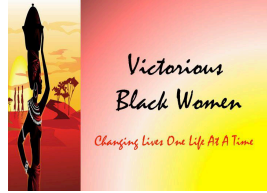


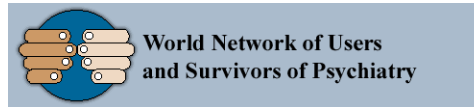


Center for the Human Rights of  
Users and Survivors of Psychiatry



**Repeal Mental Health Laws**

Documenting and challenging forced psychiatric treatment



World Network of Users  
and Survivors of Psychiatry



International  
Disability Alliance

## Joint Submission to Human Rights Committee for its review of the United States in October 2013 on nonconsensual psychiatric medication<sup>1</sup>

This report aims to provide experiential and research-based evidence for the harms done by nonconsensual psychiatric medication, and to urge the Committee to find that this practice violates Article 7 of the Covenant.

### I. Biomedical psychiatry: prejudice and faulty science set the stage for abuse

The prevailing narratives about "mental illness" in the U.S. are rigidly biomedical, locating the "mental illness" in the individual's brain, and the "underlying causes" in the individual's genes. The biopsychiatric narrative requires us to see people experiencing unusual mental phenomena or extreme distress as biologically defective and incapable of exercising agency, and this is both inaccurate and disabling. The World Network of Users and Survivors of Psychiatry considers that forced psychiatry is a harmful cultural practice based in the Global North.<sup>2</sup> There are competing theories in other countries showing better outcomes that do not require acceptance of a "broken brain", forced "treatment", and life-long dependence on psychoactive drugs.<sup>3</sup>

Psychiatric diagnoses are based on the Diagnostic and Statistical Manual (DSM) and contain lists of "symptoms" judged "abnormal" by committees largely composed of global North "experts" with commercial ties to the drug and medical device industries.<sup>4</sup> The DSM does not take social or cultural contexts into account and, according to the Director of the National Institutes of Mental Health (NIMH), there are no laboratory tests, biological markers or any objective assessments for psychiatric disorders.<sup>5</sup>

<sup>1</sup> See Annex III for information about submitting organizations.

<sup>2</sup> WNUSP submission for joint CEDAW/CRC General Recommendation/General Comment on Harmful Cultural Practices (August 31, 2011).

<sup>3</sup> Seikkula J. et al. Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*, March 2006; 16(2): 214\_/228. See also *ibid*.

<sup>4</sup> American Psychiatric Association, DSM-5 Development. <http://www.dsm5.org/MeetUs/Pages/WorkGroupMembers.aspx>.

<sup>5</sup> National Institutes of Health, National Institute of Mental health, Director's Blog, April 29, 2013. <http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml>.

Drug studies are designed and funded by industry and so are inherently biased.<sup>6 7</sup> Unsound clinical trials are then followed by biased publication and dissemination of results of only positive trials in medical journals and general media, by promotion of drugs off-label by physicians to their colleagues, by direct-to-consumer (DTC) ads in the U.S., and by attempts by industry to suppress concerns of government agencies or independent groups to address inadequate or harmful industry practices relating to research.<sup>8</sup>

The Food and Drug Administration (FDA) advisory committees are composed mainly of academic experts with ties to industry. The FDA itself is funded by the drug industry for about 50% of its work, since manufacturers must pay a fee to have a drug reviewed for approval.<sup>9</sup> There have been charges that the FDA considers the drug industry as the "client", rather than the individual human beings in the U.S, and that the FDA is a victim of "regulatory capture" by industry.<sup>10 11</sup> A December 2012 review of FDA policies and practices demonstrates that the agency does not provide "specific guidance on how risk should be related to benefit either qualitatively or quantitatively".<sup>12 13</sup>

The right to exercise free and informed consent is violated when there is no rubric to compare the benefits and harms of psychiatric drugs and the use of electroshock, and the benefits and harms are in fact determined by subjective impressions of professionals with vested interests rather than by the targeted individuals. When such treatments are imposed on unwilling individuals, they not only are unjustified, but inflict serious suffering and injury and amount to torture.

## **II. Harm caused by nonconsensual medication with neuroleptics – research and subjective evidence**

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<sup>6</sup> Moncrieff, J., Wessely, S. & Hardy, R. (1998) Meta-analysis of trials comparing antidepressants with active placebos. *British Journal of Psychiatry*, 172, 227–231.

<sup>7</sup> Robinson, D. S. & Rickels, K. ( 2002) Concerns about clinical drug trials. *Journal of Clinical Psychopharmacology*, 20, 593–596.

<sup>8</sup> Stamatakis E, Weiler R, Ioannidis JP. Undue industry influences that distort healthcare research, strategy, expenditure and practice: a review. *Eur J Clin Invest*. 2013 May;43(5):469-75. doi: 10.1111/eci.12074.

<sup>9</sup> U.S. Department of Health and Human Services. Food and Drug Administration. Prescription Drug Amendments of 1992. Prescription Drug User Act of 1992. <http://www.fda.gov/RegulatoryInformation/Legislation/FederalFoodDrugandCosmeticAct/FDCAct/SignificantAmendmentstotheFDCAct/PrescriptionDrugAmendmentsof1992PrescriptionDrugUserFeeActof1992/default.htm>

<sup>10</sup> Ray Moynihan. Alosetron: a case study in regulatory capture, or a victory for patients' rights? *BMJ*. 2002 September 14; 325(7364): 592–595. PMID: PMC1124108. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1124108/>

<sup>11</sup> David S. Egilman, Amos H. Presler. Avoiding the Regulatory Capture of the Food and Drug Administration.. *Valentin, ABArch Intern Med*. 2007;167(7):732-733. Doi:10.1001/archinte.167.7.732-b.

<sup>12</sup> Furberg CD, Levin AA, Gross PA, Shapiro RS, Strom BL. The FDA and drug safety: a proposal for sweeping changes. *Arch Intern Med*. 2006 Oct 9;166(18):1938-42.

<sup>13</sup> Lis Y, Roberts MH, Kamble S, J Guo J, Raisch DW. Comparisons of Food and Drug Administration and European Medicines Agency risk management implementation for recent pharmaceutical approvals: report of the International Society for Pharmacoeconomics and outcomes research risk benefit management working group. *Value Health*. 2012 Dec;15(8):1108-18. doi: 10.1016/j.jval.2012.06.019. Epub 2012 Nov 3.

Neuroleptic drugs, also called “antipsychotics,” are the class of medications most often administered without consent in psychiatric institutions. Both scientific research and subjective reports reveal the infliction of severe harm. These drugs, which “cause trembling, shivering and contractions, but mainly make the subject apathetic and dull his/her intelligence,” have been acknowledged since 1986 as a means of physical torture.<sup>14</sup> The Committee on the Rights of Persons with Disabilities identifies forced drugging as a human rights violation and form of torture,<sup>15</sup> and the Special Rapporteur on Torture calls for “an absolute ban on all forced and non-consensual medical interventions” in mental health settings, including the non-consensual use of “mind-altering drugs” as well as psychosurgery, electroshock, seclusion or any other restraints, for long- and short-term application.<sup>16</sup>

## **A. Research evidence**

### **Neuroleptic Medications Are Known and Established to Cause Tangible Medical Harm.**

This harm is significant, reinforcing the Special Rapporteur's concerns that forceful use of neuroleptics, or their use over a person's objections, amounts to torture or ill treatment.<sup>17</sup> These harms include: Dysphoria, Tardive Dyskinesia (TD), Akathisia, Drug-Induced Parkinsonism, Dystonia, Adverse Cardiac Effects, Autonomic Side Effects, Metabolic Syndrome, and, rarely, Neuroleptic Malignant Syndrome (NMS). Additionally, there is concern that neuroleptic medication is at least partially implicated in a well-established 13-30 year loss of life for individuals with psychiatric disabilities. Lastly, research suggests that administration of neuroleptic medication causes permanent structural changes in the brain.

