



**Center for the Human Rights of
Users and Survivors of Psychiatry**

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Access to justice:

Countering impunity for acts of disability-specific acts of arbitrary detention and torture

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Most if not all countries retain some legal provisions that authorize involuntary internment and involuntary treatment in mental health services, contrary to the CRPD and to general principles of law on non-discrimination with respect to freedom from arbitrary detention and torture. The grant of affirmative legal power to psychiatrists and other actors to carry out acts of detention and violation of the person's physical and mental integrity results in impunity for those actors under domestic law that otherwise would be available as a remedy. For example, these actors cannot be held liable in tort for false imprisonment or battery, nor can they be held criminally liable for those violations.

Too often 'access to justice' in relation to involuntary internment and involuntary treatment has been equated with the 'procedural safeguards' approach in which these acts are regulated and subject to review by a court or administrative tribunal. This approach fails to uphold the right to be free from arbitrary detention and torture, and instead legitimizes those acts with regulatory approval. Reviews only infrequently result in release from detention and cessation of forced treatment, and the underlying power is used as a bargaining chip to coerce compliance and cooperation with unwanted medication, electroshock and hospitalization, or with agreement to unwanted living arrangements and outpatient services.

Notwithstanding these impediments, however, both statutory review procedures and the power of courts generally to review acts of detention and complaints of torture or other ill-treatment under the color of law (such as habeas corpus) can play a role in enforcing the absolute prohibition of involuntary internment and involuntary treatment under international law, by following the approach outlined

in the UN Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court.¹

Arbitrary detention and role of courts

Courts as a branch of the state have the obligation to uphold the prohibition of impairment-based detention and to ensure that mental health services are based on free and informed consent of the person concerned.² States should remove any constraints on the power of courts to apply international law on the question of unlawful and arbitrary detention, torture and ill-treatment, or to progressively develop domestic law in line with international standards.³

Arbitrary detention under general international law as well as CRPD includes detention that discriminates based on disability, and unlawful detention includes detention that is contrary to international law.⁴ Involuntary commitment in mental health services in every instance constitutes arbitrary detention, as it is based on an actual or perceived impairment (mental health condition) alone or in combination with other factors. It is unlawful as such detention is contrary to CRPD, which is binding on 173 states parties as of this writing, and contrary to general principles of international law as understood by the Working Group on Arbitrary Detention.

States have the obligation to provide effective remedies and reparation for acts of arbitrary detention, including prompt release.⁵ This obligation is not being met when the state enforces, and fails to repeal, laws that affirmatively authorize impairment-based detention.

Definition and obligations related to freedom from torture

Involuntary treatment in mental health services violates a number of fundamental human rights including the right to recognition before the law, the right to security of the person, the right to respect for physical and mental integrity, the right to be free from torture and other ill-treatment, the right to be free from all forms of violence, exploitation and abuse, and the right to give or refuse free and informed consent in health care. I have elsewhere presented arguments based on both CAT article 1 and holistic factors, that involuntary mental health treatments satisfy the criteria for torture.⁶ To summarize those arguments:

¹ A/HRC/30/37.

² Id, Annex, paras 38, 103, 106(b).

³ See Id, Annex, paras 22 and 24.

⁴ Id, preliminary matter before Annex, paras 10(e), 12.

⁵ Id, Annex, paras 1, 25, 26, 107(d), (e) and (f).

⁶ Minkowitz, *The UN CRPD and the Right to be Free from Non-consensual Psychiatric Interventions*, SYRACUSE JOURNAL OF INTERNATIONAL LAW AND COMMERCE 34:405 (2007) (Minkowitz 2007a); Minkowitz, *Forced interventions and institutionalization as torture/CIDT from the perspective of persons with disabilities, presentation*

- Involuntary administration of mind altering drugs or other mind-altering procedures (electroshock, psychosurgery) causes profound suffering both long and short-term and serious harm.⁷ There is ample literature documenting these harms in mainstream psychiatric research, critical research, and human rights organizations.⁸ The first Special Rapporteur on Torture included both ‘electric shocks’ and ‘neuroleptic drugs’ among the forms of physical torture.⁹ Andrew Byrnes has written that the prohibition in the Inter-American Convention to Prevent and Punish Torture of ‘methods intended to obliterate the victim’s personality or to diminish his physical or mental capacities, even if they do not cause physical or mental pain or anguish’ was meant to address mind control techniques including the use of chemical substances.¹⁰ Peter Breggin and David Cohen point out that psychic apathy along with akathisia, a movement disorder that can also have a psychic component, are the signature effects of neuroleptic drugs; for some people the subjective effects are minor while for others they create intense anguish.¹¹ Following the Inter-American Convention, all involuntary application of such methods should be understood as torture because of their inherent properties that annihilate the personality and diminish mental and physical capacities.

delivered to OHCHR expert meeting on torture and persons with disabilities, available as Annex III to report of expert meeting at <http://www.ohchr.org/EN/Issues/Disability/Pages/UNStudiesAndReports.aspx> (Minkowitz 2007b); Minkowitz, *Advocacy Note: Forced Interventions Meet International Definition of Torture Standards*, circulated during CRPD Ad Hoc Committee drafting and negotiation process (Advocacy Note).

