



Submission to the Human Rights Committee in Response to Paragraph 19 of its Draft General Comment on Liberty and Security of the Person

I. Introduction and summary

In paragraph 19 of its draft General Comment, the Human Rights Committee has proposed standards regarding detention in the context of mental health. WNUSP has serious concerns about the standards proposed, as they reflect outdated standards that are contrary to the human rights of persons with psychosocial disabilities. Paragraph 19 reads as follows:

19. [States parties should explain in their reports what they have done to revise outdated laws and practices in the field of mental health in order to avoid arbitrary detention. Any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the person in question or preventing injury to others, must take into consideration less restrictive alternatives, and must be accompanied by adequate procedural and substantive safeguards established by law. The procedures should ensure respect for the views of the patient, and should ensure that any guardian or representative genuinely represents and defends the wishes and interests of the patient. States parties must provide programmes for institutionalized persons that serve the purposes that are asserted to justify the detention. Deprivation of liberty must be reevaluated at appropriate intervals with regard to its continuing necessity. Patients should be assisted in obtaining access to effective remedies for the vindication of their rights, including initial and periodic judicial review of the lawfulness of the detention, and to ensure conditions of detention consistent with the Covenant.]

It is clear that paragraph 19 of the draft General Comment, which is bracketed as requiring further consideration, reflects the jurisprudence of the Human Rights Committee to date. The Committee's approach to detention on mental health grounds is inconsistent with evolving standards in this area, in particular with the standards adopted in the Convention on the Rights of Persons with Disabilities (CRPD) and with views expressed by successive Special Rapporteurs on Torture and by the Office of the High Commissioner for Human Rights (OHCHR). We urge the Human Rights Committee to take a forward-looking approach in its General Comment in order to provide effective and meaningful guidance to States Parties that is informed by a disability perspective based in non-discrimination. In addition to revising the contents of paragraph 19, we urge the Committee to incorporate a disability perspective in addressing the rights of prisoners and detainees with

disabilities in jails, prisons and other detention settings, also in line with the standards of the CRPD.

The seriousness of mental health detention and compulsory treatment as a human rights violation is underscored by recent recommendations of the Special Rapporteur on Torture. Rapporteur Juan E. Méndez called for an absolute ban on nonconsensual psychiatric interventions including restraint, solitary confinement and the administration of mind-altering drugs, and for revision of legal provisions authorizing confinement and compulsory treatment in mental health settings; forced treatment and commitment must be replaced by services in the community that meet needs expressed by persons with disabilities and that respect their autonomy, choices, dignity and privacy.¹ In a statement to the Human Rights Council introducing the report, Mr Méndez said that detention on mental health grounds was unjustified, and in particular that it could not be justified by the severity of a mental illness or by a motivation to protect the safety of the person or others.² He also emphasized that the CRPD constitutes authoritative guidance on the rights of persons with disabilities in the context of healthcare.

Mr Méndez built on the jurisprudence of the Committee on the Rights of Persons with Disabilities and other treaty bodies, as well as the mandate's earlier report in 2008 focusing on torture and persons with disabilities. In that report, Manfred Nowak recognized that involuntary treatment and involuntary confinement in mental health settings was contrary to the CRPD, and that intrusive and irreversible medical treatments aimed at correcting or alleviating a disability, including the administration of electroshock or mind-altering drugs such as neuroleptics, may constitute torture or ill-treatment if enforced or administered without the free and informed consent of the person concerned.³

The Human Rights Committee has found on at least one occasion that inhuman treatment occurred in a case where allegations included the forced injection of tranquilizers.⁴

This paper addresses the connection between ICCPR Article 9 and CRPD Article 14, and elaborates on the standards with respect to detention on mental health grounds contained in the text of the CRPD and in the interpretation and application made by the Committee on the Rights of Persons with Disabilities. It further argues that the standards in the CRPD, being derived from an application of existing human rights

¹ A/HRC/22/53, 1 February 2013, paras 85(e), 89(b), 89(c) and 89(d).

² Statement on 4 March 2013, available at: <http://www.madinamerica.com/wp-content/uploads/2013/03/torture.pdf>.

³ A/63/175, 28 July 2008, paras 40, 44 and 47.

⁴ Human Rights Committee, views on communication No. 110/1981, *Viana Acosta v. Uruguay*, adopted on 29 March 1984 (CCPR/C/21/D/110/1981), paras. 2.7, 14 and 15.

law to the lived experience of persons with disabilities, articulate the correct standard to be followed by the Human Rights Committee to ensure that persons with disabilities enjoy all rights guaranteed by the Covenant on an equal basis with others, as required under ICCPR Article 2.