Neuroleptic dysphoria (ND) is an all-inclusive descriptive phrase that encompasses a variety of unpleasant subjective changes in arousal, mood, thinking and motivation induced by neuroleptic drugs.<sup>18</sup> Also sometimes referred to as “neuroleptic-induced anhedonia” this reaction has been described with virtually all conventional neuroleptics, regardless of dose or type of medication.<sup>19</sup> It has been estimated to occur in as many as 60% of persons treated with neuroleptics, and is acknowledged as a frequent reason for persons to refuse to take neuroleptics. The scientific literature has been aware of this phenomenon for nearly fifty years. It is believed to be related to the mechanism of action for these medications, and unavoidable given their intended effects on dopamine neurotransmission.

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<sup>14</sup> Special Rapporteur on Torture, E/CN.4/1986/15, paras 118, 119.

<sup>15</sup> See e.g. CRPD/C/PER/CO/1 para 30.

<sup>16</sup> A/HRC/22/53, para 89(b).

<sup>17</sup> Méndez, Juan. Statement of the Special Rapporteur On Torture, 22nd session of the Human Rights Council. 4 Mar. 2013. Pg 4-7.

<sup>18</sup> Voruganti, L., et. al. “Neuroleptic dysphoria: towards a new synthesis.” *Psychopharmacology (Berl)*. 2004 Jan;171(2):121-32. Epub 2003 Nov 27.  
<<http://www.ncbi.nlm.nih.gov/pubmed/14647964>>

<sup>19</sup> Awad, A., et. al. “Neuroleptic dysphoria: revisiting the concept 50 years later” *Acta Psychiatr Scand* 2005; 111 (Suppl. 427): 6-13.

<http://schizophreniaresearch.files.wordpress.com/2011/01/awadneurolepticdysphoria2005.pdf>.

Akathisia is a very common effect of neuroleptic medication, occurring in as many as 49% of those receiving neuroleptic medications.<sup>20</sup> Individuals experience a sense of inner restlessness, mental unease, unrest or dysphonia. Restless movements, such as rocking from foot to foot, walking on the spot, shuffling and swinging one leg on the other while sitting, may be associated with the subjective experience. Rapid pacing up and down is characteristic of severe cases; such patients may find it impossible to sit, lie or stand in any one position for more than a few minutes.<sup>21</sup> It is the same experience that many withdrawing from opiates feel,<sup>22,23</sup> except that it can become chronic in as many as a third of patients receiving neuroleptic medication. Unfortunately, akathisia is often misdiagnosed as psychotic agitation, with a consequent increase in the dose of antipsychotic, which only leads to further deterioration.

Tardive Dyskinesia (TD) is a movement disorder, occurring after months or years of neuroleptic treatment. It involves random movements in the tongue, lips or jaw as well as facial grimacing, involuntary eye movements, and random movements of the extremities. In addition to causing serious discomfort and impairment of mobility, TD can be extremely embarrassing to a person experiencing it, and frequently carries significant social stigma.<sup>24</sup> The prevalence of tardive dyskinesia is estimated to be 10 to 20 percent of individuals treated with anti-psychotic medications.<sup>25</sup> Once Tardive Dyskinesia develops, complete and persistent reversibility is rare, occurring in as few as 2% of cases.<sup>26</sup> It is frequently lifelong and irreversible, even after discontinuation of medication.

Drug-Induced Parkinsonism has essentially the same symptoms as Parkinson's disease. Parkinsonian symptoms induced by neuroleptics or dopamine depleting drugs cannot be distinguished clinically from those seen in PD.<sup>27</sup> It occurs in 15 to 40 percent of persons taking neuroleptic medication, depending on medication and dose.<sup>28</sup> The symptoms include showing little or no facial expression, soft or slurred speech, shaking hands, stiffness and slowing of movement, and difficulty writing.<sup>29</sup>

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<sup>20</sup> Barnes, T. R. E. (1995). Acute and chronic drug-induced akathisia. Psychiatrists Information Service Monograph Series, 1, 4-6.

<sup>21</sup> Beaumont, G. "Antipsychotics - The Future of Schizophrenia Treatment" *Curr Med Res Opin.* 2000;16(1) <[http://www.medscape.com/viewarticle/407762\\_4](http://www.medscape.com/viewarticle/407762_4)>

<sup>22</sup> "Tardive Akathisia & Tardive Dyskinesia" <<http://www.tardivedyskinesia.com/common-associations/akathisia.php>>

<sup>23</sup> Factor, Stewart, e.d. *Drug Induced Movement Disorders* Malden, MA: Blackwell Publishing, 2005: pp 142

<sup>24</sup> "Tardive Dyskinesia" National Alliance on Mental Illness <[http://www.nami.org/Content/ContentGroups/Hotline1/Tardive\\_Dyskinesia.htm](http://www.nami.org/Content/ContentGroups/Hotline1/Tardive_Dyskinesia.htm)>

<sup>25</sup> "Tardive Dyskinesia" Mental Health America <<http://www.nmha.org/go/information/get-info/tardive-dyskinesia>>

<sup>26</sup> Glazer, W, et. al. "Predictors of improvement in tardive dyskinesia following discontinuation of neuroleptic medication." *The British Journal of Psychiatry* (1990) 157: 585-592 doi: 10.1192/bjp.157.4.585

<sup>27</sup> Hirose, G. "Drug induced parkinsonism: A review" *J Neurol* (2006) 253 [Suppl 3]: III/22-III/24 DOI 10.1007/s00415-006-3004-8 <[http://www.nlem.in.th/sites/default/files/10\\_no2\\_drug\\_induced\\_parkinsonism.pdf](http://www.nlem.in.th/sites/default/files/10_no2_drug_induced_parkinsonism.pdf)>

<sup>28</sup> Marsden C., et. al. (1975) "Spontaneous and drug-induced movement disorders in psychiatric patients." In: Benson DF, Blumer D (eds) *Psychiatric Aspects of Neurologic Disease*. New York, Grune and Stratton, pp 219-226

<sup>29</sup> "Parkinson's disease" Mayo Clinic <<http://www.mayoclinic.com/health/parkinsons-disease/DS00295/DSECTION=symptoms>>

Dystonia typically involves muscle contractions that result in abnormal postures, such as an inability to move one's head due to neck contractions, difficulty swallowing, or a locking of one or both of one's eyes to one side with an inability to redirect one's gaze.<sup>30</sup> Acute dystonia occurs within 48 hours of beginning neuroleptic treatment in 2.5% of those treated.<sup>31</sup>

Adverse Cardiac Effects and Autonomic Side Effects from neuroleptic medications include cardiac arrhythmia, prolonged QT interval, and significant reductions in blood pressure.<sup>32</sup> In 1990 pimozide was reported to have caused 13 deaths among young patients in the United Kingdom who were using dosages in excess of 20 mg a day. In 1996 sertindole was responsible for 16 deaths from cardiac causes among 2,194 patients who participated in clinical trials.

Metabolic Syndrome typically results in significant weight gain and hyperglycemia, and has been shown to include a neuroleptic-increased risk of type 2 diabetes.<sup>33</sup> A person administered second-generation neuroleptic medication has 3.6 times the risk of developing a metabolic syndrome.<sup>34</sup> When it occurs, the onset of diabetes tends to occur within the first few months of treatment with these drugs.<sup>35</sup> Type 2 diabetes is a lifelong condition, which persons with psychiatric diagnoses may already be at increased risk for, rendering the additional risk of this irreversible condition from neuroleptics all the more concerning in the context of force.

Neuroleptic Malignant Syndrome (NMS) is rare but potentially fatal. Prospective studies have provided disparate estimates of the frequency of NMS, ranging from 0.07% to 2.2% among patients receiving neuroleptics.<sup>36</sup> The syndrome is a form of malignant hyperthermia involving muscle contractions and a life-threatening rapid rise in body temperature.

Persons in the public mental health system in the United States experience a 13-30 year loss of life expectancy.<sup>37</sup> While the exact reasons for this loss of life expectancy are in

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<sup>30</sup> Gardos, G. and Cole, J. O. (1995). The evaluation and treatment of neuroleptic-induced movement disorders. *Harvard Rev Psych.*, 33, 130-139.