⁷ Minkowitz (2007a) and (2007b) and Advocacy Note; see also articles and first-person stories at <http://absoluteprohibition.org>, www.madinamerica.com, and www.mindfreedom.org.

⁸ See 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*, section 1: Biomedical psychiatry: prejudice and faulty science set the stage for abuse, available at: http://www.chrusp.org/home/us_crpdc.

⁹ E/CN.4/1986/15, para 119.

¹⁰ Andrew Byrnes, *Torture and other Offenses Involving the Violation of the Physical or Mental Integrity of the Human Person*, in *SUBSTANTIVE AND PROCEDURAL ASPECTS OF INTERNATIONAL CRIMINAL LAW 214* (Gabrielle Kirk McDonald et al. eds, 2000), see also discussion in Minkowitz 2007a.

¹¹ Breggin, *BRAIN DISABLING TREATMENTS IN PSYCHIATRY* (2008), *PSYCHIATRIC DRUGS: HAZARDS TO THE BRAIN* (1983); Cohen, *A Critique of the Use of Neuroleptic Drugs in Psychiatry*, in *FROM PLACEBO TO PANACEA: PUTTING PSYCHIATRIC DRUGS TO THE TEST 202* (Seymour Fisher and Roger P. Greenberg, eds, 1997).

- The harm and suffering from involuntary administration of mind-altering drugs and procedures are no different for people with actual or perceived impairments than for anyone else.¹² To apply a more permissive standard is to treat people with psychosocial disabilities as being of diminished inherent worth and dignity compared with others, and runs counter to states parties' obligations under CRPD article 15 to protect persons with disabilities against torture and other ill-treatment on an equal basis with others.
- Therapeutic intent does not negate the discriminatory purpose or the destructive nature of involuntary mental health treatment.¹³ The right to health contains the freedom to control one's own body and health,¹⁴ and confers no authority on states to intervene against a person's will in his or her supposed best interest. To the extent that earlier standards permitted an exception in the mental health context, which derived from a view that mental health conditions uniquely deprive individuals of the ability to make treatment decisions, this has been overturned through CRPD Article 12 and the elaboration of General Comment No. 1.¹⁵
- The purposes for which torture is committed include under CAT article 1, obtaining confession or information, coercion or intimidation of the person or another, punishment of the person or another, and discrimination of any kind. Discrimination is always present in involuntary mental health treatment, as it entails an intolerance for the person's attributed mental or emotional state and an unwillingness to allow the person to evolve and continue freely developing his or her personality for that reason. Thus, the disability community and then the Special Rapporteur on Torture adopted (with minor variation) the formulation that prohibits forced or coerced interventions 'aimed at correcting or alleviating any actual or perceived impairment.'¹⁶ This captures the intolerance for diversity and the right to be different,¹⁷ which is a component of non-discrimination and is recognized in CRPD article 3(d).
- Other purposes under CAT article 1 are commonly present in addition to discrimination. The hostile context in which mind-altering drugs and

¹² As acknowledged by Manfred Nowak, see A/63/175 paras 38-41, 45, 61, 62-63.

¹³ A/63/175 paras 47 ('lack a therapeutic purpose OR [not AND] aim at correcting or alleviating a disability') and 49; A/HRC/22/53 paras 22, 32-35 (however note error in quote of Nowak report para 47; actual language strengthens the argument against 'therapeutic intent' or medical necessity), 61, 63, 64.

¹⁴ CESCR GC 14 paras 8 and 34.

¹⁵ CRPD GC1 paras 7, 13-15, 21, 42.

¹⁶ A/63/175 para 47.

¹⁷ Right to be different is invoked in UNESCO Declaration on Race and Racial Prejudice (1978) article 1.2.

electroshock are commonly administered by force and against the person's will is readily observable on a visit to any psychiatric ward or institution. It is not only a battle of the wills over whether the individual will submit to the prescribed treatment, but reflects an underlying dynamic aimed at breaking the person's will and submitting to the authority and ideology of the mental health professional. Punishment is also common, as forced drugging is used to put down troublemakers.

- State involvement is of three kinds: acts committed by state officials who are employees of public institutions, the state's acquiescence through its affirmative grant of power for the acts to be carried out by private entities, and the state's failure to engage due diligence to effectively prevent acts of torture and ill-treatment by enacting and enforcing a legal prohibition.
- The meaning of 'force' or 'involuntary' needs to be understood as referring to any legal, contextual or physical coercion, or the absence or free and informed consent of the person concerned. Domestic law may consider as 'involuntary' only a subset of instances of actual forced, coerced and otherwise unwanted treatments and internments. Similarly, the concept of force, while convenient as shorthand to refer to the violence of being obligated against one's own will to take mind-altering drugs, is not limited to those instances where the person has physically resisted and is overcome. The approach advocated here, and adopted by Manfred Nowak and in the CRPD Committee's approach to the standard,¹⁸ is analogous to feminist reforms of rape law from the victim's perspective, which similarly is based on coercion understood from the circumstances and/or absence of free and informed consent, rather than physical force to overcome resistance. The experience of having one's consciousness taken over by mind-altering drugs is violent and conducive to dissociation in a similar way as coerced sexual use of one's body.