II. CRPD Article 14 and its implications for Article 9 of the Covenant

The CRPD text is based, in almost every article, on existing rights recognized in the two Covenants and in other core human rights treaties. These rights are guaranteed to persons with disabilities on an equal basis as others, without any discrimination, and the obligations of States to take particular measures or ensure particular results are elaborated. Article 14 of the CRPD is based primarily on Articles 9 and 10 of the ICCPR, and also encompasses the procedural guarantees in Article 14 of the ICCPR. CRPD Article 14 reads as follows:

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
 - (a) Enjoy the right to liberty and security of person;
 - (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.

Paragraph 1 is based on the corresponding provision in paragraph 1 of ICCPR Article 9, specifying the guarantee of rights on an equal basis to persons with disabilities and (in subparagraph b) the duty to ensure that the existence of a disability shall in no case justify a deprivation of liberty. This provision was thoroughly debated in the negotiations, and negotiating parties rejected a proposal to add the term “solely” (i.e. to prohibit deprivation of liberty based solely on disability), which, in this context, would have implied permission to authorize detention based on disability in combination with some other factors.

In rejecting a permissive approach to mental health detention, the drafters and the negotiating parties of the CRPD intentionally departed from the approach contained in the earlier non-binding declaration that governed this subject matter, the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, known as the “MI Principles,” which authorized detention of a person diagnosed with a mental illness when “because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to others,” or when “in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead

to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.” The provision in the CRPD prohibits any detention based on the existence of a disability, and contains no exceptions that would accommodate mental health detention with or without additional factors.

Treaty bodies and regional human rights mechanisms, relied on the MI Principles in the past as guidance in its jurisprudence, not questioning the legitimacy of detention, institutionalization or compulsory treatment but requiring procedural safeguards. Such an approach is reflected in paragraph 19 of the draft General Comment. This guidance now must be supplanted by the CRPD.

In summing up discussion, the Chair of the CRPD negotiations commented:

The Chair noted proposals to amend 14(1)(b), however he asserted that the changes were either not substantive or represented issues that had already been thoroughly debated. He believed that the text as written is reasonably balanced and should be retained. This is essentially a non-discrimination provision. The debate has focused on the treatment of PWD on the same basis as others. PWD who represent a legitimate threat to someone else should be treated as any other person would be. The Chair believed that the text achieves this balance and encouraged informal discussion if delegates still had concerns.⁵

Paragraph 2 is based on the remainder of ICCPR Article 9, as well as Articles 10 and 14. An earlier version of the text had elaborated on the obligations with respect to specific aspects of these rights, but it was determined that a more general provision on equal guarantees to detainees, including reasonable accommodation for disability, was more appropriate given the intention that all such rights be guaranteed on an equal basis to persons with disabilities. The provision that detainees must be treated in compliance with the objectives and principles of the CRPD was derived from a disability-pertinent perspective on the right to humane treatment in ICCPR Article 10, and is useful for applying the provisions of the CRPD as a whole to the rights of persons with disabilities who are detained in jails, prisons, and other detention settings.

The Committee on the Rights of Persons with Disabilities has left no doubt that CRPD Article 14 prohibits mental health detention and compulsory treatment. Through varying language, they have consistently urged states to repeal legal provisions authorizing involuntary commitment or deprivation of liberty of persons

⁵ Daily summary of discussion at the seventh session, 19 January 2006 (Vol. 8 #4) at <http://www.un.org/esa/socdev/enable/rights/ahc7sum19jan.htm>.

with perceived psychosocial or intellectual disabilities.⁶ They have repeatedly called on states, under Article 14, to ensure that all mental health services are based on the free and informed consent of the person concerned.⁷ In addition, the CRPD Committee has found a positive component of Article 14, requiring states to allocate financial resources so as to ensure that the support that people with disabilities desire is available in the community without ever resorting to institutionalization.⁸ As noted by the Special Rapporteur on Torture, the obligation to end forced psychiatric interventions is of immediate application and scarce financial resources cannot justify its postponement.⁹

The Committee on the Rights of Persons with Disabilities has applied additional provisions of that treaty to prohibit mental health detention and compulsory treatment, and to require the repeal of contrary legal provisions. The right to enjoy legal capacity on an equal basis with others, in CRPD Article 12, includes “the individual’s right, on their own, to give and withdraw informed consent for medical treatment.”¹⁰ States must repeal legal provisions authorizing guardianship and substituted decision-making, and replace these regimes with supported decision-making, which respects the individual’s autonomy, will and preferences.¹¹ Forcible medication with neuroleptics, as well as commitment of people with psychosocial and intellectual disabilities to institutions, have been found to violate the right to freedom from torture and ill-treatment under CRPD Article 15.¹² Forced treatment in mental health services violates the right to respect for physical and mental integrity under Article 17 and must be abolished by law.¹³ Detailed recommendations with respect to mental health services, including the repeal of laws permitting involuntary treatment and confinement, were elaborated under Article 25 on the right to health:

⁶ Spain CO para 36, Peru CO para 29, China CO para 26, Hungary CO para 28, Paraguay CO para 36. OHCHR interprets Article 14 (b) in the same way, noting that the Convention “forbid[s] deprivation of liberty based on the existence of any disability, including mental or intellectual, as discriminatory.” OHCHR similarly calls for the repeal of all legal provisions authorizing confinement of persons with disabilities for their care and treatment without their free and informed consent, “as well as provisions authorizing the preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others.” (Thematic study of the High Commissioner for Human Rights on implementation on key legal measures for the ratification and implementation of the Convention on the Rights of Persons with Disabilities, A/HRC/10/48, para 48).

