World Network of Users and Survivors of Psychiatry

Center for the Human Rights of Users and Survivors of Psychiatry [1]

Relevance to Older Persons of the Convention on the Rights of Persons with Disabilities

1. Coherence of standards

Increasingly, the practice within the United Nations human rights system is to seek coherence of standards across treaty bodies and Special Procedures. As the most up to date standards on the rights of persons with disabilities, the CRPD elaborates on states' obligations to guarantee equal enjoyment of all human rights to persons with disabilities. An increasing number of concluding observations by treaty bodies, and reports issued by Special Procedures, draw on the CRPD standards for guidance in interpretation and application of their own mandates.

Regional bodies as well have taken account of the CRPD in applying their own mandates. The OAS Committee for the Elimination of All Forms of Discrimination Against Persons with Disabilities (CEDDIS) has gone so far as to re-interpret a contradictory provision of its own governing Convention in the context of CRPD Article 12. CEDDIS issued a General Observation on the need to interpret Article I.2(b) *in fine* of the Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities in the context of Article 12 of the United Nations Convention on the Rights of Persons with Disabilities.[2] The article of the Inter-American Convention stated that legal incapacitation did not constitute discrimination, and this was found to contravene the recognition of universal legal capacity in the CRPD.

Coherence of standards applies to more than ensuring that standards directly applicable to a single situation under different treaties are consistent with each other. It also means that the development of standards is informed both by expertise in a specific subject matter, including expertise developed in response to lived experience of violations, and by the treatment of this subject matter in other contexts. For example, the approach to legal capacity in the CRPD was informed by the text and General Recommendations of CEDAW on this subject (CEDAW Article 15), and with respect to children, by the text of the CRC (CRC Article 12). Similarly, standards for the rights of older persons should be informed by the human rights-based approach of the CRPD that emphasizes the provision of supports that respect an individual's autonomy, will and preferences, to facilitate equal opportunities to participate in all aspects of life to the extent the person desires.

2. Overlap between persons with disabilities, and older persons

A large number of older persons are persons with disabilities. Many individuals acquire age-related disabilities or may be perceived as having cognitive, psychosocial, sensory or physical impairments.

Individuals who acquired their disabilities at a younger age experience double discrimination as they become older, and also have particular needs and concerns as older persons, including a likelihood that they will experience concerns as older persons at a younger chronological age than others. This may be due to the nature of a person's impairment, social factors or a combination. Persons with psychosocial disabilities who use psychiatric medications may experience a number of health problems as adverse

[1] For information about submitting organizations, see Annex I.
[2] http://pablorosales.com.ar/es/wp-content/uploads/2011/09/CD-Version-Discapacidad.pdf.

effects of these medications, including problems of the neurological, endocrine, metabolic, and cardiovascular systems and cognitive difficulties. The use of psychiatric medications, particularly neuroleptics, is also associated with a shortening of the life span. According to a recent UK study, neuroleptics are administered "off-label" to around 180,000 people with dementia diagnoses in the UK every year. This drugging leads to the premature deaths of 1,800 of these people each year[3].

The most discriminatory treatment against older persons is directed against older persons who have or are perceived as having disabilities, particularly those who may need a great deal of support. In particular, restriction of legal capacity and institutionalization without the person's prior free and informed consent are practices used against older persons as well as younger persons with disabilities. It is rarely the case that age alone is the reason for such measures to be taken, they are almost always motivated by a perception that the person has some type of disability, whether an age-related or non-age-related disability.

The Convention on the Rights of Persons with Disabilities directly applies to all older persons who are persons with disabilities or who are targeted for discrimination because they are perceived as persons with disabilities.[4] Any further elaboration on the rights of older persons must not derogate from the rights guaranteed to older persons with disabilities under the CRPD. Older persons who experience discrimination based only on age will likely benefit from an extension of the paradigm found in the CRPD, since it is grounded in non-discrimination and encompasses both formal and substantive equality. It is a paradigm that promotes respect for inherent human dignity, requires equitable distribution of resources, and encourages both social solidarity and recognition of the contributions made to society by individuals who otherwise may be relegated to a marginal existence.

3. Legal capacity and freedom from institutionalization in the CRPD

The Convention on the Rights of Persons with Disabilities was developed to redress all forms of discrimination against persons with disabilities, including those who need a great deal of support to live in the community and to exercise their legal capacity. The CRPD treats these issues within a framework of non-discrimination, accommodation and support that respects the person's autonomy, will and preferences.

CRPD Article 12 provides that persons with disabilities:

- Are entitled to be recognized everywhere as persons before the law
- Must be recognized as having equal legal capacity as others in all aspects of life
- Must be provided with access to support that the individual may need in exercising her or his legal capacity
- Are assured protection against any abuse of their right to have and exercise legal capacity, including by standards requiring that all measures respect the person's autonomy, will and preferences; are tailored to the person's own needs; and provide opportunities for review to ensure that the support arrangements are working satisfactorily.