<sup>31</sup> Rupniak, N, et. al. "Acute dystonia induced by neuroleptic drugs" *Psychopharmacology (Berl)*. 1986;88(4):403-19. <<http://www.ncbi.nlm.nih.gov/pubmed/2871578>>

<sup>32</sup> Fayek, M., et. al. "Psychopharmacology: Cardiac Effects of Antipsychotic Medications" *Psychiatric Services* 2001; doi: 10.1176/appi.ps.52.5.607 <<http://ps.psychiatryonline.org/article.aspx?articleID=85863>>

<sup>33</sup> De Hert, Marc, et. al. "Metabolic syndrome in people with schizophrenia: a review" *World Psychiatry*. 2009 February; 8(1): 15–22. <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2656262/#B1>>

<sup>34</sup> De Hert M, et. al. "Prevalence and incidence rates of metabolic abnormalities and diabetes in a prospective study of patients treated with second-generation antipsychotics." *Schizophr Bull*. 2007;33:560–560.

<sup>35</sup> Lieberman, Joseph A. "Metabolic Changes Associated With Antipsychotic Use" *Prim Care Companion J Clin Psychiatry* 2004;6[suppl 2]:8–13 <<http://www.psychiatrist.com/pcc/pccpdf/v06s02/v06s0202.pdf>>

<sup>36</sup> Adnet, P., et. al. "Neuroleptic malignant syndrome" *Br. J. Anaesth.* (2000) 85 (1): 129-135. doi: 10.1093/bja/85.1.129 <<http://bja.oxfordjournals.org/content/85/1/129.full>>

<sup>37</sup> Colton C., et. al. "Congruencies in increased mortality rates, years of potential life lost, and causes of death among public health clients in eight states." *Prev Chron Dis* 2006;3 (April):1-14. <[http://www.cdc.gov/pcd/issues/2006/apr/pdf/05\\_0180.pdf](http://www.cdc.gov/pcd/issues/2006/apr/pdf/05_0180.pdf)>

dispute, it is likely that the harmful effects of neuroleptic medication, especially the cardiac and metabolic effects, are a contributing factor to this discrepancy between the normal lifespan and that seen by persons with psychiatric disabilities.<sup>38</sup> Even if the contribution of the medications is only partial to this loss of life, the forcible administration of them is tantamount to the forcible deprivation of a significant portion of a human being's life.

Lastly, there is strong evidence that neuroleptic medication produces irreversible changes in the human brain, becoming more pronounced the longer one is on them.<sup>39</sup> Very few studies have been done on nonmedicated patients, and, tellingly, studies of neuroleptic changes to the brains of normal controls would be unconscionable. With the documented risk of changing the brains of human beings – indeed their very essences – free and informed consent of the person concerned is essential. Given the number and variety of irreversible negative effects from neuroleptics, along with the evidence of structural changes induced by them in the brain, the administration of neuroleptic medication by force is akin to maiming. Even if the claims of therapeutic purpose and effect are accepted at face value, it is still maiming if done over the objections of the one so modified.

## **B. Impact of neuroleptics on those affected**

### **The subjective effects of neuroleptic treatment inflict a level of suffering tantamount to torture.**

Neuroleptic medication antagonizes dopamine receptors in the brain, along with a variety of other actions that vary from drug to drug, which is simultaneously the source of its sometimes-desired effects and its significant adverse effects.<sup>40</sup> Although research literature recognizes the existence of Neuroleptic Dysphoria, it does a poor job of communicating the human experience so named.

Leonid I. Plyushch, a soviet mathematician subjected to neuroleptic treatment in 1973, described his experience:<sup>41</sup>

I noted with horror the daily progression of my degradation. I lost interest in politics, then in scientific problems, finally in my wife and children. My speech became blurred; my memory worsened. In the beginning, I reacted strongly to the sufferings of other patients. Eventually I became indifferent. My only thoughts were of toilets, tobacco and the bribes to the male nurses to let me go to the toilet one more time. Then I began to experience a

<sup>38</sup> <http://www.nasmhpd.org/docs/publications/MDCdocs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf>.

<sup>39</sup> Smieskova, R., et. al. "The Effects of Antipsychotics on the Brain: What Have We Learnt from Structural Imaging of Schizophrenia? – A Systematic Review" *Current Pharmaceutical Design*, Volume 15, Number 22, August 2009, pp. 2535-2549(15)

<sup>40</sup> Miller, R. "Mechanisms of Action of Antipsychotic Drugs of Different Classes, Refractoriness to Therapeutic Effects of Classical Neuroleptics, and Individual Variation in Sensitivity to their Actions" *Curr Neuropharmacol*. 2009 December; 7(4): 302–314. doi: 10.2174/157015909790031229 PMID: PMC2811864  
<<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2811864/>>

<sup>41</sup> "SOVIET UNION: The Psukhushka Horror." *Time*. Time, 16 Feb. 1976. Web. 19 Apr. 2013.  
<<http://www.time.com/time/subscriber/printout/0,8816,918016,00.html>>

new thought: 'I must remember everything I see here, I told myself, so that I can tell about it afterwards.'

Here are several more descriptions from survivors:

**Aubrey Shomo recounts (U.S.):**<sup>42</sup> I know how major tranquilizers feel. I've had to. They change a person. The vigor of human experience fades to shades of gray. Life becomes dull, boring, long. Creativity slips into nothingness. The very human spirit is dulled. You can go from the rapture of being alive to wondering if you even are. They will make you calm. They will make you behave. They might even help with your problems, but they can dampen what really matters - what makes you alive. They majorly tranquilize.

**Three-and-a-half years on Zyprexa**<sup>43</sup>

"If you or someone you know is taking this drug; Here is what happened to me while I was on it for 3 and 1/2 years.

- 1) Type 1 diabetes
- 2) high cholesterol and triglycerides
- 3) more severe blood pressure problems
- 4) **Severely restricted communicative skills (e.g. I could comprehend everything, but Zyprexa is known to cause disturbances in the area of the brain which controls speech in humans). As a result I went from an extremely outgoing personality brimming with thought and interactions...to an almost invisible lump of, well...who knows what?! Not being able to coordinate speech and thought meant the whole process from listening, reasoning and speaking out with own opinions became a two or three minute process. Of course, by the time I was finally able to speak...the conversation had moved on. The longer I was on the drug; the more effort communication became; until I just sank into a pessimistic fog and I withdrew from my family and friends.**
- 5) Five hospitalizations for pancreatitis in a 2-3 year period.
- 6) One of those hospitalizations was 23 days with 21 of them in ICU on a ventilator.
- 7) Deepening dependence on insulin for higher and higher doses being needed.
- 8) One hospitalization for a week when my digestive tract shut down.
- 9) My appendix has been removed
- 10) My gall bladder has been removed

Before I started taking Zyprexa because of a court ordered hospitalization; I took medicine for high blood pressure and a diuretic. Nothing else. Nothing considered psychotropic.

Now I take 14 physical medications and 3 psychotropics."

**Will Hall's account (US)**<sup>44</sup>

I ended up in the locked unit of public psychiatric ward in San Francisco. I was never asked if I wanted to go to the hospital, or given options or support in figuring out what to do. I was just observed for several hours in a clinic, and then they announced that I

<sup>42</sup> "The Manifesto of a Noncompliant Mental Patient" n.p., 2006. 9 Sep. 2013.

<<http://manifesto.aubreyshomo.net/>>

<sup>43</sup> <http://psychrights.org/index.htm>.

<sup>44</sup> <http://beyondmeds.com/2009/04/29/will-halls-updated-recovery-story/>

couldn't leave. I was told I was a danger to myself and that it was for my own good, but like so many people it was really being in the wrong place at the wrong time.

