THE UNITED NATIONS CONVENTION OF THE RIGHTS OF PERSONS WITH DISABILITIES AND THE RIGHT TO BE FREE FROM NONCONSENSUAL PSYCHIATRIC INTERVENTIONS

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It is the contention of this paper that forced psychiatric interventions violate the universal prohibition of torture. The Convention on the Rights of Persons with Disabilities (CRPD) lays the basis for this argument to be developed in a series of steps, starting from its recognition of equal legal capacity and free and informed consent of persons with disabilities, and equal right to respect for physical and mental integrity, as well as the freedom from torture and cruel, inhuman or degrading treatment or punishment. These obligations, contained in Articles 12, 25, 17, and 15 respectively, will require immediate cessation of forced psychiatric interventions. But there is a need to go further, and examine the serious nature and consequences of forced psychiatric interventions as a violent assault, in most cases sanctioned if not perpetrated by the state, affecting every aspect of a person's life: the body, the mind, the personality, the social relationships, and the spiritual values or higher meaning. Based on an examination of these factors, and the internationally accepted definitions of torture, I will argue for recognition of forced psychiatric interventions as a grave violation of human rights, necessitating criminalization of perpetrators and reparations for victims and survivors.

I. INFORMED CONSENT

Article 25 of the CRPD requires States Parties to ensure that health care is provided to persons with disabilities on the basis of free and informed consent, on an equal basis with others.[1]

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1. Article 25(d) reads:

> [States Parties shall:] Require health professionals to provide care of the same quality to persons with disabilities as to hers, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care. . .
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> Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106, at 25(d), U.N.

The right to be free from nonconsensual medical treatment has been recognized by the Committee on Economic, Social and Cultural Rights (CESCR) as one of the freedoms incorporated in the right to the highest attainable standard of health.[2] Thus, the right to free and informed consent is not merely a function of domestic laws, but is one of the human rights and fundamental freedoms that is guaranteed to all persons, and that must be applied without discrimination based on disability.[3]

Any limitation of the right to free and informed consent that applies only to persons with disabilities, or disproportionately affects persons with disabilities, would constitute discrimination.[4] Typical mental health legislation setting out standards and procedures by which psychiatric interventions can be imposed against the will of a person must now be considered unlawful.[5] Similarly, any customs or practices by which psychiatric interventions are imposed without seeking free and informed consent must be abolished.[6] States Parties are under an affirmative duty to ensure that health care providers (whether private or public) respect the free and informed consent of persons with disabilities, to the same extent as guaranteed to others under domestic and international law. If a country has passed legislation authorizing coercive medical interventions on the general population, its lawfulness would depend on a) whether it has a discriminatory effect on persons with disabilities, and b) whether it meets the criteria for limitations set out in CE SCR General Comment No. 14, paragraph 28, interpreting the general limitations clause of International Covenant on Economic, Social and Cultural Rights (ICESCR) Article 4.[7] Particular attention

Doc. A/RES/61/106 (Dec. 13, 2006) [hereinafter CRPD].

2. U.N. Econ. & Soc. Council [ECOSOC], Comm. on Econ., Soc., & Cultural Rights, *General Comment No. 14: Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights*, ¶ 8, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter *General Comment No. 14]*.

3. General Comment No. 14 uses the phrase "the right to be free from nonconsensual treatment," which is equivalent to free and informed consent. *See* U.N. Econ. & Soc. Council [ECOSOC], Comm'n on Human Rights, *Situation of Detainees at Guantánamo Bay*, ¶ 82, U.N. Doc. E/CN.4/2006/120 (Feb. 27, 2006) *(prepared by* Leila Zerrougui, Leandro Despouy, Manfred Nowak, Asma Jahangir, & Paul Hunt) [hereinafter *Situation of Detainees at Guantánamo Bay]*.

4. *See also* CRPD, *supra* note 1, art. 5.

5. *See id.* art. 4(1)(b).

6. Id.

7. The relevant portion of paragraph 28 reads: "Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society." U.N. Econ. &

should be paid to the requirement that such measures be in accordance with international human rights standards, such as the scope of the protection of physical and mental integrity under International Covenant on Civil and Political Rights (ICCPR) Article 7, and the Convention Against Torture (CAT), which have as yet been insufficiently analyzed with respect to the medical and health context.

Statements in General Comment No. 14 purporting to authorize coercive "mental health treatment"[8] are incompatible with the provisions of the CRPD and can no longer be taken as authoritative. Similarly, the Principles on the Protection of Persons with Mental Illness, insofar as they purport to authorize and regulate exceptions to free and informed consent,[9] can no longer serve as a guide to interpretation of human rights norms, with the advent of a binding treaty establishing a higher standard of protection.

Neither "disability" nor "persons with disabilities" is defined in the CRPD. However, it should not be doubted that persons with psychosocial disabilities[10] are covered by the Convention. Article 1 mentions both persons with "mental" and "intellectual" impairments, ensuring that "mental" refers to the psychosocial dimension.[11] While the provision refers only to people with "long term" impairments and does not mention imputed impairment or disability, [12] it is non-exhaustive and should not limit coverage of the Convention where such a result would be counterproductive. In particular, the obligations of non-discrimination cannot be properly implemented if they are to depend on the details of a person's experience with disability; the mere fact that a person is perceived as having a disability, and accorded

Soc. Council [ECOSOC], Comm. on Economic, Social and Cultural Rights, *General Comment No. 14*, ¶ 28, U.N. Doc. E/C.12/2000/4 (Nov. 8, 2000).

8. *See id.* ¶ 34.

9. *See* Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, G.A. Res. 119 at Principle 11, U.N. Doc. A/RES/46/1 19 (Dec. 17, 1991).

10. The World Network of Users and Survivors of Psychiatry uses the term "users and survivors of psychiatry" to refer to people who self-define as having experienced madness and/or mental health problems, or having used or survived mental health services. World Network of Users and Survivors of Psychiatry (WNUSP), *Statutes*, art. 3, *available at* http://www.wnusp.net/wnusp%20evas/Dokumenter/statutes.html (last visited May 3, 2007). Psychosocial disability is the preferred term when referring to this type of disability, rather than "mental illness" which can be pejorative. *See* International Disability Law Caucus, News Page for Monday, August 31, 2006, *available at* http://www.un.org/esa/socdev/enable/rights/ahc8docs/ahc8idcreactcomp1.doc (last visited May 3, 2007).

11. CRPD, *supra* note 1, art. 1.

12. Id.

adverse treatment as a result, is enough to invoke these provisions.