The Committee on the Rights of Persons with Disabilities has clarified the requirements for implementation of Article 12 in the context of Concluding Observations addressed to states parties. Its most detailed elaboration of these requirements, which is relevant to all countries, the Committee said:

> The Committee urges the state party to adopt measures to repeal the laws, policies and practices which permit guardianship and trusteeship for adults and take legislative action to replace

[3] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108302.pdf
The US Food and Drug Administration has also warned that use of neuroleptics increases the rate of death among elderly people by 60 to 70 percent:
http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/DrugSafetyInformationforHeathcareProfessionals/PublicHealthAdvisories/ucm053171.htm

[4] CRPD/C/ESP/CO/1, paragraphs 19-20; CRPD/C/CHN/CO/1, paragraphs 25-26.

regimes of substituted decision-making by supported decision making, which respects the person's autonomy, will and preferences, in the exercise of one's legal capacity in accordance with Article 12 of the CRPD. In addition, the Committee recommends the state party in consultation with DPOs to, prepare a blueprint for a system of supported decision-making, and legislate and implement it which includes:

a. Recognition of all persons' legal capacity and right to exercise it;

b. Accommodations and access to support where necessary to exercise legal capacity;

c. Regulations to ensure that support respects the person's autonomy, will and preferences and establishment of feedback mechanisms to ensure that support is meeting the person's needs;

d. Arrangements for the promotion and establishment of supported decision-making.[5]

CRPD Article 14 provides that persons with disabilities:

- Are entitled to liberty and security of the person on an equal basis with others
- Must not be deprived of their liberty based on a disability (including involuntary institutionalization and hospitalization)
- If deprived of their liberty through any process, have a right to equal guarantees as others, and to be treated in compliance with the CRPD standards including by provision of reasonable accommodation.

As an application of the equal right to both liberty of the person and security of the person, Article 14 requires states to abolish involuntary institutionalization and to ensure that all mental health services are based on the free and informed consent of the person concerned.[6] (CRPD Articles 15, 17 and 25 also prohibit forced psychiatric interventions and require that mental health services, and any other health care or services provided to persons with disabilities, are based on free and informed consent of the person concerned.)[7]

Article 14 may also require that positive measures be taken to allocate financial resources to persons with psychosocial and intellectual disabilities who require a high level of support, so that they are neither confined in institutions nor confined in their own homes.[8]

CRPD Article 19 provides that persons with disabilities:

- Have the right to live in the community with choices equal to others
- Must have the opportunity to choose where and with whom to live, and not be compelled to live in a particular living arrangement
- Must be provided with access to in-home, residential and community support services needed to live in the community, including personal assistance (which can include advocacy support)
- Must be inclusively served by community services and facilities for the general population.

Article 19 requires states to put in place a wide range of supports and accommodations that people with disabilities may need to live in the community.[9] Financial resources must be placed at the service of such programs, and re-examination of the allocation of funds may be required to shift resources from institutions to programs that support independent living in the community.[10]

4. Issues of concern affecting older persons

---

[5] CRPD/C/CHN/CO/1, paragraph 22. See also CRPD/C/HUN/CO/1, paragraphs 25-26.
[6] CRPD/C/ESP/CO/1, paragraph 36; CRPD/C/HUN/CO/1, paragraph 28; CRPD/C/CHN/CO/1, paragraph 26.
[7] CRPD/C/TUN/CO/1, paragraphs 28-29; CRPD/C/PER/CO/1, paragraphs 30-31; CRPD/C/CHN/CO/1, paragraphs 27-28 and 37-38.
[8] CRPD/C/CHN/CO/1, paragraph 26.
[9] CRPD/C/PER/CO/1, paragraphs 32-33.
[10] CRPD/C/HUN/CO/1, paragraphs 33-35; CRPD/C/CHN/CO/1, paragraphs 31-32.

WNUSP would like to raise issues that come within our work advocating the rights of users and survivors of psychiatry, which includes the rights of older persons with psychosocial disabilities, and any older persons who are confined in psychiatric institutions or who are being administered psychiatric drugs.

Article 5 of the CRPD protects older persons with disabilities against discrimination based on age as well as against discrimination based on disability; therefore older persons with disabilities have a right to not be institutionalized against their will based on age, disability, or a combination of any such factors. Older persons with disabilities must not be placed against their will in psychiatric institutions, social care homes, nursing homes, rehabilitation facilities or any other housing arrangement or discriminatory detention regime.