Courts, as a branch of the state, can take a similar approach as with arbitrary detention, to upholding the prohibition and effective prevention of torture and other ill-treatment under international law. Courts and tribunals operating under statutory review authority, human rights competence or habeas corpus power should understand their responsibility to provide effective access to justice by persons with disabilities in regard to torture and other ill-treatment.

Courts themselves should become informed about the standards under the CRPD, which represent the highest, most protective and most specific authority on the rights of persons with disabilities to be free from all forms of torture and other ill-treatment, including disability-specific forms such as involuntary mental health

¹⁸ A/63/175 para 47; the Committee has picked up the formulation 'free and informed consent of the person concerned.'

treatment,¹⁹ and failure to prohibit and effectively prevent the involuntary application of mind-altering drugs and procedures. Persons with disabilities may not have the terminology or legal knowledge to argue that these acts are torture, and should not have the burden of proving that their suffering rises to a particular level or otherwise meets any particular criteria in order to be granted relief. Victims should be treated with the sensitivity required towards all victims of torture, and should be offered any relevant reasonable and procedural accommodations related to their disability and to their situation as victims dealing with the after-effects of state-condoned violence and abuse. All instances where cooperation or consent occur under threat or coercive circumstances demonstrating no effective right to refuse that will be respected, legal or physical force is used, accurate information is not provided about adverse effects, or the free and informed consent of the person has otherwise not been obtained, should be understood to constitute the violation of torture as discussed above.

The primary need is cessation of violations and guarantee of repetition; courts should aim to go further and provide all forms of systemic and individual reparation but should not delay the enforcement of a prohibition on involuntary treatment affecting the individual complainant. Whenever it is within the competence of the court to do so, remedies to cease and desist from torture and arbitrary detention should be applied broadly to protect all individuals at risk and bind all relevant public and private actors in the jurisdiction.

Recommendations for states

States should uphold their obligations to provide effective access to justice for victims of disability-specific forms of detention and torture, by ensuring that their legislation allows courts to give effect to international human rights guarantees that require the setting aside of domestic legal provisions. They should ensure that immunity is withdrawn from psychiatrists and other actors who perpetrate or are complicit in involuntary interment and involuntary treatment in mental health services, and that such acts are subject to liability under the penal law and the law of tort, not as medical malpractice only but as battery and forced imprisonment. They should repeal provisions that affirmatively grant power to psychiatrists and other actors to perpetrate these acts, or that implicitly recognize such grant of power by regulating criteria and procedures. They should ensure that courts and statutory review mechanisms are informed about CRPD-based human rights standards, and that in the repeal of provisions on mental health internment and involuntary treatment, such review mechanisms are not dismantled but instead are mandated to direct the release of anyone who wishes to leave a mental health setting or stop any mental health treatment, and to make any auxiliary orders within the court's power to provide for the person's resettlement in the community in accordance with his or her will and preferences, in line with the standards on independent living.

¹⁹ Involuntary mental health treatment is disability-specific as a discriminatory justification of acts that otherwise are already understood to constitute torture.

States should ensure that their laws providing remedies and reparation for arbitrary detention and for torture and other ill-treatment cover disability-specific forms including involuntary internment and involuntary treatment in mental health services. They should ensure that national torture prevention mechanisms are well informed and equipped to apply CRPD-compliant standards upholding the absolute prohibition of involuntary internment and involuntary treatment.²⁰

States should allocate specific funding to legal services and disability advocacy services to undertake work on CRPD-related advocacy and individual and strategic litigation. If these services do not have the capacity to engage in law reform/test case litigation to seek compliance with international law, the potential for persons with disabilities to avail themselves of legal remedies relating to breach of their CRPD rights is severely restricted.²¹

Independent monitoring of facilities and services where persons with disabilities are at risk of arbitrary detention and torture can promote access to justice by informing service users and residents of their human rights and conducting investigative inquiries. Whether conducted under OPCAT or CRPD articles 16 and 33, the highest standard of human rights protection should be applied as discussed in this submission, and sensitivity to the situation of victims and destructive power imbalances that can mask the actuality of violence and abuse. Experts who are users and survivors of psychiatry should be included in monitoring mechanisms and teams at all levels and stages.

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The Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP) is a user and survivor-run human rights organization that is accredited to ECOSOC with special consultative status. CHRUSP aims to provide strategic leadership in human rights advocacy, implementation and monitoring relevant to people experiencing or labeled with madness, mental health problems or trauma. In particular, CHRUSP works for full legal capacity for all, an end to forced drugging, forced electroshock and psychiatric incarceration, and for support that respects individual integrity and free will. Please see www.chrusp.org.

²⁰ See CHRUSP et al, OPCAT monitoring of psychiatric institutions and related issues in other forms of detention: CRPD Framework, available at <http://www.chrusp.org/home/resources>.

²¹ Thanks to Fleur Beaupert for these recommendations.