The right to free and informed consent implies more than freedom from outright force or coercion. It also requires provision of accurate, accessible information about the nature of a proposed treatment or service. Deceptive or misleading information (such as omission of significant, permanent memory loss as an effect of electroshock) would violate the right to free and informed consent, and consent obtained through deception should be treated as coercion since it does not express the person's free will.

II. LEGAL CAPACITY

It is perhaps unfair to give second place to legal capacity, when it is the most revolutionary of the new norms articulated in the CRPD. For the purposes of this paper, however, it does seem to follow a logical order. The right to free and informed consent is, or requires, an exercise of legal capacity, and without a guarantee of equal legal capacity to persons with disabilities, the right to free and informed consent would offer little if any guarantee against forced psychiatric interventions.

CRPD Article 12(2) states, "States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life."[13] This guarantee is the heart of the Convention for people with psychosocial disabilities. All laws directed at restricting our freedom and self-determination are premised on an equation of psychosocial disability with legal incapacity, and legal incapacitation is the primary way that the law deals with persons with psychosocial disabilities. A guarantee of legal capacity on an equal basis with others in all aspects of life should result in the elimination of all such legal regimes.

The Convention replaces the dualistic model of capacity versus incapacity with an equality-based model that complements full legal rights to individual autonomy and self-determination with entitlement to support when needed, to ensure substantial equality of opportunities to exercise those rights. It is a model that reflects established principles in international human rights, such as the universality, indivisibility, interdependence, and inter-relatedness of all human rights,[14] and the recognition that the realization of economic, social and cultural rights are necessary to the dignity and free development of the personality of

13. *Id.* art. 12(2).

14. World Conference on Human Rights, June 14-25, 1993, *Vienna Declaration and Programme of Action*, ¶¶ 63-65, U.N. Doc A/CONF. 157/23 (July 12, 1993).

any individual.[15]

Application of this support model to the needs of persons with psychosocial disabilities will require innovation and should draw on existing programs that may not have been understood as support in the exercise of legal capacity. Peer support, recovery-based services, community support networks, and personal assistance may all help people with psychosocial disabilities in ways related to decision-making or the exercise of legal capacity. A program developed in Skåne, Sweden by users and survivors of psychiatry and funded by the Swedish government provides "personal ombudsperson" (PO) service to people who have "mental health problems of the most difficult sort (living entirely in a symbolic world of their own, living barricaded in their apartments, or living homeless in the streets)."[16] The PO is accountable entirely to the client, under full confidentiality and keeping no permanent records, and must work patiently to establish a relation and wait until the client "knows and dares to tell" what he or she needs.[17] It is a successful program that accommodates people with psychosocial disabilities who would not seek or accept such services under other conditions. In addition, advance crisis planning and designation of supporters/advocates can be adapted from the incapacity context where it was developed (as advance directives and health care proxies) to a full capacity context where it can function more effectively to ensure selfdetermination.[18]

Children do not have legal capacity on an equal basis with adults; however, the "evolving capacities" of children with disabilities are recognized[19] and they have equal rights with other children to freely express their views, which are to be given due weight in accordance with the child's age and maturity, on matters concerning themselves.[20] Children with disabilities are further entitled to disability and age-appropriate assistance in realizing this right, applying the support model to children's decision-making.

15. Universal Declaration of Human Rights, G.A. Res. 217A, at 22, U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc A/810 (Dec. 12, 1948).

16. PO-Skåne – Personal Ombudspersons in Skåne, *available at* http://www.peoplewho.org/documents/jesperson.decisionmaking.doc (last visited Mar. 23, 2007).

17. Id.

18. See id.

19. CRPD, *supra* note 1, art. 3(h).

20. Convention on the Rights of the Child, G.A. Res. 44/25, art. 12(1), U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/RES/44/736 (1989) [hereinafter CRC]; CPRD, *supra* note 1, art. 7(3).

If legal capacity is limited for reasons unrelated to disability, such as a person's status as convicted criminal, the CRPD requires that persons with disabilities be treated equally with others, and such limitations must not violate other norms. In particular, free and informed consent, as it protects the integrity of the person, may not be restricted due to any status imposed as a consequence of criminal behavior.[21]

A. Interpretation of "Legal Capacity"

Legal capacity refers to an individual's status and authority within a given legal system. It encompasses both passive rights (such as ownership or inheritance of property) and active rights (such as the rights to conclude contracts, administer property, appear in court as a party or witness, or give or refuse consent to medical procedures).

In legal systems that distinguish between "capacity for rights" and "capacity to act," the term "legal capacity" is best translated as "capacity to act" or as a combination of both. Capacity to act implies personal authority to exercise rights and responsibilities; without it, a person may have rights and responsibilities in name only, and decision-making authority can be transferred to another person or institution. Capacity to act presupposes the capacity to have rights.

The official U.N. translations of the term "legal capacity" in Article 12(2) are inconsistent; some refer to the capacity to act, some refer to the capacity for rights, and one incorporates both.[22] This should not be an obstacle to a universal interpretation; the approach most consistent with the object and purpose of the treaty (full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities[23]) is to guarantee all aspects of legal capacity on an equal basis to persons with disabilities. There is precedent for this approach in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Committee's interpretation of "legal capacity" in CEDAW Article 15 as referring to the capacity to

21. *See Situation of Detainees at Guantánamo Bay*, *supra* note 3, ¶ 82.

22. The Arabic translation of "legal capacity" is "ahlia al qanounia," incorporating both capacity to act and capacity for rights; the Chinese is "falv quanli nengli" meaning capacity for rights; the French is "capacité juridique" meaning capacity to act; the Russian is "pravosposobnost" meaning capacity for rights; the Spanish is "capacidad jurídica" meaning capacity for rights. The English term "legal capacity" in the original text means capacity to act. International Disability Caucus, Communication on the Translation of Legal Capacity (Oct. 19, 2006).

23. CRPD, *supra* note 1, art. 1.

act, despite translations that suggest otherwise.[24]

Controversy erupted over the insertion and later removal of a footnote to Article 12(2) restricting the meaning of legal capacity in three of the six official U.N. languages to "capacity for rights."[25] Removal of the footnote reaffirmed the intent of the community of nations to guarantee legal capacity universally and without limitations.