[...]That began a year-long stay in the public mental health system. I needed help, but instead I was treated like a disobedient child with a broken brain, punished and controlled, including more than two months in a locked unit. I went from being a human being to being a mental patient. I was put in restraints – not because anything I did but they said it was just for transporting me to the hospital. After being restrained I had nightmares that I was being raped, and I still have flashback reactions to anything that reminds me of that experience. During the time I was in the system I was locked in an isolation cell, threatened with being strip-searched, given more than a dozen different drugs, and subjected to patronizing group therapy that never acknowledged what was really going on.

**I spent several months taking a very powerful 'anti-psychotic' tranquilizer drug called Navane, used to treat schizophrenia. It completely changed my personality and denied me the most basic sense of who I was; it made me stupider, slower, fatter, and also, because of the side effects, at times more desperate and suicidal. At one residential facility I was at, a man had killed himself right before I arrived. A patient who was his friend told me why: he was having severe side effects from his meds and no one was listening to him. The meds were why he jumped off the roof and killed himself, not mental illness. When I was on medication it was impossible to know how much of my pain was the medication, not the problems I had to begin with.**

**I have photos of that time, and the look in my eyes is totally different, not me, a different person. I was basically a zombie, but I was being docile so they considered it recovery. Today I worry that I might have some lingering side effects from the Navane and other drugs I took, including twitching in my body, memory disturbances, and worsened panic. There could be other long term damage that I may never be able to sort out and recognize.**

#### **Joanna Badura's account (Poland)<sup>45</sup>**

I will always remember this conversation: I was talking to a young psychiatrist with a rather impressive list of scholarly publications. I told him that I was having serious doubts as to my diagnosis. I told him that I felt a strong wish to come off neuroleptics. I described in detail the effects my drug had on me. I mentioned what I had read about neuroleptic-caused brain damage. [...]The doctor's reaction was like a blow. According to him, the diagnosis was correct and I should take a neuroleptic for years. And coming off my "medication" was highly likely to lead to "drug-resistant psychosis" and might even make ECT necessary

[...] I will always remember, too, the words "chemical lobotomy". **The effect of the drug Largactil (chlorpromazine), which I trustfully swallowed when I knew nothing about neuroleptics. I remember sleeping for hours, feeling like a zombie and having difficulty in getting up from a chair, and the intense pain in my joints.** Even before I read the words "chemical lobotomy", I knew that these drugs could not be good for me.

<sup>45</sup> <http://www.madinamerica.com/2013/02/close-encounters-with-biopsychiatry/>

[...] None of the psychiatrists I have come across has made an effort to find out about the exact circumstances of my mental breakdown. They all seemed to believe that I was simply yet another individual who had something wrong with her brain.[...] As to myself, however, I knew since the very beginning that I suffered a highly spectacular breakdown because of intense emotional distress.. [...]After some days, I was committed to a psychiatric hospital. I was told that if I were not compliant, I might be put into restraints and injected with a drug. I chose, of course, to be very compliant, even though the nurse who took me to the ward behaved almost as if I were a young offender. I very soon began to be forcibly given neuroleptics: I knew that if I resisted, I would be injected with the drugs.

This was a mixed ward, which undeniably worsened my mental state. I was offered absolutely no form of psychotherapy and I was not allowed to go outdoors for a month. **When the first neuroleptic (Olanzapine) did not seem to have any effect on me, I was given Trilafon (perphenazine). The effects terrified both me and my family. I found it increasingly difficult to make any movements, I developed severe Parkinson-like symptoms and I finally began to have difficulty even in eating and brushing my teeth. I was also unable to read. My psychiatrist needed some convincing before he agreed to change the drug to another one, Abilify.[...]**

**The idea that someone like me must take neuroleptics was becoming increasingly disturbing to me. I suffered from akathisia and had some difficulty in having conversations with other people. I had attacks of drowsiness, often even at work. Symptomatically, doctors seemed to believe that I should just put up with all the unpleasant effects of the drug. And they did not tell me that my difficulties in reading (longer texts began to frighten me!) were caused by the drug: for several months, I believed that it was due to my “illness” and thought with sadness that I might never again enjoy reading as much as in the past. When I told my psychiatrist about a worsening of my eyesight, he claimed that it had nothing to do with the neuroleptic, which later proved to be blatantly untrue. When I mentioned my fear of tardive dyskinesia, he was just as dismissive. When I told other psychiatrists that I woke every night to realize that the fingers of my hand were numb, they simply chose not to comment on it.**

#### **Helena King's account (Ireland)**

I got elated after my first baby in 1970. After 6 weeks at home breastfeeding they put me in a mental hospital. There I was made mentally ill by haldol and largactil. I was then deeply depressed and even forgot about my baby. I had the shakes, lockjaw and a terrible thirst and drooling. I couldn't even walk.

#### **Impact of neuroleptics on children; a mother's perspective Becky Murphy (US)<sup>46</sup>**

The recent reports by ABC News and the Senate Hearing on December 1, 2011, which was presided over by Senator Tom Carper, are the latest of many investigations and hearings into psychiatric drugs being used on foster children. But the fact is that the indiscriminate use of psychotropic drugs prescribed off-label is widespread, and not limited to children in foster care. Children who live with their parents often have the same

<sup>46</sup> <http://www.madinamerica.com/2012/02/op-ed/>.

safety and protection issues as children in foster care and experience equally harmful effects from the drugs.

My youngest son was placed in a [foster] home that had twelve reports filed with Child Protective Services. After he was victimized, I believe that the State of Washington attempted to cover it up, with little regard for how this would cause my son further harm.[...]

**My son was first given Risperdal when he was seven years old in 1995 to “treat” his aggression. The betrayal of trust I felt when I learned about what this class of drug does to the human body is overwhelming.**[...] The claim that my son’s condition psychiatric diagnosis was caused by a genetic or an inherited biological defect is not supported by any available scientific evidence. Psychiatrists have been claiming that they are “medically treating” unidentified diseases without ever discovering a biological dysfunction or disease process that causes a single one of the psychiatric diagnoses.

It was during this period of time that my son sustained serious injuries from the massive amounts of drugs prescribed to him, over my vehement protests. **He has suffered from akathisia and tardive dyskinesia since he was 13 years old.** [...] I have yet to meet a parent of a child prescribed a neuroleptic or other psychiatric drugs who was given accurate information about the risks. I have met many parents who voiced concerns about their child’s deteriorating health once they were put on neuroleptics, but who were totally unaware that the drugs could be causing these problems. **In one case, the child became obese, diabetic, had high cholesterol, suffered heart damage and became aggressive. All are well-known adverse effects of neuroleptics. But neither the 14-year-old nor his mother was told that these problems might be caused by the drug.**

[...] **A psychiatrist told me last year that any parent who objects to giving psychiatric drugs to their child would, at best, be perceived as ill-informed, and at worst, as being impaired themselves. Implicit in this statement is a belief that no one has a right to NOT consent to psychiatric drugs being given to their children.** It is heartbreaking as a mother to know that the treatment my son received caused further trauma and disability.

[...] There are times I am haunted by memories. **I can remember when my eight-year-old child suddenly claimed that his eyes didn’t work, and that I was the only one who believed him. Imagine finding out a decade later that one of the known effects of neuroleptics is on eye function, and how even adults complain that the drugs make it difficult to read. My son was in third grade and could read only with extreme difficulty, and no one but his mother believed him that there was a problem with his eyes. My son was then given another diagnostic label, as his psychiatrist determined that his refusal to read and do schoolwork was because he had Oppositional Defiant Disorder. His behaviors were then seen as further evidence of his having a genetic or biological defect in need of a psychiatric label and a psychiatric drug.** This is only one of many painful experiences that I cannot remember without crying.“

In each instance, attention is called to a diminishing of the power of human volition, as well as the loss of many of the aspects of human emotional and cognitive experience that make life worth living.

Such a tradeoff might be a valid choice, although a sobering one, when made by the person so affected with full knowledge of the effects and of alternative approaches including the choice to avoid potent drugs and seek personal support or practice self-nurturance. Only the person experiencing the effects neuroleptics have on them can distinguish help from torture, for what is the purpose of torture other than to destroy and overcome human volition?