⁷ Spain CO para 36, China CO para 26, Hungary para 24, Paraguay CO para 36.

⁸ China CO, para 26, Argentina CO, para 24, Paraguay CO, paras 34, 36.

⁹ SRT 2013, paragraph 89(b).

¹⁰ Hungary CO para 26, Paraguay CO para 30.

¹¹ China CO, others.

¹² China CO paras 14-15, Peru CO paras 30-31.

¹³ Tunisia CO paras 28-29.

The Committee advises the state party to adopt measures to ensure that all health care and services provided to persons with disabilities, including all mental health care and services, is based on the free and informed consent of the individual concerned, and that laws permitting involuntary treatment and confinement, including upon the authorisation of third party decision-makers such as family members or guardians, are repealed. It recommends the state party to develop a wide range of community-based services and supports that respond to needs expressed by persons with disabilities, and respect the person's autonomy, choices, dignity and privacy, including peer support and other alternatives to the medical model of mental health.¹⁴

Applying Article 19, the Committee calls on States Parties to “consult with organizations of persons with disabilities on developing support services for persons with disabilities to live independently in accordance with their own choice.”¹⁵

III. Analysis of Article 9 with respect to psychiatric detention

1. Unequal enjoyment of right to liberty and security of the person

ICCPR Article 2 requires States Parties to respect and ensure to all individuals the rights recognized in the Covenant “without distinction of any kind,” including disability.¹⁶ So long as there exists a separate regime of detention that targets persons with disabilities, persons with disabilities are denied their equal rights under Article 9 of the Covenant, violating Article 9 and Article 2. Such detention regimes, operating under color of domestic law, also violate Article 26. This analysis was advanced by persons with disabilities during the drafting and negotiation of the CRPD, and contributed to the adoption of CRPD Article 14.

We urge the Committee to declare, in its forthcoming General Comment on liberty and security of the person, that psychiatric detention regimes, or any other form of detention based on disability, deprive persons with disabilities of the right to equal enjoyment of liberty and security of the person, contrary to Articles 2 and 9 of the Covenant.

2. Arbitrary detention

¹⁴ China CO para 38.

¹⁵ China CO para 32.

¹⁶ See Concluding Observations on Ireland, A/55/40, paras.422-451, 2000, para 29: “The Committee recommends that further action be taken to ensure full implementation of the Covenant in these matters:
(e) Ensuring the full and equal enjoyment of Covenant rights by disabled persons, without discrimination, in accordance with article 26”; see also Zephiniah Hamilton v Jamaica, communication no 616/1996, 23 July 1999, CCPR/C/66/D/616/1995.

Psychiatric detention should be recognized as arbitrary detention, because of its discriminatory character, because of the unreliable nature of the criteria used to justify the detention, and because the ostensible purposes of the detention are either illegitimate or ill-served by resorting to a detention scheme.

According to the draft General Comment, “the notion of ‘arbitrariness’ is not to be equated with ‘against the law’, but must be interpreted more broadly to include elements of inappropriateness, injustice, lack of predictability, and due process of law.”¹⁷ As the Committee has rightly noted, “detention on discriminatory grounds in violation of Article 26 may also be arbitrary.”¹⁸

The Committee has found a violation where criminal law penalizes conduct of one sector of the population (mutually consenting sexual activity by same-sex partners) but does not penalize comparable conduct by others.¹⁹ The Committee has also objected to the broadly defined crime of “unlawful association” and to preventive administrative detention, which were used to round up large numbers of individuals including political activists and homosexuals.²⁰ In the latter case, the Committee urged the State Party to eradicate the scheme of preventive administrative detention.²¹

Psychiatric detention is comparable to these situations in which the Committee has found a violation of the Covenant. It is a scheme of preventive administrative detention, uniquely applicable to individuals who have been given a psychiatric diagnosis. While such schemes of detention have been enacted into law in most countries, they represent an arbitrary exercise of the power of detention, including the power to define grounds for detention under domestic law. The criteria for detention are vague, allowing free rein to prejudice and stereotyping on the part of mental health professionals, the police and members of the general public who instigate a psychiatric detention, and on the part of the judiciary. Discrimination based on actual or perceived psychosocial impairment is always present; discrimination based on other factors such as gender, race, sexual orientation, sensory or physical impairment, condition of homelessness, age, as well as political activity or opinion, and spiritual or cultural beliefs, is often present as well.²²

¹⁷ Draft GC para 13.