Interpretive statements made by some delegations demonstrate that equal legal capacity will require vigilance in implementation and monitoring. A group of countries in the Arab region expressed the opinion that legal capacity in Article 12 should be limited to the capacity for rights, "in accordance with the national laws of these countries."[26] Such an interpretation must be rejected, since it discriminates against persons with disabilities and elevates national law above international human rights. Canada's opinion that the phrase "equal basis with others" does not require true equality but only a rebuttable presumption[27] must likewise be rejected as a form of

discrimination. Other countries, supported by the International Disability Caucus, expressed an opposing point of view; both Chile and the Philippines supported the capacity to act,[28] and the European Union (EU) along with others insisted that legal capacity have a universal interpretation,[29] in contradiction to the group that sought limitation

24. Comm. on the Elimination of Discrimination against Women, *Report of the Committee on Elimination of Discrimination against Women, General Recommendation 21: Equality in Marriage and Family Relations*, art. 15, cmt. ¶¶ 7-8, U.N. Doc. A/49/38(SUPP) (Jan. 1, 1994). A survey of concluding observations revealed that CEDAW does not apply disparate standards, but uses the term "legal capacity" with the same meaning, irrespective of the language used by the State Party, with an emphasis on the capacity to act.

25. The footnote in Article 12 of the Draft Convention on the Right of Persons with Disabilities reads, "In Arabic, Chinese and Russian, the term 'legal capacity' refers to 'legal capacity for rights,' rather than 'legal capacity to act.'" U.N. Econ. & Soc. Council [ECOSOC], Ad Hoc Comm. on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, U.N. Doc. A/AC.265/2006/L.6 (Aug. 14-25, 2006).

26. Letter from Hamad al Bayati, Chairman of the Group of Arab States for December 2006, Permanent Representative of Iraq to the United Nations, to the Chairman of the Ad Hoc Committee on Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, U.N. Doc. A/AC.265/2006/5 (Dec. 5, 2006).

27. *See* U.N. Enable, Contributions by Governments: Canada, *available at* http://www.un.org/esa/socdev/enable/rights/ahc7canada.htm (last visited Mar. 23, 2007).

28. *See* U.N. Enable, Contributions by Governments: Philippines, *available at* http://www.un.org/esa/socdev/enable/convstatementgov.htm#phi (last visited May 3, 2007). (Personal notes on the statements made by Chile, on file with author).

29. Letter from Kristi Lintonen, Representative of the Presidency of the European Union, Permanent Representative of Finland to the United Nations, to Chairman of the Ad

based on national laws.

III. RIGHT TO RESPECT FOR PHYSICAL AND MENTAL INTEGRITY

CRPD Article 17 recognizes a right of persons with disabilities to respect for physical and mental integrity, on an equal basis with others.[30] It may be fitting that the first recognition of the right to respect for integrity at the international level comes in connection with disability, reaffirming that disability is not a loss of physical or mental integrity, but a situation in which people possess their own physical and mental integrity that deserves respect equally with others. This "[r]espect for difference and acceptance of persons with disabilities as part of human diversity and humanity"[31] complements the legal recognition of individual autonomy and self-determination contained in Article 12, and provides another basis for understanding forced psychiatric interventions as a human rights violation.

The right to respect for integrity of the person is recognized in regional human rights treaties and may also be seen as a positive and more general expression of the right to be free from torture and cruel, inhuman or degrading treatment or punishment. As interpreted by the Human Rights Committee, ICCPR Article 7 aims "to protect both the dignity and the physical and mental integrity of the individual."[32]

The treatment of the right to respect for integrity in regional treaties may provide additional guidance as to how it should be interpreted in the CRPD. In the American Convention on Human Rights, it is part of the article on torture and humane treatment of persons deprived of liberty.[33] It is non-derogable (as, of course, is ICCPR Article 7). The jurisprudence interpreting this right has

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Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, U.N. Doc. A/AC.265/2006/6 (Dec. 5, 2006).

30. CRPD, *supra* note 1, art. 17. Article 17 reads in full: "Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others." *Id.*

31. *Id.* art. 3(d).

32. Office of the High Comm'r for Human Rights, Human Rights Comm., *Compilations of general comments and general recommendations adopted by Human Rights Treaty Bodies*, at 30, U.N. Doc. HRI/GEN/1/Rev.1 (July 29, 1994) (referring to General Comment 20, ¶ 2).

33. Organization of American States, American Convention on Human Rights art. 5, Nov. 22, 1969, O.A.S.T.S. No. 36, 1144 U.N.T.S. 123. Paragraph 1 states "Every person has the right to have his [or her] physical, mental and moral integrity respected." *Id.* art. 5(1). The inclusion of moral integrity is interesting and useful, and seems to correspond to the prohibition of degrading treatment.

emphasized the context of deprivation of liberty, but extends also to persons affected by the deprivation of liberty of a family member, and violations that seem close in nature to cruel, inhuman and degrading treatment. In the European Charter of Fundamental Rights, the right to respect for integrity is coupled with a list of aspects of this right that must be respected in the medical and biological fields, including "free and informed consent of the person concerned, according to the procedures laid down by law."[34] Any laws regarding free and informed consent would have to comply with non-discrimination and equal recognition of legal capacity, as discussed above, and the provision does not appear to allow for any substantive regulation or limitation of the right, consistent with its elevation as an aspect of respect for integrity of the person. The African Charter on Human and People's Rights, alone among the regional treaties, addresses the right in somewhat ambiguous terms, declaring that "[h]uman beings are inviolable" and have the right to life and integrity of the person, yet provides only that no one shall be deprived arbitrarily of this right.[35] To summarize, the most protective interpretation of the right to respect for integrity, as derived from the Human Rights Committee General Comment and the regional treaties, is that it is non-derogable, includes respect for free and informed consent of the person concerned, is closely related with the prohibition of torture and cruel, inhuman or degrading treatment or punishment, and is understood broadly to protect against acts done in a public or private capacity.

IV. TORTURE AND CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

CRPD Article 15 prohibits torture and cruel, inhuman or degrading

34. Charter of Fundamental Rights of the European Union art. 3, 2000 O.J. (C 364) 1, 9. Article 3 reads in full:

> Right to the integrity of the person
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> 1) Everyone has the right to respect for his or her physical and mental integrity.
> 2) In the fields of medicine and biology, the following must be respected in particular:
>
> – the free and informed consent of the person concerned, according to the procedures laid down by law,
>
> – the prohibition of eugenic practices, in particular those aiming at the selection of persons,
>
> – the prohibition on making the human body and its parts as such a source of financial gain,
>
> – the prohibition of the reproductive cloning of human beings.

Id.