Furthermore, such a significant effect on a human being is in no way less severe than the effects of typical criminal sanctions, and, as such, should be considered analogous to corporal punishment, which this Committee has condemned as a violation of Article 7 of the Covenant.

### III. Vulnerable groups targeted

#### A. Children, including those in foster care

According to the UN Special Rapporteur on Torture, inadequate weight is given to the views of children with disabilities in health-care settings in relation to forced medical interventions.<sup>47</sup> Children have no opportunity to give meaningful informed consent prior to receiving psychiatric medications, and children who have been removed from their families and placed in foster care are particularly vulnerable to all forms of violence, abuse and exploitation including forced medication. As told to journalist Katie Rucke,<sup>48</sup> veterans of foster care describe their experiences:

Hours after Texas Child Protective Services removed 5-year-old [Tristen](#) from the care of his mother and placed him in a foster home, Tristen's foster parents took him to see a psychiatrist, citing concerns the young boy was depressed. That day, a psychiatrist prescribed Tristen three medications: one for anger, one for depression and one to help the 5-year-old relax. Now an adult and out of the foster care system, Tristen says he recognizes he was depressed that day, but he says he never needed any medication — his feelings were only natural given the circumstances. "They just took the thing that meant the most to me," he said. "My family." Passed from foster home to foster home all over the state of Texas, Tristen says no one ever asked him how the pills made him feel, despite the fact that he would often spend time in his room crying because he felt his medicines were slowly tearing his chest apart.

[Aisha](#) was in foster care for 15 years and spent a great deal of time in a home with her brother and 13 other children. Of the children in Aisha's home, she says everyone was on medication when she arrived — except for her. But the first time she was taken to the doctor, she was prescribed 200 milligrams [sic] of Prozac to help her depression, as well as 200 milligrams of Seroquel so she could sleep at night. "Foster parents should not be allowed to diagnose foster children," Aisha said. While Aisha was taking two medications, the other children in the foster home were taking at least five pills each. She said some kids took as many as 13 pills and were so accustomed to medication that they would swallow all of them at once.

<sup>47</sup> A/63/175 (28 July 2008) para 57.

<sup>48</sup> Rucke, Katie. (2013, July 29). "America's foster care system: Test lab for big pharma, cash cow for caretakers?" Retrieved from <http://www.mintpressnews.com/america-foster-care-system-psychiatric-drugs-depression/166065/>.

When 14-year-old Elnita was taken away from her family by Texas Child Protective Services and placed in a foster home, she was given a medication for depression that she says she did not need. "I was a shy person," Elnita explained, adding that she was struggling to get used to her new living environment, which was filled with several other young girls and caretakers she didn't know. "I wasn't ready for that." But like Tristen, she was forced to take the medication. Elnita was prescribed 500 milligrams of an antidepressant and said every time she or one of the other girls in her foster care home cried or screamed out of frustration, they were put into an isolation room or given more drugs to calm down. While in foster care, Elnita was on four different kinds of depression pills. Despite the fact that the medicines made her slow, caused her to struggle to focus at school and gave her terrible nightmares, her foster parents and her social worker denied her request to be taken off the high dosage.

Children outside the foster care system are also vulnerable to forcible medication. Aubrey Shomo recounts the following, from Colorado:

I was eight years old when I was diagnosed, but it wasn't until I was 14 that I really had a sense of what my rights ought to have been. I was on neuroleptics for psychosis, and I had just been admitted to the psychiatric hospital under my mother's signature. She had lied about my behavior to have me admitted. Unfortunately, her signature was all that was required. I asked for a habeas corpus proceeding, but was denied one. My age meant only my guardian had to approve of what was happening to me. I wasn't allowed to contact the outside world in order to try to find an ally or some kind of support. When I tried to make a point of how I was essentially a prisoner, I was taken down and restrained to demonstrate that fact to me.

Even when I got out, I was on medication over my objection for the next three years, objecting each time I had a chance, and being overruled and ignored each time I objected. Eventually, I stopped on my own and the State used another set of allegations from my mother to try to keep me in treatment, going to court even though they knew the allegations to be false. It didn't matter that they were false, though. I didn't even get a chance at a fair hearing. Everything was decided by my mental health worker. The mental health worker described his job as "using a 2x4" to keep me in line with treatment. I barely made it out of the system by keeping my head down and escaping notice when my legal status changed from child to adult, slipping through the cracks to freedom.

Federal, state, and local governments are involved in administering psychiatric medications to children via the medical system and foster care systems, providing significant financial profit for foster parents, drug companies, and doctors. Despite the acknowledgement that children's problems are primarily due to poverty and family problems, prescriptions for neuroleptics have increased fivefold in children ages 2-17 receiving Medicaid services, the government-funded health insurance for low-income families.<sup>49</sup> A similar increase was found in the rate of prescription of neuroleptics to all

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<sup>49</sup>Woodward, Paul (2013). Abuse of psychiatry in U.S. far more extensive than occurred in Soviet Union. Retrieved from <http://www.eurasiareview.com/13052013-abuse-of-psychiatry-in-us-far-more-extensive-than-occured-in-soviet-union-oped/>

children, from the 1990s through the 2000s.<sup>50</sup> Neuroleptics frequently cause a variety of adverse effects for which the children are prescribed additional drugs with additional adverse effects. Neuroleptics triple the risk of type 2 diabetes arising in children and teens, with most of the risk occurring in the first year of administration.<sup>51</sup> As described in Section II above, the adverse effects of neuroleptics are well documented, and their use on any child is alarming. The extent and consequences of prescribing to children are shown in the death of four year old Rebecca Riley died after having taken Seroquel, Zyprexa (both neuroleptics), and two other psychiatric drugs since the age of two.<sup>52</sup>

As described above, children are often medicated for normal emotional responses and normal variations of attention.<sup>53</sup> Yvette McShan of Victorious Black Women notes that in her experience as an advocate, it is common that children who have been prescribed stimulants and other psychiatric drugs go on to experience addiction problems.

## **B. Older persons**

In the United States, 26% of older adults housed in long term congregate care facilities (“nursing homes”) receive antipsychotic (neuroleptic) medications.<sup>54</sup> Among those diagnosed with dementia the rate is 40%, despite the Food and Drug Administration (FDA) warning that persons with dementia are at serious risk of medical complications including stroke and death from taking these drugs.<sup>55</sup> Neuroleptics are also doled out to older people in the community who need extra support that they are not receiving. In 2011, the Inspector General of the Department of Health and Human Services Daniel Levinson noted that such drugs — which include Risperdal, Zyprexa, Seroquel, Abilify and Geodon — are “potentially lethal” to many of the patients getting them and that some drug manufacturers illegally marketed their medicines for these uses “putting profits before safety.” The drugs are typically used to control behavior that is annoying or troublesome to staff or other residents, and without seeking or obtaining the individual’s free and informed consent; often there is no discussion of the medication with the individual and his or her family. The effects of these drugs, including extreme fatigue, apathy, confusion and distress and personality changes, are dismissed as symptoms of dementia or mental illness.

In 2011, the Centers for Medicare and Medicaid Services (CMS) considered regulations to require nursing homes to hire independent pharmacists to assess residents’ prescriptions, but finally decided not to issue these rules. Instead, in May 2012, CMS instituted a program aimed at reducing the prescription of antipsychotic drugs in such

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<sup>50</sup> Mark Olfson, Carlos Blanco, Shang-Min Liu, Shuai Wang, Christoph U. Correll. National Trends in the Office-Based Treatment of Children, Adolescents, and Adults With Antipsychotics. *Arch Gen Psychiatry*. 2012;69(12):1247-1256. doi:10.1001/archgenpsychiatry.2012.647.

<sup>51</sup> Brauser, Deborah. (2013, August 22). More proof antipsychotics boost kids’ diabetes risk. Retrieved from <http://www.medscape.com/viewarticle/809942>; see also <http://www.internalmedicineneews.com/single-view/antipsychotics-triple-risk-of-type-2-diabetes-in-young-people/e91193377ff41033df3357a3aa095aa3.html>.