¹⁸ Draft GC para 17.

¹⁹ See footnote 56 in draft GC.

²⁰ CO Honduras 07, CO Colombia 10 (HRC).

²¹ CO Colombia 10 (HRC).

²² Research and data monitoring show, for example, that black and minority ethnic people are disproportionately caught up in the extreme sides of psychiatry and mental health services (informal and civil commitment, forensic secure wards, seclusion and other forced psychiatric situations.) Fernando S (1991) *Mental Health, Race and Culture* London: Macmillan/MIND Publications, Lawlor C, Johnson S, Cole L and Howard LM (2010) 'Ethnic variations in pathways to acute care and

This discrimination is persuasively documented not only in the scientific research, but in the first-person accounts of individuals who have been detained and forcibly 'treated' on mental health grounds often for years on end.²³ Their testimonies point to the common use of psychiatric detention as a means to control and punish those who defy social or gender norms or are political dissidents. These statements also highlight the role of relatives and others who stand to gain financially in organizing detention, and the near complete discrediting (character assassination) of psychiatric detainees who want to challenge their incarceration.

The diagnostic classification systems of psychiatry are highly subjective to the point of being arbitrary; each new iteration of the Diagnostic and Statistic Manual (DSM) of the American Psychiatric Association is met with renewed criticism and there are currently several professional-led initiatives under way to boycott this classification system, some of which also condemn the International Classification of Diseases, the other major diagnostic system in use.²⁴ Homosexuality was once listed as a mental illness, and some modern controversies center around "borderline personality disorder" which labels gendered behavior of women as an illness,²⁵ the pathologization of young people's experiences,²⁶ and the inclusion of voice-hearing as a symptom of schizophrenia; many voice hearers dispute that this experience is inherently problematic and find ways to work with their voices positively.²⁷ The label of schizophrenia as a whole is under investigation by UK researchers; and both service users and survivors, and mental health practitioners, are increasingly finding that psychiatric diagnosis is both harmful and unnecessary. Psychiatric

compulsory detention for women experiencing a mental health crisis.' International Journal of Social Psychiatry, 8 November, online version.

²³ Minkowitz, Tina and Dhanda, Amita, eds. (2006) First Person Stories on Forced Interventions and Being Deprived of Legal Capacity. Pune: WNUSP and BAPU Trust. This publication includes testimonies from India, Japan, Peru, the United States, New Zealand, Australia, Lithuania, Ireland and Italy.

²⁴ Petition from the International DSM-5 Response Committee comprised of mental health professionals in the US, the UK, and across the globe underwritten by the American Psychological Association: <http://dsm5response.com/>; Statement from the Association for Women in Psychology:

<http://www.awpsych.org/index.php/bias-in-psychiatric-diagnosis-dsm-v-portal>.

²⁵ Shaw, C., & Proctor, G. (2005). Women at the margins: A critique of the diagnosis of borderline personality disorder. *Feminism & Psychology*, 15 (4), 483-490.

²⁶ Sammy Timini. *Pathological Child Psychiatry and the Medicalization of Childhood* Routledge: London, 2002.

<http://www.wired.com/wiredscience/2012/11/psychiatry-set-to-medicalize-hissy-fits/>.

²⁷ Intervoice "One of a Million" campaign: <http://www.intervoiceonline.org/news-events/campaigns/one-of-a-million>. Hearing Voices Network UK position statement on DSM5 and Diagnoses: <http://www.hearing-voices.org/wp-content/uploads/2013/05/HVN-Position-Statement-on-DSM5-and-Diagnoses.pdf>.

diagnosis consists simply in establishing patterns of behavior that may or may not occur together, and declaring such patterns to be pathological. Psychiatrists admit that there is no scientific evidence to claim that mental illness is an “illness” in anything but a metaphorical sense, and in particular there is no support for the assertion that psychiatric diagnoses are caused by a chemical imbalance in the brain.²⁸ The newest DSM-5 has also attracted strong criticisms because of the large number of DSM-5 panel members who are funded by the pharmaceutical industry.²⁹ The National Institute of Mental Health, research arm of psychiatry in the United States, now acknowledges that the DSM is invalid.³⁰

Typical criteria applied in psychiatric detention, in addition to psychiatric diagnosis itself, can be paraphrased as either a likelihood of harm to the person or to others, or a need for care and treatment that can only be provided in a closed institution. The treatment criterion suffers from the same flaws as psychiatric diagnosis, and more. The adverse effects of psychiatric medications are well known not only to those whose bodies are harmed but also to the medical profession³¹ and to human rights experts; the first Special Rapporteur on Torture in 1986 included among the forms of torture:

Administration of drugs, in detention or psychiatric institutions neuroleptics, that cause trembling, shivering and contractions, but mainly make the subject apathetic and dull his intelligence³²

Neuroleptics, frequently called “antipsychotics,” are the type of drug most likely to be used involuntarily; furthermore medication is the primary treatment modality offered in psychiatric institutions. Early psychiatric literature referred to these drugs as a “chemical lobotomy” and “chemical straitjacket,” acknowledging the effect if not the purpose of behavior control.³³ Like lobotomy, neuroleptics damage the brain, particularly when used for long periods of time; in modern practice it is common for individuals to be told that they must remain on these drugs lifelong,

²⁸ Jonathan Leo and Jeffrey Lacasse, *Psychiatry’s Grand Confession*, available at: <http://www.madinamerica.com/2012/01/psychiatrys-grand-confession/>.

