seek support" (with respect for individual autonomy, will and preference) and as the need for skilled first responders to address complex situations that may include conflict between individuals as well as potential support needs. At the present time, only medical-model mental health crisis teams and emergency medical personnel are presented as the alternative to law enforcement, so that the options presented are mental health institutionalization and treatment or criminal arrest. In the US individuals resisting involuntary commitment have been killed by police who approach their resistance as analogous to resisting arrest. First responders need to be trained in the CRPD standards prohibiting involuntary commitment and involuntary treatment, in de-escalation of crisis, and in viewing the world from the perspective of the person with psychosocial disability. Services and supports beyond the medical model capable of addressing support needs in crisis situations need be made available to all concerned, without coercion and with sensitivity to the needs of those who

have been traumatized by mental health services and/or who are uninterested in mental health services.

*D. What must be done to eliminate treatment practices that fail to respect the individual's autonomy, will and preferences?*

12. The resolution does not address the question of coercive psychiatric interventions as an issue of harm and violation that goes beyond the purview of clinical practice. There is thus the risk that recommendations will be made to clinicians and to state authorities responsible for public mental health services, to eliminate or merely to reduce such practices, while leaving untouched the domestic laws that legalize and fail to prohibit them. Furthermore, framing the issue as one of clinical practice fails to account for systemic coercion throughout the mental health system as it is constituted under such laws: informed consent cannot truly exist for anyone so long as mental health service providers have the tool of coercion at hand. As the CRPD Committee acknowledged in General Comment No. 1, the fact that survivors repeatedly describe coercive interventions as violence needs to become part of the narrative acknowledged by mental health services: so long as service providers and mental health authorities fail to address the aggressive, destructive, invasive, and highly traumatizing nature of coerced psychiatric interventions, attempts at reform will be merely window dressing to cover practices that amount to torture and other ill-treatment, by preserving intact the legal and social power devolved to the mental health system and to psychiatrists in particular, to impose their will on those whom they designate as their patients in the name of the victims' best interest.
13. This characterization of psychiatry as a system characterized by torture and ill-treatment does not demonize anyone, nor would it be unfair to point to psychiatrists in particular as aiming to preserve their powers under that system. We have encountered such protests repeatedly, including a letter to the Lancet Psychiatry by seven psychiatric authors including Benedetto Saraceno, formerly head of the mental health unit within WHO, and a letter from the World Psychiatric Association and the American Psychiatric Association to the Special Rapporteur on Torture, which led to that mechanism's stepping back from CRPD-compliant standards, to the detriment of people with disabilities and the human rights regime. UN human rights mechanisms should not hesitate to anger powerful interests and professions when necessary to uphold human rights of persons in vulnerable circumstances like those who are harmed by psychiatry. Upholding the CRPD standards implies both giving substantial weight to the views of persons with psychosocial disabilities as human rights defenders belonging to the impacted group, above the views of medical professionals whose interests conflict with the persons concerned, and prescribes such an approach as the substantive remedy for human rights violations at the level of implementation in national law and policy. It is therefore a true question of paradigm; choosing to uphold

CRPD requires rejection of psychiatric prerogatives and power to impose coercive treatment and deprivation of liberty, and there is no halfway measure between tolerating and prohibiting such coercion. OHCHR should steer a clear course for human rights, as charted by the CRPD Committee in General Comment No. 1 and the Guidelines on Article 14: there is no justification to use a person's actual or perceived (alleged) mental health condition to deprive them of the right to make decisions about treatment, services, or support; forced treatment violates not only Articles 12 and 14 but also Article 15, amounting to an act of torture or other ill-treatment. The highest obligation of under international law, the prohibition of torture and other ill-treatment, demands an immediate cessation to all interventions in mental health services that are forced or without the free and informed consent of the person concerned. This includes the system of involuntary commitment and forced treatment as a whole, as an institution or regime that segregates, harms, marginalizes, humiliates, and causes severe suffering to people with psychosocial disabilities everywhere it is practiced. *The report needs to make it clear that legal abolition and prohibition of this entire system and all its components is required in order to meaningfully incorporate a human rights perspective into mental health services.*

14. The issue of consent needs to be addressed in some further detail. CHRUSP uses the term forced treatment to mean not only treatment administered using additional physical force, but treatment under coercive circumstances and/or without the free and informed consent of the person concerned, parallel to the understanding of rape as being defined by coercive circumstances and/or absence of consent. The report should be sure to include all ways that forced treatment manifests or may be described. Furthermore, CRPD General Comment No. 1 (GC1) sets out relevant standards including the obligation to provide access to independent support for decision-making regarding mental health services, and the duty to respect a person's decision to refuse treatment. While we assume familiarity of OHCHR with the General Comment and will not explain it in depth here, two elements require careful consideration: the best interpretation of will and preferences when after significant efforts it is not practicable to determine the individual's will and preferences, and the role of advance directives.
15. The best interpretation standard is only to be used after significant efforts are made, and the implication is that it must be subject to a requirement of good faith and not devolve to a de facto best interest determination. Significant efforts include the use of all possible supports and accommodations as described in the General Comment, keeping in mind the duty to respect the person's decision once it has been expressed in any manner. Supporters independent from mental health services need to be involved to provide support, advocacy, and interpretation as needed for the person whose free and informed consent is being sought, with a clear mandate of accountability to that individual and not to any service provider or other authority.

16. Advance directives can be a useful way for individuals to plan and direct the treatment and services that will be provided to them, but raise questions about the relationship between previously expressed will and preferences, and will and preferences expressed at the time when the decision is carried out. For example, a person may request the administration of a low dose of haloperidol if her friend and chosen supporter perceives that she is experiencing extreme anguish and not talking, and that soothing and comforting do not bring her out of the state after being tried for a period of twenty-four hours, but then when a nurse approaches with the pill or injection she shakes her whole body to indicate no, and fights back when they attempt to persuade her. If the rights to legal capacity and personal integrity is to be upheld at all times including crisis situations (GC1 paragraph 18 and 42), the drug should not be administered by force based on her advance directive; instead, supporters, service providers and first responders are obligated to continue to provide as much support as the person needs, of a kind that is acceptable to the person, for as long as needed. Advance directives should be used and relied on as a default plan for services and supports, subject to the individual's exercise of legal capacity at any time including during a crisis to change his or her will and preferences.
17. Lastly, it should be specified that the history of mental health services and their contemporary practices warrant a high threshold for consent to administration of any psychiatric treatment. Factors of concern include the legal and social permission to violate individuals' autonomy and integrity, the effects of which are likely to persist even past legal prohibition; the weight of evidence of serious harm caused by the treatments even when non-coercive; the vulnerable position of people with psychosocial disabilities in law and society, which again is likely to persist even past legal reforms to remove all traces of legal incapacity and discrimination. Affirmatively expressed consent should be required, and there should be no case in which psychiatric treatment can be administered as a default lifesaving measure or read into an interpretation of will and preferences absent an advance directive.

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