<sup>52</sup> <http://gaia-health.com/gaia-blog/2012-08-18/how-do-these-people-sleep-she-was-4-and-shes-dead-by-psychiatry/>

<sup>53</sup> Baughman, F. A. (2006). *The ADHD fraud: How psychiatry makes “patients” of normal children*. Canada: Trafford Publishers.

<sup>54</sup> <http://www.theconsumervoive.org/advocate/antipsychotic-drugs>.

<sup>55</sup> <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/DrugSafetyInformationforHeathcareProfessionals/PublicHealthAdvisories/ucm053171.htm>

facilities by promoting nonpharmacological alternatives and requiring facilities to report their use of antipsychotic drugs. While states that have adopted this program are reporting success at meeting the targeted reduction (9-15%), there are still large numbers of older persons who are drugged without their consent. Also in 2012, an amendment was introduced to S. 3187, the Food and Drug Administration Safety and Innovation Act, which would have required informed consent to administer antipsychotic drugs to individuals diagnosed with dementia; however, since informed consent was to include substituted consent as well as consent of the person concerned, it too would have had limited effect.

**The impact of neuroleptics, especially on older people  
USA Today Magazine, 05-01-1994, pp 44)**

"[On Thorazine] my thoughts spun and never got too far. My hands were rubber and I could hardly hold a fork. After six weeks . . . I felt like my mind had been put through a meat grinder. No longer could I think clearly; no longer could I speak articulately; no longer could I act confidently."

"I was unable to speak. No matter how hard I tried, I couldn't say anything out loud and spoke only with the greatest difficulty.... It was as if my whole body was succumbing to a lethal poison."

[On the use of neuroleptics on older people]: Jerome Avorn, director of the program for the Analysis of Clinical Strategies at Harvard: "Drugs do work. They do quiet them down. So does a lead pipe to the head." Larry Hodge, administrator at the Life Care Center in Tennessee: "Too often they were so zonked out during their meals that their heads were in the mashed potatoes."

Wilda Henry told The Arizona Republic that her 83-year-old mother became "a vegetable" five weeks after taking Haldol. Her mother was "left her mother babbling, drooling, shaking, and unable to control her bowel functions"

Anise Debose of Washington, D.C., said her 76-year-old father entered a nursing home as an active, talkative person. Four days later, after taking Mellaril and four other drugs, "He was restrained to a chair as rigid as a board when I saw him. His head was thrown back and his mouth was limply hanging down. Both eyes were closed. The impression all of us had was that he was dead."

### **C. People incarcerated in jails and prisons**

Nonconsensual medication takes place in "special needs units" of prisons where people diagnosed with a mental health condition are segregated from the general prison population. These units are notoriously abusive and practice restraint and solitary confinement as well as nonconsensual medication, as shown in descriptions by former prisoners.

Yvette McShan is founder of Victorious Black Women, a consumer organization supporting ex/con, African American Women & Women of Color, LBGTQ, with mental health and substance abuse challenges in the unserved/underserved communities to own their own voice, "to tell society we are not our diagnoses or the disparities of life we

were born into.” Ms McShan describes her own journey:

“They have a prison inside the prison and I was there too; it’s called SHU or “Security Housing Unit.” I was diagnosed as schizophrenic, and because of this diagnosis I was made to be in the isolation unit, in a one-person cell. Being diagnosed as schizophrenic was a way the criminal system controlled me with medication. They had me in the 5150 tank till I got out of jail. Then I went to prison. When I went to prison they didn’t care what kind of medication you were on. They do a whole different medical thing as long as you’re not violent. You don’t have to take psychiatric medications unless you take them already. While in prison I was sent to SHU and made to take medication because I spit on a girl I was in a relationship at the time, because she was cheating on me with another.

“Since 1/31/2000, the last time I was in prison, it has changed. When I was paroled I had to take this medication. That was the first and the last time I took medication in prison – they made me take the medication because I had gotten in a fight. That was a violent act, and it was part of my parole to take the Geodon until I got off parole.

“We all have hopes and dreams. VBW wants you to know, whatever your dream is, if you’re willing to do the work, if you love yourself, not only you’re a voice in society, you’re your own voice first. I’m my best example because I believe in me and I know what I have experienced and I know what other people have experienced because they’re like me. They don’t see me as a provider, they see me as an associate, or someone easy to talk to that really cares, I’m not looking down on you. I’m offering hope not only to you but to myself too.

“A provider saw something in me and spoke into my life, and that really changed my life. I promise you I felt like an animal and he taught me no you’re not. He found out what I like and what I do. Now I see he’s a good therapist, because I have some education and I learned what he was doing; I do some of it myself. At that time I thought of myself as an animal because I acted like that - throwing feces over that concrete wall. Looking back I don’t think I was out of my mind, I was acting like that in the environment I was in, in isolation. Isolation is no good for any human being, not being by yourself without anything. I don’t know if there was a bible in there - if not for my spirituality I don’t know what would have happened. That man saw something in me. He gave other people medication but he didn’t give me medication, he gave me candy. I’m not on drugs today and he played a major part in that.”

Ojore Lutalo, who spent time in the Special Needs Unit of a New Jersey prison, depicted the “Drug Therapy Chairs” in an art collage, which includes this written description:<sup>56</sup>

The two (2) forced medication chairs are located in a room in one of the prison’s “special needs units” called #1-EE which is located in the south compound section of the prison here at Trenton State Prison (TSP). The chairs are situated side-by-side. The chair is designed to restrain a prisoner(s) from being able to move his or her arms, legs or mid-section of their bodies.

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<sup>56</sup> See Annex I.

A prisoner(s) is placed in the chair to be forced medicated. They [gap in original] in the chairs with Velcro straps. They use to be secured in those chairs with handcuffs. Some prisoner(s) have a sheer, black head net placed over their head and face. In some cases a gag made of white cloth is placed over the prisoner's mouth underneath the black head net to prevent the prisoner(s) from spitting – or verbalizing his/her protest over being forced medicated!

Once a prisoner(s) is secured in the chair, a nurse injects the prisoner with some kind of psychotropic drug intravenously. The attending nurse is suppose to test the prisoner's heart rate and blood pressure every fifteen (15) or twenty (20) minutes in the event the prisoner might possibly go into cardiac arrest from the forced ingestion of the psychotropic drug.

The prisoner(s) is kept in the chair for a minimum of four (4) hours; most times more; after the prisoner(s) is removed from the chair, he or she are stripped naked and given a quilted gown, and placed in a cold cell with nothing but a filthy piece of foam for sleeping purposes!

The use of forced medication cannot be justified by a motivation to control a person's behavior any more than it can be justified by a belief that the medication is in the person's best interests. A highly invasive act, forced psychotropic medication inflicts suffering not only on the body but also on the mind and personality, and must be considered off-limits whether used as a control measure or for any other reason.