35. African Union, African Charter on Human and Peoples' Rights art. 4, June 27, 1981, O.A.U. Doc. CAB/LEG/67/3 Rev. 5, 21 I.L.M. 59.

treatment or punishment, including nonconsensual medical experimentation, and requires states to take effective measures to prevent persons with disabilities, on an equal basis with others, from being subjected to such treatment. While the provisions of CRPD discussed above may be sufficient to protect against all nonconsensual psychiatric interventions, it is important to also address them as a form of torture or cruel, inhuman or degrading treatment or punishment. The provisions of international law prohibiting torture and cruel, inhuman or degrading treatment or punishment are among the most serious obligations placed on any state; the prohibition of torture in particular has the status of a peremptory norm of international law that can never be derogated and is imposed independent of whether a state is party to any particular treaty. Cruel, inhuman, and degrading treatment or punishment, unlike torture, is not defined in international law, but similar preventive obligations apply, and these obligations also require eliminating conditions that facilitate torture or cruel, inhuman or degrading treatment or punishment.

The Human Rights Committee has considered cases in which nonconsensual psychiatric intervention was alleged to violate ICCPR Article 7, but most were found inadmissible on procedural grounds[36] or unsubstantiated for lack of sufficient argument or information.[37] In one case, a prisoner alleged repeated injections with psychiatric drugs over a period of three years, but it is unclear whether the Committee considered this fact in its conclusion that the complainant had been subjected to inhuman treatment.[38] The Human Rights Committee and the Committee Against Torture have also addressed inhuman and degrading treatment in psychiatric institutions including the use of cage beds,[39] and the European Committee to Prevent Torture has prohibited

36. *See, e.g.*, T.P. v. Hungary, Decision of the Human Rights Committee under the International Covenant on Civil and Political Rights concerning Comm'n No. 496/1992, U.N. Doc. CCPR/C/47/D/496/1992 (Apr. 1, 1993); K.L.B.-W. v. Australia, Decision of the Human Rights Committee under the International Covenant on Civil and Political Rights concerning Comm'n No. 499/1992, U.N. Doc. CCPR/C/47/D/499/1992/Rev. 1 (June 7, 1993); Mohamed Refaat Abdoh Darwish v. Austria, Decision of the Human Rights Committee under the International Covenant on Civil and Political Rights concerning Comm'n No. 679/1996, U.N. Doc. CCPR/C/60/D/679/1996 (July 28, 1997).

37. *See, e.g.*, Bozena Fijalkowska v. Poland, Decision of the Human Rights Committee under the International Covenant on Civil and Political Rights concerning Comm'n No. 1061/2002, U.N. Doc. CCPR/C/84/D/1061/2002 (July 11-19, 2005).

38. *See* Antonio Viana Acosta v. Uruguay, Decision of the Human Rights Committee under International Covenant on Civil and Political Rights concerning Comm'n No. 110/1981, U.N. Doc. CCPR/C/OP/2 (Mar. 29, 1984).

39. *See, e.g.*, U.N. Human Rights Comm., *Report of the Human Rights Committee Vol. I*, at 54, ¶ 82(13), U.N. Doc. A/58/40 (1993) (discussing the use of cage beds in Slovakia).

the use of direct electroshock irrespective of the medical judgment of any doctor or hospital in favor of this method of treatment,[40] demonstrating a willingness to apply their mandate in the psychiatric setting even to matters of purportedly therapeutic treatment. The European Court of Human Rights has rejected claims that nonconsensual psychiatric interventions amount to torture, inhuman or degrading treatment or punishment, articulating a standard of therapeutic necessity that permits force to be used "to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom [the medical authorities] are therefore responsible."[41] This standard, based on a premise of incapacity, is incompatible with CRPD Article 12(2) and should no longer be regarded as valid.

Nonconsensual psychiatric and medical interventions have been contemplated as torture or cruel, inhuman or degrading treatment in treaty negotiations and by U.N. Special Rapporteurs. In the development of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), Portugal proposed an amendment stating that the use of psychiatry for any of the purposes in paragraph 1 would be regarded as torture.[42] In the CRPD negotiations, the first working text of the article on torture and cruel, inhuman or degrading treatment or punishment included a provision protecting persons with disabilities from "forced interventions and forced institutionalisation [sic] aimed at correcting, improving or alleviating any actual or perceived impairment."[43] This would have included medical interventions and other practices such as religious ceremonies that aim to eradicate an actual or perceived impairment against the person's will. Although the provision drew a great deal of support, there was resistance to adding to the concept of torture and cruel, inhuman or degrading treatment or punishment and interpretation in the disability context is left to the implementation and monitoring

40. *European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment, The CPT Standards*, at 55, ¶ 39, CPT/Inf/E (2002), *available at* http://www.cpt.coe.int/en/documents/eng-standards-scr.pdf (last visited Mar. 27, 2007).

41. Herczegfalvy v. Austria, App. No. 10533/83, 15 Eur. H.R. Rep. 437, ¶ 82 (1992).

42. J. HERMAN BURGERS & HANS DANELIUS, THE UNITED NATIONS CONVENTION AGAINST TORTURE: A HANDBOOK ON THE CONVENTION AGAINST TORTURE AND OTHER CRUEL, INHUMAN, OR DEGRADING TREATMENT OR PUNISHMENT 42 (1988).

43. Ad Hoc on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, Working Group to the Ad Hoc Comm., *Report of the Working Group to the Ad Hoc Committee*, art. 12, ¶ 2, U.N. Doc. A/AC.265/2004/WG.1 (Jan. 16, 2004).

process.[44]

The first U.N. Special Rapporteur on Torture listed among methods of physical torture, "[a]dministration of drugs, in detention or psychiatric institutions, . . . [including] neuroleptics, that cause trembling, shivering and contractions, but mainly make the subject apathetic and dull his intelligence. . . ."[45] The Special Rapporteur analyzed the nature of torture in terms that capture the experience of being drugged or electroshocked against one's will:

> What distinguishes man from other living beings is his individual personality. It is this individual personality that constitutes man's inherent dignity, the respect of which is, in the words of the preamble of the Universal Declaration of Human Rights, "the foundation of freedom, justice and peace in the world." It is exactly this individual personality that is often destroyed by torture; in many instances, torture is even directed at wiping out the individual personality. Torture is the violation par excellence of the physical and mental integrity – in their indissoluable interdependence – of the individual human being. Often a distinction is made between physical and mental torture. This distinction, however, seems to have more relevance for the means by which torture is [practiced] than for its character. Almost invariably the effect of torture, by whatever means it may have been [practiced], is physical and psychological. Even when the most brutal physical means are used, the long-term effects may be mainly psychological, even when the most refined psychological means are resorted to, there is nearly always the accompanying effect of severe physical pain. A common effect is the disintegration of the personality.[46]

More recently, a group of five U.N. Special Rapporteurs investigating the situation of detainees at Guantánamo Bay considered violent force-feeding of detainees on hunger strike to be torture, following a similar precedent in the European Court of Human Rights,[47] and also concluded that force-feeding and drugging violated the right to

44. *See* Unofficial Daily Summaries of Negotiations, *available at* http://www.un.org/esa/socdev/enable/rights/ahc5sum28jan.htm and http://www.un.org/esa/socdev/enable/rights/ahc5sum4feb.htm (last visited May 19, 2007).