²⁹ Of the DSM-5 task force members, 69% report having ties to the pharmaceutical industry, an increase from the 57% of DSM-IV task force members. Cosgrove, Lisa; Drimsky Lisa (March 2012). "A comparison of DSM-IV and DSM-5 panel members' financial associations with industry: A pernicious problem persists". *PLoS Medicine* 9 (3): 1–5.

³⁰ Thomas Insel, Director’s Blog: Transforming Diagnosis, April 29, 2013, available at: <http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml>.

³¹ As documented in Peter Breggin, *Psychiatric Drugs: Hazardous to the Brain* (1983) [Breggin 1983] and David Cohen, *A Critique of the Use of Neuroleptic Drugs in Psychiatry*, in Fisher and Greenberg, eds., *From Placebo to Panacea: Putting Psychiatric Drugs to the Test* (1997) [Cohen 1997].

³² E/CN.4/1986/15, paras 118, 119.

³³ See Breggin 1983 and Cohen 1997.

and to continue the drug regimen despite evidence of neurological damage (in particular the movement disorder known as tardive dyskinesia, which is both physically and socially disabling).³⁴ Neuroleptics damage a number of other bodily systems and shorten the lifespan.³⁵ Polypharmacy (prescription of several drugs at the same time) is rife; this practice arguably constitutes human experimentation without free and informed consent, as no testing is required on drug combinations prior to prescribing and enforcing such a regimen. The treatment provided by psychiatry shows both an alarming unconcern for the subjective well-being of the individuals being treated, and a failure to even meet its own goal of successfully treating diagnosable mental illness.³⁶ Custodial care without treatment, on the other hand, is considered inhumane, acknowledging that deprivation of liberty as such is not beneficial.

The “likelihood of harm” criterion amounts to an acknowledgement that preventive administrative detention is being practiced, based on disability. Psychiatrists are no better than police or security forces at predicting that a particular individual will commit an act of violence; there is no sense in which the conditions or mental states diagnosed as mental illness progress in a predictable manner that would give psychiatrists any meaningful expertise in linking such mental states to a likelihood of violent behavior. Psychiatric detention, when used out of concern for the safety of others, attempts to fill gaps in the mandate of criminal justice and law enforcement systems, without comparable due process,³⁷ and to avoid the censure that would surely meet general schemes of preventive detention in democratic societies by targeting a population that is uniformly silenced, misunderstood, and scapegoated in the law as well as in the community. Gaps in the effectiveness of law enforcement and criminal justice must be met within those systems, whose personnel must also be trained in non-discrimination and the duty to reasonably accommodate a person’s disability.³⁸

Detention that is meant to protect the person from harming her or himself, or from being harmed by others, may be sincerely meant to provide a measure of safety and respite, but is misguided and counterproductive. Detention takes away a person’s ability to control the immediate environment or to create conditions that she or he may subjectively experience as safe and nurturing, while exposing the individual to many unsafe conditions such as forced medication, seizure-causing electroshock to the brain, restraint and solitary confinement, invasion of privacy, rape and sexual assault, forced psychotherapy, an environment of intimidation and neglect of basic

³⁴ Id.

³⁵ Studies cited in <https://www.madinamerica.com/2011/11/%EF%BB%BFearly-death-associated-with-antipsychotics/>.

³⁶ Robert Whitaker, *Mad in America* (2001) and *Anatomy of an Epidemic* (2010).

³⁷ Cf. draft General Comment paragraph 15, “The regime must not amount to an evasion of the limits on the criminal justice system by providing the equivalent of criminal punishment without the applicable protections” (footnote omitted).

³⁸ See CRPD Article 13, and CO on Paraguay, para 32.

needs and dignity. Loss of life can occur in psychiatric institutions, through suicide, overmedication, electroshock, restraints, failure to properly treat physical health problems, or a combination of factors. This is especially harmful to women and girls, who have almost uniformly been subjected to some form of rape or sexual assault, invasion of personal space, and denial of the validity of subjective experience. Not only are these conditions harmful in the short term, they have caused vast, and largely unrecognized, iatrogenic trauma and disability, for which the psychiatric system prescribes more of the same.