#### **D. Adult women and men who receive psychiatric diagnoses through the mental health system**

The vast majority of people undergoing nonconsensual psychiatric medication are women and men who receive psychiatric diagnoses. Individuals who refuse medications can be ordered by a court to undergo such treatment, can be drugged against their will for behavior control in situations that institutional staff deem to be an "emergency," and can be held against their will in psychiatric hospitals where they are also medicated against their will.<sup>57</sup> Court-ordered treatment outside of closed institutions is lawful in 42 states and is known as "outpatient commitment" and "assisted outpatient treatment."<sup>58</sup> Two survivors speak out:

My name is Patricia Bauerle, and I live in Tucson, Arizona in the United States of America. I have been repeatedly involuntarily hospitalized and court-ordered to psychiatric involuntary medication "treatment" in the United States approximately once a year ever since April of 2000 even though mental health courts have consistently found me to not present a "danger to self" or "danger to others" and merely be "persistently and/or acutely disabled." I have always been court-ordered to "treatment" in the state of Arizona, most of the time in Pima County and once in Maricopa County. Many times I have often also been involuntarily medicated in psychiatric hospitals when no court orders have been in effect even though I never presented any realistic danger to anyone at any time, though hospitals at times used inflammatory language in attempt to justify their use of involuntary medication on me, such as referring to my arguing as being

<sup>57</sup> <http://treatmentadvocacycenter.org/legal-resources/state-standards>

<sup>58</sup> [http://en.wikipedia.org/wiki/Outpatient\\_commitment](http://en.wikipedia.org/wiki/Outpatient_commitment)

“combative” or merely checking boxes of “threat to self” and “threat to others” without providing any additional justification, especially since there was not any except for my trying to verbally assert grievances with the hospital staff. When I was in the state of Minnesota, the hospital staff placed me on an “emergency hold” even no “emergency” existed involving me and used that as justification to medicate me daily during my two weeks of being involuntarily hospitalized there. Throughout my thirteen years of being involuntary medicated, I have suffered numerous adverse effects including sleeping excessively, significant weight gain, the locking of my jaw, involuntary eye closures, stiffness of my right arm at a right angle, facial tardive dyskinesia, and akathisia with my legs involuntarily moving back and forth.<sup>59</sup>

Outpatient commitment is hell because once they've got you in the system they don't let you go. If you get outpatient committed too many times – They outpatient commit people who they call noncompliant. You can't even say to them “I don't want to take this drug for the rest of my life” because you're called noncompliant.  
- Rosary Marinaro, under outpatient commitment for approximately 2 years at present

#### **IV. Complaints about forced drugging received by MindFreedom International**

MindFreedom International, one of the organizations submitting this report, works for human rights in the mental health system. Over the past few months, MFI has seen an increase in people who are involved with the mental health system contacting its office for assistance. There are a variety of requests, some people are asking for referrals to resources in the area but most are requesting either someone to directly talk with for peer support and/or for MFI to issue a human rights alert through its MindFreedom shield program because they are being threatened with or experiencing forced mental health treatments.

Here are some examples of the types of calls MFI receives every week at its office:

- A person is being forced into a psychiatric hospital.
- A person is being forcibly drugged and requests someone to help.
- A person is being forced to go to a mental health day program and take psychiatric drugs, which the person does not want to do.
- An individual wants to activate the MindFreedom shield and lives in a rural area; the person feels violated when forced on psychiatric drugs.
- A person would like someone to call him for support.
- A person requests information on coming off psychiatric drugs.
- A family member would like help with getting his son out the hospital; is concerned about forced drugging.
- An individual wants advocacy help to refuse medications.

MindFreedom shield alerts have included:

In 2008, Ray Sandford, a Minnesota resident, had more than 40 involuntary electroshocks<sup>60</sup> over his expressed wishes on an outpatient basis. A human rights alert was issued to the public to call and write letters to the Governor of Minnesota and

<sup>59</sup> See Patricia Bauerle's affidavit, Annex II.

<sup>60</sup> [http://www.huffingtonpost.com/dr-peter-breggin/electroshock-treatment\\_b\\_1373619.html](http://www.huffingtonpost.com/dr-peter-breggin/electroshock-treatment_b_1373619.html)

psychiatric hospital administrators where he was receiving outpatient electroshock. As a result of human rights action, Ray's new guardians support his right to say no to forced interventions such as electroshock.

In 2011, a MindFreedom alert was issued for Elizabeth Ellis, a resident of Minnesota living peacefully in her home, who was under court order for regular involuntary electroshocks. Elizabeth Ellis refused to report for the outpatient electroshocks and was transported back inside the psychiatric institution for forced maintenance electroshock procedures.

In 2013, an Action Alert was issued to Free Alison Hymes. Alison Hymes is confined to Western State Hospital in Stanton, Virginia. She's receiving shots of prolixin every two weeks against her will as a daily dose of anti-convulsion drug, Lamictal. Alison Hymes was the recipient of a kidney transplant following poisoning with psychiatric drugs after a previous incident of psychiatric malpractice. Alison Hymes is still in the psychiatric hospital and wants to get out, live in her own home and community.

## **V. Inadequacy of constitutional safeguards and PAIMI programs**

The United States in its answer to Question 15 cited constitutional safeguards, the federal Protection and Advocacy for Persons with Mental Illness Program (PAIMI), and regulations on the use of restraint.<sup>61</sup> They do not attempt to justify the practice of nonconsensual medication, nor do they address the significant harm it causes.

Constitutional protections are not sufficient to prohibit and prevent nonconsensual medication. The U.S. does not recognize a clear right under the Constitution to be free from nonconsensual medication and electroshock. While a right has been recognized (under the Fourteenth Amendment) to be free from such interventions unless there are compelling state interests and no less intrusive alternative, this right is uniformly ignored in practice.<sup>62</sup> Federal, state, and local courts typically view involuntary medication and electroshock as serving the interests of the person being subjected to these procedures, despite the intense suffering and injurious consequences that this entails. Even when individuals are given the opportunity to exercise choice in mental health services, the information provided is typically inaccurate, omitting the enormous risks of psychiatric treatments, such as tardive dyskinesia and other serious adverse effects of neuroleptic drugs described in Section II above, and the potential for ECT to cause permanent cognitive impairment.<sup>63</sup>

The regulations on restraint cited by the government permit the use of physical as well as chemical restraint (i.e. use of psychotropic drugs to immobilize a person) when "required to treat a patient's medical symptoms." This is an open door to the use of

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<sup>61</sup> CCPR/C/USA/Q.4/Add.1, paras 72-73.

<sup>62</sup> Gottstein, James B. (Jim). (2008). "Involuntary commitment and forced psychiatric drugging in the trial courts: Rights violations as a matter of course." *Alaska Law Review*, 25, 51-105.

<sup>63</sup> Susan Rogers, the director of the National Mental Health Consumers' Self-Help Clearinghouse cited in Frank Gluck's (2013, August 18) article, "Electro-shock therapy sees a resurgence" in *USA Today*. Retrieved from [http://www.usatoday.com/story/news/nation/2013/08/18/electro-shock-therapy-sees-a-resurgence/2668073/?utm\\_source=feedburner&utm\\_medium=feed&utm\\_campaign=Feed:+usatoday-NewsTopStories+%28News+-+Top+Stories%29](http://www.usatoday.com/story/news/nation/2013/08/18/electro-shock-therapy-sees-a-resurgence/2668073/?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed:+usatoday-NewsTopStories+%28News+-+Top+Stories%29).

chemical restraint on any individual who has been given a psychiatric diagnosis, and it should be noted that use of restraints and nonconsensual medication on such individuals has been specifically condemned by the Special Rapporteur on Torture.<sup>64</sup>

The PAIMI program is administered by the Substance Abuse and Mental Health Service Administration and the Center for Mental Health Services and funding is given to states to investigate incidents of abuse and neglect of individuals diagnosed with a mental illness. PAIMI is not required to respond to all complaints from individuals, and is limited in its capacity to do so as a result of funding and priorities. Furthermore, investigative mechanisms are of no avail unless the operative legal standard prohibits nonconsensual psychiatric interventions, which is not the case in any jurisdiction within the United States.

## **VI. Recommendations**

We urge the Committee to adopt the following Concluding Observations with respect to Question 15:

The Committee notes with concern that the United States permits nonconsensual medication of adults and children who have been given a psychiatric diagnosis, both within psychiatric institutions, in the community (as “outpatient commitment”) and in situations of particular vulnerability such as foster care, jails and prisons, and services for older persons. Existing laws and regulations, including the standards applied under the federal Constitution, are insufficient to establish a requirement of free and informed consent of the person concerned with respect to all psychiatric medication and other mental health services.

It is questionable whether fully free and informed consent to psychiatric drugs is possible under the prevailing circumstances. Psychiatric drugs are not subjected to proper testing to establish safety and efficacy, are often used in untested combinations, and are prescribed pursuant to diagnostic classifications that are acknowledged to be invalid.