45. Special Rapporteur, *Report of the Special Rapporteur on the Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ¶ 119, U.N. Doc. E/CN.4/1986/15 (Feb 19, 1986), *available at* http://ap.ohchr.org/documents/E/CHR/report/E-CN_4-1986-15.pdf (last visited Mar. 27, 2007).

46. *Id.* ¶ 4.

47. Nevmerzhitsky v. Ukraine, App. No. 54825/00, 43 Eur. H.R. Rep. 32 (2005). *See Situation of Detainees at Guantánamo Bay*, *supra* note 3, ¶ 54, n.73 (noting the judgment on force feeding in Nevmerzhitsky v. Ukraine).

health since informed consent is "essential, [as it is a] 'logical corollary' [of] the right to refuse treatment."[48] This reaffirms that medical judgment cannot override individual autonomy. Further, medical procedures used in ways that harm rather than heal may amount to torture.

B. Consideration of Nonconsensual Psychiatric Interventions in Light of the Definition of Torture

The principle of non-discrimination and the obligation in CRPD Article 15(2) to prevent torture and cruel, inhuman or degrading treatment or punishment from being done to persons with disabilities, on an equal basis with others, requires serious consideration of whether, and under what circumstances, nonconsensual psychiatric interventions can amount to torture, under definitions in use in international law.

The Inter-American Convention to Prevent and Punish Torture goes the farthest of any human rights instrument in directly prohibiting the use of techniques aimed at the disintegration of the personality or reduction of physical or mental capacities, which would include psychotropic drugs and brain-damaging procedures like electroshock and psychosurgery.[49] Such methods are defined as torture, irrespective of whether they cause pain or suffering. This acknowledges destruction for its own sake as a type of torture, unlike the complex definition in CAT, which requires purpose and the intentional infliction of pain and suffering. While the CAT definition can also be seen to apply to nonconsensual psychiatric interventions, it is easier to see the relationship to the Inter-American definition, which is acknowledged to refer to mind-control techniques including use of chemical substances.[50]

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48. *Situation of Detainees at Guantánamo Bay*, *supra* note 3, ¶ 82.

49. *See* Organization of American States, Inter-American Convention to Prevent and Punish Torture, Sept. 12, 1985, O.A.S.T.S. No. 67, 25 I.L.M. 519.

> For the purposes of this Convention, torture shall be understood to be any act intentionally performed whereby physical or mental pain or suffering is inflicted on a person for purposes of criminal investigation, as a means of intimidation, as personal punishment, as a preventive measure, as a penalty, or for any other purpose. *Torture shall also be understood to be the use of methods upon a person intended to obliterate the personality of the victim or to diminish his physical or mental capacities, even if they do not cause physical pain or mental anguish.*
>
> The concept of torture shall not include physical or mental pain or suffering that is inherent in or solely the consequence of lawful measures, provided that they do not include the performance of the acts or use of the methods referred to in this article.

Id. art. 2 (emphasis added).

50. *See* Andrew Byrnes, *Torture and other Ofenses Involving the Violation of the Physical or Mental Integrity of the Human Person, in* SUBSTANTIVE AND PROCEDURAL

It also helps to distinguish nonconsensual psychiatric interventions from consensual treatment. The voluntary use of inherently harmful substances or procedures should not be considered torture, but may be the subject of regulation, particularly where medical practices are involved, to protect the public against harm where alternatives may be available.

The CAT definition is the most widely applicable. It reads:

> For the purposes of this Convention, the term torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.[51]

This can be broken down into the following elements, which will be addressed in turn.

- Severe physical or mental pain or suffering
- Intentionally inflicted
- For purposes such as:
    - Obtaining information or a confession
    - Punishment
    - Intimidation or coercion
    - Any reason based on discrimination of any kind
- By or at the instigation of or with consent or acquiescence of a public official

1. Severe Mental or Physical Pain or Sufering

Severity of pain and suffering experienced by the victim varies,

ASPECTS OF INTERNATIONAL CRIMINAL LAW 214 (Gabrielle Kirk McDonald et al. eds., 2000).

51. Convention Against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res. 39/46, at 1, U.N. Doc. A/RES/39/46 (Dec. 10, 1984) [hereinafter CAT].

depending on the particular methods used, duration, context, and personal characteristics (such as age and health, and feelings or beliefs about the experience). As Andrew Byrnes has pointed out, "pain and suffering" might be understood to include not only the conscious experience of the victim but also the effects of certain methods on deeper levels of the personality, and subsequent physical and psychological effects.[52] First person accounts attest to both physical and mental pain and suffering caused by nonconsensual administration of neuroleptic drugs, electroshock, and other psychiatric interventions, at the time of the experience and extending long afterwards. Electroshock is experienced by many as a death of part of the self, due in part to its destruction of chunks of memory and identity.

Electroshock is terrifying, especially if administered without anesthesia or muscle relaxants the body shakes in a convulsion that can cause fractures. (However, use of anesthesia and muscle relaxants in "modified electroshock" necessitates the use of more electricity to achieve a seizure, which can cause increased brain damage.) Neuroleptic drugs can have a similar effect of loss or separation from self, causing terror and panic that may lead to desperate acts. Neuroleptic drugs have the signature effects of psychic apathy or numbing and movement disorders such as akathisia (extreme restlessness and agitation) with a psychological as well as physical manifestation. David Cohen, in a meta-analysis of psychiatric literature on neuroleptic drugs, offers the following:

> Almost all of [SANELINE's] callers report sensations of being separated from the outside world by a glass screen, that their senses are numbed, their willpower drained and their lives meaningless. It is these insidious effects that appear to trouble our callers much more than the dramatic physical ones, such as muscular spasms.[53]

> [T]he problem [of akathisia] is often subjective, described differently by patients: inability to sit still, a sense of gloom and anxiety originating in the abdomen, restless legs, and so forth. In "mild" cases, the individual may show no visible movement (especially if there is a co-occurring akinesia) but nevertheless feel significant psychic agitation or muscular tension. When visible, the motor agitation typically takes the form of shifting weight from foot to foot or walking on the spot, inability to keep legs still, shifting of body

52. *See* Byrnes, *supra* note 50, at 215.