Concern for a person's safety and well-being must be met with genuine support and care that acknowledges our human limitations and takes a harm-reduction approach rather than attempting to close the person off from independent life and society. Harm-reduction approaches offer support in ways that the individual can welcome and receive as such, and respect the individual's autonomy, choices, dignity and privacy. Examples include needle-exchange programs for users of addictive drugs; programs to provide blankets, food, clothing and portable shelters to people living in the streets who may choose for any number of reasons not to utilize indoor shelters; shelters for victims of domestic violence, which trust that the individual is in the best position to judge the danger she is in and whether to leave. Good practices in mental health and peer support, including in situations involving suicide and self-harm, adopt a similar approach, spending the time to get to know a person, acknowledging the person's strengths, seeing the world from her or his point of view, and offering support for which the person has expressed a need. These are the types of measures that would meet the criteria established under the CRPD, particularly in Article 12 which requires the replacement of substituted decision-making with supportive decision-making that respects the individual's autonomy, will and preferences.

Prior to the CRPD, psychiatric detention was thought to be a necessary evil, to be tolerated reluctantly and hedged with procedural safeguards as a nod to the requirements of human rights. The Working Group on Arbitrary Detention, writing in 2005, deplored "the phenomenon of mental disability or illness" and considered that it was necessary to take measures involving the restriction or deprivation of liberty in the interest of the mentally ill, or of society as a whole." The CRPD reversed this perspective, holding society accountable for providing care, support and reasonable accommodation to persons with psychosocial disabilities based on the person's own choices and expressed needs,³⁹ and deploring disability-based detention and institutionalization⁴⁰ as human rights violations that must be eradicated.

We urge the Committee to declare, in its forthcoming General Comment on liberty and security of the person, that detention on mental health grounds or in mental health settings discriminates based on disability and is a form of

³⁹ CRPD Articles 2, 3, 5, 12, 17, 19, 25 and 26.

⁴⁰ CRPD Articles 14 and 19.

arbitrary detention; that it is always unjustified; that it cannot be justified by a motivation to protect the safety of the person or others or by an alleged need for care or treatment; and that it must be abolished rather than being legitimized through regulation and procedural safeguards.

IV. Psychiatric detention and compulsory treatment violate the right to security of the person

According to the draft General Comment, “The right to ‘security of person’ in article 9 is independent from the right to liberty of person, and refers to freedom from bodily injury, including fatal injury” (footnote omitted).⁴¹ Psychiatric detention and compulsory treatment inflict significant bodily injury as detailed in section III.2 above. Restraint and solitary confinement, as well as medications, electroshock and psychosurgery, inflict bodily harm and can cause loss of life. As noted by the Special Rapporteur on Torture, while medical treatments may cause pain and suffering and yet be fully justified, the absence of personal free and informed consent to intrusive and irreversible treatments aimed at correcting or alleviating a disability, which includes psychiatric medications, electroshock and psychosurgery, can mean the difference between a fully justified treatment and an act of torture or ill-treatment. The centrality of consent in distinguishing medical violence from an act of care is similar to the role played by consent in distinguishing rape from an act of sexual intimacy.

The action of psychiatric medications, electroshock and psychosurgery on and within the body is a form of violence and injury when administration is enforced against the person’s will or in the absence of free and informed consent, irrespective of whether the individual complied due to intimidation or ignorance of her or his human rights, or whether physical force was used to overcome the person’s resistance.⁴² (In this paper, the term “forcible medication” is intended to be understood as including any medication without the free and informed consent of the person concerned, invoking the standards applied by the Committee on the Rights of Persons with Disabilities and by the Special Rapporteur on Torture.) It should be noted that non-consensual medication takes place both inside and outside of institutions, and that court-ordered compulsory treatment in the community, which features medication as the primary treatment regimen, is a growing trend throughout the world that expands the subjection of persons with disabilities to measures of control outside the law enforcement and criminal justice systems. Non-consensual medication is also of concern in housing arrangements where individuals can be required to comply with prescribed psychiatric treatment as a condition of retaining eligibility for the housing program, in prisons, and in

⁴¹ Draft General Comment, para 8.

⁴² See Minkowitz, Forced interventions and institutionalization as torture/CIDT from the perspective of persons with disabilities, presentation to OHCHR expert meeting on torture and persons with disabilities, available at: <http://www2.ohchr.org/english/issues/disability/docs/torture/AnnexIII.ppt>.

institutional living arrangements designed for older persons or persons with disabilities, which may be called “social care homes” or “nursing homes” or by other names. States also have a duty to use due diligence to protect individuals against non-consensual medication that psychiatrists, caregivers or family members may administer by deception (e.g. hiding drugs in a person’s drink or food), or by coercion and intimidation lacking any pretense to legal justification.