Nonconsensual medication with psychiatric drugs of a variety of classes including neuroleptics causes serious adverse effects including neuroleptic dysphoria, akathisia, tardive dyskinesia, metabolic syndrome, cardiac problems and physical changes to the brain, and inflicts physical suffering and mental anguish.

**The Committee recommends comprehensive reform of federal and state laws and practices to:**

- a) Eliminate nonconsensual medication and other acts of coercion in mental health services, wherever they are provided;**
- b) Raise awareness of the harm done by neuroleptics and other psychiatric drugs;**
- c) Ensure that all instances of nonconsensual medication and other acts of coercion in mental health services are reported and investigated as acts of abuse and that individuals so victimized are afforded effective remedy and reparation; and**

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<sup>64</sup> A/HRC/22/53 paras 63, 89(b).

**d) Channel resources into alternatives to the medical model of mental health.**



Annex II: Affidavit of Patricia Bauerle

Affidavit concerning involuntary medication and electroshock in U.S.

My name is Patricia Bauerle, and I live in Tucson, Arizona in the United States of America. I have been repeatedly involuntarily hospitalized and court-ordered to psychiatric involuntary medication "treatment" in the United States approximately once a year ever since April of 2000 even though mental health courts have consistently found me to not present a "danger to self" or "danger to others" and merely be "persistently and/or acutely disabled." I have always been court-ordered to "treatment" in the state of Arizona, most of the time in Pima County and once in Maricopa County. Many times I have often also been involuntarily medicated in psychiatric hospital s when no court orders have been in effect even though I never presented any realistic danger to anyone at any time, though hospitals at times used inflammatory language in attempt to justify their use of involuntary medication on me, such as referring to my arguing as being "combative" or merely checking boxes of "threat to self" and "threat to others" without providing any additional justification, especially since there was not any except for my trying to verbally assert grievances with the hospital staff. When I was in the state of Minnesota, the hospital staff placed me on an "emergency hold" even no "emergency" existed involving me and used that as justification to medicate me daily during my two weeks of being involuntarily hospitalized there. Throughout my thirteen years of being involuntary medicated, I have suffered numerous adverse effects including sleeping excessively, significant weight gain, the locking of my jaw, involuntary eye closures, stiffness of my right arm at a right angle, facial tardive dyskinesia, and akathisia with my legs involuntarily moving back and forth.

This past July of 2013, when I was involuntarily hospitalized in the state of Arizona's Maricopa County, I had a roommate who was of Eastern European descent and who spoke broken English who was repeatedly involuntarily medicated against her will and eventually subjected to electroshock. There seemed to be no one at the hospital who spoke her native language, and her native language did not appear to be one of those languages for which a list of available telephone interpreters was eventually posted.

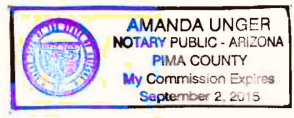
I attest to the above to be true and accurate to the best of my knowledge.

9-9-13  
Date

Patricia Bauerle  
Signature

The above was subscribed to me on 9-9-13

STATE OF Arizona  
COUNTY OF Pima } ss.  
SUBSCRIBED AND SWORN TO BEFORE ME  
THIS 9 DAY OF Sept, 2013  
BY Patricia Bauerle  
NOTARY PUBLIC



### Annex III: Organizations submitting this report

The **Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP)** provides strategic leadership in human rights advocacy, implementation and monitoring relevant to people experiencing madness, mental health problems or trauma. In particular, CHRUSP works for full legal capacity for all, an end to forced drugging, forced electroshock and psychiatric incarceration, and for support that respects individual integrity and free will.

Tina Minkowitz, Esq.  
[tminkowitz@earthlink.net](mailto:tminkowitz@earthlink.net)  
[www.chrusp.org](http://www.chrusp.org)

The **Victorious Black Women** and Women of Color take a stand for those who are misunderstood, disenfranchised, marginalized, discriminated against and overlooked by being a voice for mental health and substance abuse consumers in communities of California. The Victorious Black Women are dedicated to enlightening, educating and informing all members of society to treat all consumers with mental health, substance abuse challenges; Whether Ex/Cons, TAY (transition age youth), Veterans, Older Adult, Gay, lesbian, bisexual, and transgender with dignity and respect. The Women of Victorious Black Women choose to encourage awareness and understanding about those affected by mental health, substance abuse, homelessness challenges in order to reduce disparities, barriers, stigma and discrimination that exist and prevail in the African American and Women of Color community.

Yvette McShan  
[victoriousblackwomen@yahoo.com](mailto:victoriousblackwomen@yahoo.com)

The **Law Project for Psychiatric Rights (PsychRights)** is a public interest law firm whose mission is to mount a strategic litigation campaign against forced psychiatric drugging and electroshock in the United States. The public mental health system is creating a huge class of chronic mental patients through forcing them to take ineffective, yet extremely harmful drugs. Currently, due to the massive growth in psychiatric drugging of children and youth and the current targeting of them for even more psychiatric drugging, PsychRights has made attacking this problem a priority. Children are virtually always forced to take these drugs because it is the adults in their lives who are making the decision. This is an unfolding national tragedy of immense proportions. As part of its mission, PsychRights is further dedicated to exposing the truth about these drugs and the courts being misled into ordering people to be drugged and subjected to other brain and body damaging interventions against their will.

James B. (Jim) Gottstein, Esq.  
[jim.gottstein@psychrights.org](mailto:jim.gottstein@psychrights.org)  
[www.psychrights.org](http://www.psychrights.org)

**MindFreedom International** (MFI) is an independent coalition rooted in a global movement to change the mental health system. The majority of MindFreedom's membership, board and staff identify themselves as psychiatric survivors. However, membership is open to everyone who supports MFI's human rights goals. Advocates, mental health professionals, family members, and the general public are all valued members and leaders in the MindFreedom community, and MFI is one of the few mental health advocacy groups that does not accept money from government, drug companies, mental health systems or religious groups.

[office@mindfreedom.org](mailto:office@mindfreedom.org)  
[www.MindFreedom.org](http://www.MindFreedom.org)

The **Campaign to Repeal Mental Health Laws** is working for the repeal of mental health laws in the United States and Canada that allow people to be deprived of their liberty, drugged, restrained, electroshocked and otherwise treated against their will in the name of “psychiatric help.” The United Nations has called on countries to abolish such laws to comply with human rights obligations and has said that forced psychiatric treatment/interventions can amount to torture. The purpose of the campaign is to educate the public about all forms of forced psychiatric treatment/interventions and, most importantly, to take action to eradicate laws that allow these human rights violations to occur.

[repealingmentalhealthlaws@gmail.com](mailto:repealingmentalhealthlaws@gmail.com)  
<http://repealmentalhealthlaws.org>

**Intentional Peer Support** creates, develops and supports non-coercive alternatives to mainstream psychiatric services. We provide dialogic- based training for peer support workers and develop and consult with Peer-run alternatives to hospitalization.

Chris Hansen  
[info@intentionalpeersupport.org](mailto:info@intentionalpeersupport.org)

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.<sup>65</sup> 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.

Jolijn Santegoeds and Salam Gomez, chairs  
[admin@wnusp.net](mailto:admin@wnusp.net)  
[www.wnusp.net](http://www.wnusp.net)

The **International Disability Alliance (IDA)** is the international network of global and regional organisations of persons with disabilities (DPOs), currently comprising eight global and four regional DPOs. Each IDA member represents a large number of national DPOs from around the globe, covering the whole range of disability constituencies. IDA’s mission is to advance the human rights of persons with disabilities as a united voice of DPOs utilising the CRPD and other human rights instruments, and to promote the effective implementation of the CRPD, as well as compliance within the UN system and across the treaty bodies.

Victoria Lee  
[vlee@ida-secretariat.org](mailto:vlee@ida-secretariat.org)  
[www.internationaldisabilityalliance.org](http://www.internationaldisabilityalliance.org)

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<sup>65</sup> In its statutes, “users and survivors of psychiatry” are self-defined as people who have experienced madness and/or mental health problems, or who have used or survived mental health services.