53. David 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).

> position while sitting. Akathisia . . . is often mistaken for psychotic agitation; this may result in a NLP dose increase, which worsens the akathisia. . . . In extreme cases, it has led to suicide and homicide.
>
> Akathisia is frequently accompanied by a dysphoric mental state, described by some normal subjects as a "paralysis of will." A medical student who received 1 mg of HPL [haloperidol, frequently used neuroleptic] described the sensation of an external force forcing him to move. [Researchers] described the case of a 34-year-old man on fluphenazine who developed a severe akathisia and attributed his agitation to an external force. . . . [Other researchers] described patients who experienced psychotic flare-ups, making statements such as "A woman tried to strangle me last night," "I burn inside," and "A pair of pliers squeezed my body and throat." However, the authors stressed that the symptoms were subjective accounts of objective manifestations of disturbing EPS [extra-pyramidal symptoms, such as akathisia].[54]

A great deal more could be written on the known effects of neuroleptic and other psychiatric drugs, electroshock and psychosurgery, both from scientific literature and first-person accounts. Long-lasting harm from electroshock includes permanent memory loss and cognitive difficulties. Neuroleptics cause a variety of "tardive" or late-appearing syndromes, particularly movement disorders that are also usually permanent. Both electroshock and neuroleptics can wreak havoc in people's lives, by virtue of the psychological trauma caused by the direct effects of those methods (e.g., death of the self or destruction of part of the self) and by being subjected to such treatment at the hands of fellow human beings. The extent and type of suffering is comparable to other methods that have been understood to amount to torture.

Aggravating factors in the context and personal characteristics of victims emphasize the violation. The context of nonconsensual psychiatric interventions is usually under loss of liberty where length of detention is indeterminate and may depend on one's apparent compliance with arbitrary standards. Many people are taken in their late teens or early twenties, before they have had a chance to experience their adult powers and competencies. Most, but not all, are taken when they are in the midst of intense psychological experiences, so that the suffering caused by additional trauma can be unbearable.

2. Intentionally Inflicted

The intent required under CAT is general intent, rather than

54. *Id.* at 206 (internal citations omitted).

specific intent, that the victim experience severe mental or physical pain or suffering. If certain acts by their very nature cause severe mental or physical pain or suffering, a perpetrator cannot claim benign intent. The signature effects of neuroleptic drugs, electroshock, and similar methods are well documented both in psychiatric literature and in first-person accounts.[55] The controversy over therapeutic use of toxic psychotropics is also well known, with many individuals having strong feelings and beliefs against such use. Administration of such substances or procedures against a person's will, requiring the overcoming of resistance by intimidation or physical force, can only be seen as a hostile act, within the meaning of intentional infliction of severe mental or physical pain or suffering.

3. For Purposes Such As: Obtaining Information or a Confession, Punishment, Intimidation or Coercion, or Any Reason Based on Discrimination of Any Kind

The purposes enumerated are not an exhaustive list, but may encompass other similar purposes as appropriate. The purpose of obliterating or destroying an individual's personality or diminishing his or her physical or mental capacities should be incorporated into the interpretation of the CAT definition. It would not be identical to the Inter-American Convention definition, since pain and suffering would remain as an element to be shown, but the destruction of the individual by overcoming his or her will and resistance, independent of any other purpose, is central to the act of torture and its recognition as such would be appropriate. Changing the personality, which entails destruction of identity, self-concept, relationship to the world, and inner subjective experience, may be a process of growth when embarked on by choice – however, when imposed by another person, it is violent in the extreme, irrespective of the rationale of the perpetrator. Similarly, diminishing the capacity for intense experiences may be sought with the aid of

55. *See id.;* PETER BREGGIN, PSYCHIATRIC DRUGS: HAZARDS TO THE BRAIN (1983); ROGER BREGGIN, ELECTROSHOCK: ITS BRAIN DISABLING EFFECTS (1979); ELLIOT VALENSTEIN, GREAT AND DESPERATE CURES: THE RISE AND DECLINE OF PSYCHOSURGERY AND OTHER RADICAL TREATMENTS FOR MENTAL ILLNESS (1986); ELLIOT VALENSTEIN, BLAMING THE BRAIN: THE TRUTH ABOUT DRUGS AND MENTAL HEALTH (1998). For first person accounts, *see, e.g.*, MindFreedom, Personal Stories, www.mindfreedom.org/personal-stories/personal-stories/ (last visited Mar. 26, 2007); Center for Advocacy in Mental Health (CAMH), First Person Stories on Forced Interventions and Being Deprived of Legal Capacity, http://www.camhindia.org/first_person_stories.html (last visited Mar. 26, 2007); ECT.org, Personal Stories of Electroconvulsive Therapy, http://www.ect.org/category/personalaccounts/ (last visited Mar. 26, 2007).

psychotropic drugs of various kinds, but imposed by another person it constitutes a terrible subjection and loss. These purposes are the essence of psychiatric interventions, and can only be redeemed by fully free and informed consent.

Obtaining information and a confession, in the psychiatric context, is related to the purpose of changing or undermining the personality. It has been said that psychiatrists want to obtain a confession of mental illness, as a sign of capitulation. Yet even then, the abuse does not stop. It is only intensified, since the medical paradigm of mental illness does not allow for cure or recovery, but only management through repressive interventions that diminish a person's global capacities for thought, emotion, concentration, creativity and spontaneous action. Obtaining information or a confession is also part of a larger dynamic of winning the loyalty of the person and betrayal of former beliefs or comrades. This self-betrayal is one of the aims of coercive psychiatry, in that the person is pressured to accept a self-definition based on deficit rather than strength, to see him or herself through the eyes of others, as deserving of management rather than self-determination. Unfortunately, in the absence of meaningful alternatives, this purpose often succeeds.

Punishment is often implicit in nonconsensual psychiatric interventions, starting with deprivation of liberty and continuing with unrestrained cruelty and dehumanizing treatment, such as physical restraints, accompanied by injection of neuroleptics or administration of electroshock. The experience is one of being punished not so much for specific acts, but for having caused concern, annoyance, or anger in others. While modern psychology rejects such blaming of victims, it is still the rule in the practice of nonconsensual psychiatry.