As noted in Sections I and III above, psychiatric institutionalization and psychiatric treatment inflicted inside or outside of institutions against a person’s will have been recognized as forms of torture and ill-treatment. They have also been recognized as constituting violence against women.⁴³

We urge the Committee to declare, in its forthcoming General Comment on liberty and security of the person, that psychiatric detention and compulsory treatment violate the right to security of the person and can amount to torture or to cruel, inhuman or degrading treatment or punishment.

IV. Conclusions

Psychiatric detention and compulsory treatment violate the Convention on the Rights of Persons with Disabilities, which constitutes authoritative guidance for the interpretation and application of human rights, including those recognized in the Covenant, insofar as they affect persons with disabilities. These practices should be recognized as violations of the right to liberty and security of the person contained in Article 9 of the Covenant, bearing in mind that they have also been recognized as forms of ill-treatment and torture.

We urge the Committee to declare, in its forthcoming General Comment on liberty and security of the person, that:

1) Psychiatric detention regimes, or any other form of detention based on disability, deprive persons with disabilities of the right to equal enjoyment of liberty and security of the person, contrary to Articles 2 and 9 of the Covenant.

2) Detention on mental health grounds or in mental health settings discriminates based on disability and is a form of arbitrary detention; it is always unjustified; it cannot be justified a motivation to protect the safety of the person or others or by an alleged need for care or treatment; and it must be abolished rather than being legitimized through regulation and procedural safeguards.

⁴³ OHCHR Thematic Study on violence against women and girls and disability, March 2012, A/HRC/20/5, para 53(d),(e).

3) Psychiatric detention and compulsory treatment violate the right to security of the person and can amount to torture or to cruel, inhuman or degrading treatment or punishment.

Annex I: Extract from WNUSP's Implementation Manual for the UN CRPD, February 2008

Non-coercive alternatives; reframing notions of 'safety' and 'risk' with regard to shared risk and responsibility; and pre-crisis planning

Summary prepared by Chris Hansen and Shery Mead

The Chinese symbol for crisis has two parts: "danger" and "opportunity". Many of the most defining and pivotal revelations and changes in our lives emerge from such painful and chaotic times. Forced treatment of people deemed to be experiencing a mental health crisis assumes the worst, and in denying people their voice and choice, denies them also the chance to redefine themselves, change, grow and find the awaiting opportunities. The trauma experienced in such loss frequently damages our sense of autonomy, worth and self-determination. We come to believe that we are bad or dangerous, or that we require others to make decisions for us because we are incapable. One of the greatest losses we experience is the loss of our sense of who we are in the context of our community. An experience of forced treatment causes us to abandon our lives, and we return to a community that sees us as dangerous, vulnerable, volatile and "ill".

A number of peer-run alternatives to crisis have been developed over the years, and there is now a growing body of research available to both confirm their effectiveness, and to support their ongoing development. In their Crisis Hostel research project, Jeanne Dumont and Kristine Jones, found that the test group (who could choose between the hostel and hospitalization), had better healing outcomes, greater levels of empowerment, higher levels of self care, and a reduction in traditional crisis services than the control group who could only access the hospital. One study examined changes in the stories of people who had many previous hospitalizations and were now using a trauma-informed peer run crisis alternative. They found that, where many people had taken on a strong identity of "mental patient" after repeated hospitalizations, the alternative outcome included "critical learning" (being able to redefine one's role, and *not* seeing one's self as "crazy").

A user/survivor tells a story of multiple losses and stresses that left her feeling that suicide was the only viable solution:

"In hospital I was treated as though I deserved to be punished. People treat their animals better than many psychiatric patients are treated. Any self-respect I had quickly disappeared. As a result of a rather long hospitalization I lost my well-paid management job, custody of one of my children, my friends and social supports, and ended up having to rely on benefits, the food-bank and other charities. It has taken me many, many years to regain my sense of self, and to this day I still struggle with the sense of shame and 'otherness' this experience created. The sad thing is that if someone

had lent me a caring ear and helped me to see the options, none of this would have happened.” (user/survivor of psychiatry)

The best-intentioned use of coercion can lead to irreparable damage.

“I was forced into hospital, held down and drugged. I now have post-traumatic stress and flash-backs from that time that are worse than any ‘diagnosis’ I was given before then. I would far rather have been sent to the police station and borne the consequences of a person who had violated the law than treated as person who is unable to reason.” (user/survivor of psychiatry)

The widely-held view that coercive treatment potentially saves lives and protects society is a form of social control that fails to acknowledge the cost and the damage to the individuals concerned. It also overlooks the number of people who as a result can't find a way out of the mental health system ('chronic mental patients') and the countless other social problems forced treatment creates.

Crisis alternatives are not only imperative, then, as an alternative to what is frequently experienced as the trauma of forced treatment, but there is growing evidence that they are more effective in many measurable ways.