WNUSP members report that older persons are confined at a high rate in psychiatric institutions, where many of them are placed in restraints for long periods of time, due to the effects of medications, which increase the likelihood of falls. It is also common for older persons in any institutional setting, including hospitals and rehabilitation centers as well nursing homes, "old age homes," social care institutions and psychiatric institutions, to be heavily medicated with psychiatric drugs, including neuroleptics, without the person's free and informed consent.[11]

Psychiatric institutionalization and forced medication has especially targeted people with dementia. In Japan, access to personal assistance services and other disability-related services is more restricted for older persons than for younger persons with disabilities; older persons who need wheelchairs receive an inferior type of chair that is not designed for the individual and not appropriate for persons with disabilities, and they have insufficient access to personal assistance services, leading to institutionalization, especially in psychiatric institutions where people with dementia are expected to remain until they die.

Psychiatric drugs are used improperly as a chemical restraint and management tool, and they are also given routinely a sedative to blunt anxiety and distress, without considering whether alternative supports are available to meet emotional needs and deal with difficult life issues, so that individuals would have a range of options necessary for true free and informed consent. Humane and practical alternative forms of support exist; in the case of dementia, there is clear evidence that non-drug options can provide respite without damaging health and shortening the life span[12.]

Psychiatric drugs have serious adverse effects, and are particularly detrimental for older persons; effects can be exacerbated when a number of psychoactive drugs are given at the same time (polypharmacy) and when psychiatric drugs interact with drugs prescribed for other reasons. Electroshock (electro-convulsive therapy or ECT) is also administered disproportionately to older persons, particularly older women, as a treatment for depression.[13] Electroshock has been found to cause physical damage to the brain, as well as cognitive impairment and permanent memory loss.[14]

---

[11] http://www.telegraph.co.uk/health/healthnews/6264962/Scandalous-abuse-of-the-elderly-prescribed-antipsychotics-in-hospital-exposed.html
http://www.nytimes.com/2011/05/10/health/policy/10drug.html

12 In the UK, Focused Intervention Training and Support (FITS) has been developed as a humane replacement for the neuroleptic drugging people diagnosed with dementia. This approach is based on the understanding that an individual's "symptoms" may be due to the care that person is receiving, their environment and social interactions. Non-drug support involves one-on-one conversation and stimulating activities matched to the person's interests, abilities, history and personality. It also attends to potential underlying health issues and environmental triggers. For more information, see http://alzheimers.org.uk/FITS

[13] Weitz, D. (1997). Electroshocking elderly people: another psychiatric abuse. Changes: International Journal of Counselling Psychology and Psychotherapy, (May) vol.15, no.2. See also this more recent newspaper report: "In the fiscal year 2010-2011, the most recent year for which statistics are available, 16,259 ECT treatments were administered throughout Ontario, an increase of more than 350 per cent in seven years. A breakdown by age and gender reveals startling subsets, especially a 1,300-per-cent treatment increase for patients in the 55-59 age cohort. The statistics also reveal that women outnumber men nearly two to one in the 60-to-64 age bracket." http://www.thestar.com/news/gta/2012/12/13/electroshock_therapy_more_prevalent_in_ontario_but_guidelines_are_minimal.html

[14] Sackeim article; Linda Andre

These practices violate the human rights of older persons, including the right to be free from torture and ill-treatment. The Special Rapporteur on Torture has recently called for an absolute ban on forced and nonconsensual psychiatric interventions, including the nonconsensual administration of psychosurgery, electroshock and mind-altering drugs including neuroleptics, as well as restraints and solitary confinement for short or long periods of time.[15] He furthermore called for revision of laws that allow detention on mental health grounds or in mental health facilities,[16] and clarified in a separate statement that such detention is unjustified, and in particular cannot be justified by either the severity of the disability or by a motivation to protect the person or others.[17]

Another issue raised by WNUSP members is that older women and persons with psychosocial disabilities in some countries are labeled as witches and targeted for persecution and killing on this basis.[18] These practices too constitute torture and ill-treatment; states have an obligation to exercise due diligence to prevent such mistreatment even when state actors are not directly involved.

Finally, older persons in many countries are deprived of basic necessities and even the means of survival, such as food and water; they are prevented from getting equal and equitable access to resources, violating the right to an adequate standard of living and ultimately the right to life.

These violations of the human rights of older persons provide ample reason for the creation of a new binding instrument. Such an instrument must be informed by the best available standards that already apply to the rights of older persons, including those in the CRPD, and by the self-advocacy and lived experiences of older persons, including those older persons who need a great deal of support, and including older persons with psychosocial, intellectual, cognitive, sensory and physical disabilities.

---

[15] A/HRC/22/53, paragraph 89(b).
[16] A/HRC/22/53, paragraph 89(d).
[17] Statement of Mr. Juan Mendez, Special Rapporteur on Torture, available at: https://dk-media.s3.amazonaws.com/AA/AG/chrusp-biz/downloads/277461/torture_english.pdf.
[18] See E/2012/51, paragraph 16.

Annex I, Information on organizations making this submission

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.[19] 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.

Moosa Salie, Chairperson
admin@wnusp.net
www.wnusp.net

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
www.chrusp.org

[19] In its statues, "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.