Psychiatry is also used to punish people for socially nonconforming behavior and political activities and ideologies, and cruel treatment is often heightened against people who complain about mistreatment or injustice inside psychiatric institutions. Such punishment may involve increased use of neuroleptics and electroshock, as well as restraint and seclusion, restriction of visitors, and physical and sexual assault. Electroshock in particular has been exposed as punishment-oriented,[56] and this is likely true of neuroleptics as well.[57]

56. A writer in the U.K., who wishes to remain anonymous but allowed me access to her arguments regarding electroshock (ECT) punishment (on file with author) [herein after Anonymous Author's Arguments]. She writes:

> There is another aspect to the business of ECT as punishment besides the patient's view that it punishes (as interpreted by psychiatrists), and this is the attitudes of the

Electroshock has been used predominantly on women, and male doctors have called it a "mental spanking" to chastise reluctant women into

psychiatrists who inflict ECT on vulnerable recipients. Abse, with Ewing, in a several page analysis of the attitudes of shock therapists, described an attitude of thinly veiled hatred and violence towards patient-victims. Their list of "Statements of shock therapists in USA and Britain" includes,

> "Hit him with all we've got."
> "Knock him out with EST."
> "Why don't you put him on the assembly line?"
> "If he would not get any better with one course, give him a double-sized course now."
> "The patient was noisy and resistive so I put him on intensive ECT three times a day."
> "The psychiatrist had. . .given his opinion that it [ECT] would prove beneficial to the patient [a female alcoholic] by virtue of its effect as 'A mental spanking.'"
> "She's too nice a patient for us to give her ECT."

Anonymous Author's Arguments (citing Abse & Ewing, *Transference and Countertransference in Somatic Therapies*, J. NERVOUS & MENTAL DISEASES (1956)). Abe and Ewing commented on statements made by User psychiatrists,

> Clearly the main attitudes expressed are those of hostility and punishment. . .
> In one hospital which employed a large number of relatively untrained personnel, it was clear that such members of the staff used ECT as a threat. Even non-psychotic voluntary patients reported threats of "You will go on the shock list" for such a lack of cooperation as disinclination to eat a full meal! Certainly such openly threatening remarks are usually confined to the least understanding and most junior attendants who are enjoying a new sense of power. This is sometimes connected with an unconscious participation in the "omnipotence" of the shock therapist.

Id.

Ruffin [and others] conducted interviews to ascertain the attitudes of nurses, student nurses and attendants assisting with both ECT and ICT and they found that,

> Not one of the 34 insulin ward personnel was judged to look upon this treatment as a means of controlling or punishing difficult patients. However, nearly a third of the [25] electroconvulsive personnel regarded shock as a controlling or punitive device. The auxiliary personnel. . .seemed to share many of the attitudes described as common among shock therapists. . .The bare suggestion in our results of more grossly sadistic, destructive fantasies associated with electro-shock adds some weight to this conception.

Anonymous Author's Arguments (citing Ruffin, et al., *Attitudes of Auxiliary Personnel Administering Electroconvulsive and Insulin Coma Treatment: a Comparative Study*, 131 J. NERVOUS & MENTAL DISEASES 241-46 (Sept. 1960)).

Ruffin *et al.* provided "a few statements of the electroshock group" ward personnel to "clearly indicate the controlling, punitive attitudes often involved in the application of electroshock," including, "I was glad to see it come this week. . .One patient continually wanted pills and whined and complained; now he is better. . .It makes hard to manage patients easy to manage." *Id.*

57. Mental Hygiene Law Court Monitoring Project: Part 1 of Report, *Do Psychiatric Inmates in New York Have the Right to Refuse Drugs? An Examination of Rivers Hearings in the Brooklyn Court, available at* http://psychrights.org/states/newyork/courtmonitoringreport.htm (last visited May 3, 2007) [hereinafter Court Monitoring Report].

assuming a subordinate role to their husbands.[58] A woman of my acquaintance was taken by police to a psychiatric ward, where she was drugged with neuroleptics after her abusive husband called them to complain that she was trying to cut down a tree with a chain saw. Street preachers from certain communities in Brooklyn, New York meet with hostile treatment in the psychiatric system, where their claims of being persecuted for their activities are used against them to rationalize detention and nonconsensual administration of neuroleptics.[59] The use of shock and neuroleptics for behavior control, as evidenced by legal standards for the use of psychiatric drugs in "emergency" situations characterized by a threat of danger to self or others[60] and quality of care standards authorizing use of electroshock to treat behavior that is seen as characteristic of an underlying mental illness,[61] is further evidence of purposes of punishment and coercion, however medicalized.

Intimidation and coercion through nonconsensual psychiatric interventions is accomplished both directly, by the action of psychotropics on the brain and mind, and indirectly, by inducing compliance in the hope of securing release or better conditions of confinement. In some cases the behavior desired by the psychiatrist and institutional staff is clear, as when women are pressured to put on makeup and present a more feminine appearance as a sign of "getting better." In other cases it is less clear what psychiatrists may accept as behavior justifying release, but coercion to adopt some mannerisms or behavior sufficient to demonstrate absence of mental illness is implicit.

In one instance, administration of one drug was used to coerce compliance with another. On a visit to a friend who was incarcerated in a psychiatric ward, I asked the doctor there why she was giving my friend the neuroleptic ziprasidone (trade name: Geodon), which was making her vomit and feel generally miserable. The doctor's answer was to induce her to take risperidone, another neuroleptic that was only available in pills and not injections.

It is likely that such incidents of specific coercion are not rare, given the autocratic power exercised by psychiatrists and other staff in a

58. *See* Bonnie Burstow, *Electroshock as a Form of Violence Against Women*, 12 VIOLENCE AGAINST WOMEN 372 (Apr. 2006), *available at* http://vaw.sagepub.com/cgi/reprint/12/4/372.pdf (last visited Mar. 26, 2007).

59. Court Monitoring Report, *supra* note 57.

60. *See, e.g.*, Rivers v. Katz, 504, N.Y.S.2d 74 (1986).

61. *See* N.Y. STATE COMM'N ON QUALITY OF CARE, SURVEY OF THE PROVISION OF ELECTRO-CONVULSIVE THERAPY (ECT) AT NEW YORK STATE PSYCHIATRIC CENTERS (Aug. 7, 2001), *available at* http://www.cqcapd.state.ny.us/hottopics/ectsurvey.htm (last visited Mar. 26, 2007).

total institution. New technologies are being developed to coerce compliance with psychiatric drugs, in particular an implant that would require surgery to remove, risking death from Neuroleptic Malignant Syndrome, which, if it develops, requires quick preventive action.[62] Legal mechanisms are also being developed that manifest the purpose of coercion. Outpatient commitment is based on the premise that nonconsensual administration of psychiatric drugs can prevent some individuals from engaging in violent acts, and that such nonconsensual intervention on people who are labeled with psychiatric diagnoses is a medical treatment rather than a prohibited interference with individual liberty and integrity.[63] While the purpose of preventing violent behavior is lawful, it cannot be accomplished in a manner that discriminates based on disability or that violates human rights.