Peer-run crisis alternatives can operate from a set of assumptions completely different from traditional services. Traditional services focus on finding a diagnosis and treating it (predominantly pharmacologically) whereas crisis alternatives can focus on how people have made meaning out of their experience, building mutually responsible relationships, and creating “new stories.” Peer-run crisis alternatives that are trauma-informed recognize that past trauma (including psychiatric hospitalization) results in a way of seeing and relating that leaves people disconnected, isolated, and shamed, providing an awareness of how people's individual painful life experiences (physical, sexual and emotional abuse, major loss, disaster, war, forced treatment, etc.) impact every aspect of their lives.

Understanding that the way we see, relate, act and know occurs within the context of our histories, there is no assumption of a 'problem', and therefore no need for assessment or evaluation. Instead peers work at developing new ways of communicating their needs and feelings to one another without threat or coercion. For some of us, for example, thinking and speaking of Suicide is a way of dealing with our strong feelings. To be able to talk about what those feelings are (acknowledging that Suicide is not a feeling); when, why and how they arise, and having the option of exploring other ways of expressing them without the threat of hospitalization requires both the willingness to sit with the discomfort on both sides of the conversation, and the courage to negotiate other ways of thinking and talking about it.

Trauma-informed peer support does not assume a diagnosis or a problem. Instead, the focus is on developing relationships that are committed to mutual learning, growth and challenging of one another. The traditional 'expert-patient', or 'helper-helpee' roles are replaced by the expectation of a mutual relationship involving give and take. Being constantly the receiver of services has meant that many of us have lost much of our sense of having valid and respected roles within our communities.

Crisis alternatives can provide the opportunity to challenge the traditional notions of risk and safety. Risk, safety and liability define and drive much of the mental health services provided currently. The underlying message we assimilate as service users is that we are dangerous, fragile and out of control. Safety becomes about other people's discomfort.

Peer crisis alternatives, on the other hand, can offer the safety of trusting relationships that are mutually negotiated. We can begin to talk about shared risk, shared responsibility, and to start to practice new ways of responding when we have strong feelings. Power is discussed honestly, and we can support one another in taking risks in an environment where making mistakes is not just tolerated, it is encouraged.

As well as offering a response to crisis that will listen, validate, explore and challenge old and new ways of making meaning, crisis alternatives can provide the opportunity to develop a 'pro-active crisis plan or interview'. This is a structured pre-prepared process that can serve as a type of advance directive, as well as being one resource with which to enhance the development of the relationship. Individuals practicing peer support are taught to use the interview as a template to guide them in a process of discussion and growing dialogue.

Some crisis alternatives provide a venue- usually a home-like environment in the community where people can stay for a few nights in the company of peers. Others provide home-based services or peer-run options at a venue open during the day.

Here are some questions that may provide the basis of a crisis interview and plan:

1. What peer support/crisis alternative is and what it's not (not about treatment, people not seen as ill, but seen as responsible adults trying to learn something).
2. Relationships and the importance of mutual healing (it needs to work both ways, exploring how mutual relationships have been helpful and/or taken our power).
3. Facilitate a non-illness story (building on a person's subjective experience and language).
4. Thinking "from a distance" (How might someone else describe your difficult experiences)?

5. Think together about the kinds of things that make a difference (Crisis as opportunity for growth rather than returning to baseline).

After the basic introduction is built, some guideline questions are suggested:

Crisis Interview:

1. If you use this crisis alternative instead of another crisis service, and it worked really well for you, what would be different in your life?

What are some other things in your life that have already led to that kind of difference?

How will we know if that's what's happening while you're here?

2. Can you describe a positive experience you've had in which people were able to challenge you into trying new things? Who were the people involved? What were they doing?

What do you need in order to "hear" that challenge from people here?

How will you challenge us if you feel that we're "stuck?"

3. Imagine that there is no mental health language.

Describe yourself on a really good day (what are you feeling, what are you doing, with whom)?

On a really bad day:

4. Can you describe a time when you were headed towards a really bad time and you decided, and then were able, to turn it around?

Who or what helped?

What did they do?

When you've turned it around, what were you able to accomplish?

5. What would you be willing to try when you're using the crisis alternative?

How will you/we know if you're trying it?

What do you want to make sure we're doing while you're here?

How will you/we know if we're trying?

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Annex II: Information about submitting organization

The **World Network of Users and Survivors of Psychiatry (WNUSP)** is an international organisation of users and survivors of psychiatry, advocating for human rights of users and survivors, and representing users and survivors worldwide.⁴² The organisation has expertise on the rights of children and adults with psychosocial disabilities, including on the latest human rights standards set by the CRPD, which it played a leading role in drafting and negotiating. WNUSP is a member organisation of IDA and has special consultative status with ECOSOC. WNUSP supports its members to advocate before UN treaty bodies, and has provided expertise to UN bodies including the Special Rapporteur on Torture, the Subcommittee on Prevention of Torture and the Committee on the Rights of Persons with Disabilities. WNUSP is currently engaged with processes for review of the Standard Minimum Rules on the Treatment of Prisoners and for the development of an instrument on the rights of older persons.

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