Discrimination is different from the other purposes in that it is not necessarily goal-oriented, but a motivation for the prohibited act ("any reason based on discrimination"). Discrimination has been said to create the conditions for torture in that it contributes to dehumanizing the victim, and can make victims less credible or not fully entitled to equal protection in the eyes of police or other authorities to whom they might complain for redress.[64] This is certainly the case with respect to nonconsensual psychiatric interventions. An activist who regularly visited and advocated for people in psychiatric institutions once reported that she was told, "You can't dial 911 [emergency number in use throughout the United States to reach police and other first responders] in here." Discrimination is inherent in nonconsensual psychiatric interventions since the failure to respect free and informed consent and the physical and mental integrity of the person is explicitly based on categorization through psychiatric diagnosis as a person with a psychosocial disability.

62. *See* Canadian Movement Disorders Group, Drug Induced Movement Disorders: Neuroleptic Malignant Syndrome, *available at* http://www.cmdg.org/Movement_/drug/Neuroleptic_Malignant_Syndrome/neuroleptic_malignant_syndrome.htm (last visited May 10, 2007).

63. While having committed violent acts is only one of the predicates giving rise to IOC eligibility, it is emphasized in legislative campaigns characterized by disinformation and hate speech, such as a newspaper headline in the fall of 1999 reading large capital letters, "GET THE VIOLENT CRAZIES OFF THE STREETS" and in naming New York's outpatient commitment law for a woman killed by a man who was unsuccessfully seeking psychiatric treatment. *See, e.g.*, *Get the Violent Crazies of the Streets*, N.Y. DAILY NEWS, Nov. 19, 1999, at 1; Kendra's Law, N.Y. [MENTAL HYG.] LAW § 9.60 (McKinney 2007).

64. U.N. Econ. & Soc. Council [ECOSOC], Comm'n on Human Rights, *Civil and Political Rights, Including Questions of: Torture and Detention*, at 11, U.N. Doc. E/CN.4/2002/76 (Dec. 27, 2001) (*prepared by* Sir Nigel Rodley).

4. By or at the Instigation of or with Consent or Acquiescence of a Public Oficial

The CAT definition, unlike ICCPR Article 7, requires some connection with public officials for an act to qualify as torture.[65] In the case of nonconsensual psychiatric interventions, this will ordinarily be the case, since many psychiatric institutions are government-run, and others function under comprehensive and detailed public laws, regulations, and licensing requirements. Where a positive duty exists on the part of government to protect individuals against violence by private actors, and government fails to act, this may constitute acquiescence, particularly if discrimination plays a part in the failure. In rare situations where no laws or regulations govern private institutions, it may well be the case that complicity may be inferred from failure to provide protection or meaningful redress against nonconsensual psychiatric interventions.

C. Obligations

To comply with obligations under CRPD Article 15, as well as ICCPR Article 7, CAT, and the Inter-American Convention to Prevent and Punish Torture, States Parties to those conventions should ensure that their laws on torture and cruel, inhuman or degrading treatment or punishment are applied and enforced in a non-discriminatory manner, including criminal prosecution of cases arising in the psychiatric context, which encompasses nonconsensual interventions. Nonconsensual interventions and other inhuman and degrading practices in the psychiatric context (such as restraint and seclusion, and deprivation of liberty based on psychiatric criteria) should be criminalized in their own right, to ensure clarity and generality with respect to the prohibition of these acts. Asylum should be granted to individuals fleeing psychiatric persecution, whether based on disability or another social or political identity that the individual cannot or should not be required to disavow.[66] Nonconsensual psychiatric interventions should be banned, and effective measures taken to prevent them, in all contexts, including prisons, nursing homes, schools and foster care, as well as in psychiatric institutions. The obligations of CRPD Article 16, on preventing exploitation, violence and abuse, including education of

65. CAT, *supra* note 51.

66. *See* Pitcherskaia v. INS, 118 F.3d 641 (1997) (holding that a lesbian can make a claim of psychiatric persecution notwithstanding the perpetrator's "couching actions that torture mentally or physically in benevolent terms such as 'curing' or 'treating' the victims").

family members and care providers and monitoring of facilities and programs serving people with disabilities, and provision of recovery and reintegration services for victims, respecting autonomy and dignity of the person,[67] should extend to prevention of nonconsensual psychiatric interventions as well. Furthermore, effective prevention requires elimination of conditions that give rise to or facilitate nonconsensual psychiatric interventions, such as deprivation of liberty and loss of control over personal decision-making, and bundling of services that requires individuals to choose between accepting unwanted psychiatric interventions and losing a home or losing services that are wanted.

Obligations also extend to reparations,[68] which have both an individual and a collective dimension. Individuals may require compensation, restoration of previous status and possessions, to the extent possible, and rehabilitation (meaning recovery and reintegration services in this context). Collective measures under the categories of satisfaction and guarantees of non-repetition go beyond individuals, while retaining a concern with individual victims at their center. Such measures include changing laws and policies, retraining, and maintaining an accurate historical record, the development of which can also contribute to building social awareness and overturn historic prejudices. CRPD Article 8 should also be noted with regard to awareness-raising activities;[69] where persons with disabilities have been subjected to extreme forms of exclusion and violence, awareness-raising obligations will need to be a core part of human rights campaigns, without in the least diminishing the immediate obligation to ensure compliance by public officials and refuse to give effect to laws that constitute discrimination.

CONCLUSION

For users and survivors of psychiatry, nonconsensual interventions have been a source of trauma that persists because its disclosure often leads to greater discrimination, including the risk of additional periods of incarceration and forced interventions. With the advent of CRPD, a new era is in the making, in which large numbers of people will no longer have to fear nonconsensual psychiatric interventions and will

67. CRPD, *supra* note 1, art. 16.

68. *See,* Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law, Human Rights Res. 2005/35, U.N. Doc. E/CN.4/RES/2005/35 (April 19, 2005).

69. *See* CRPD, *supra* note 1. art. 8.

have a better opportunity to heal individual trauma and to participate actively in social change. Users and survivors of psychiatry will need to join with others to re-examine the nature of madness and find appropriate ways of supporting people experiencing madness, including non-violent conflict resolution where conflict arises. These changes have already begun, thanks to the movement that began to take shape some thirty years ago, and the norms in CRPD are the fruit of those efforts and give us the ability to come within reach of our long-sought goals.