Tina Minkowitz

Summary of Points related to Expert Meeting December 13-14, 2012

1. The Special Rapporteur can add value to what was done by his predecessor, by making explicit a few points that were implicit in Mr Nowak's report and by updating it with elements from jurisprudence of the Committee on the Rights of Persons with Disabilities (and other treaty bodies insofar as their interpretation is helpful.)

2. All the issues discussed in the expert meeting should be addressed in a uniform framework, drawing out the common themes, particularly related to stigmatized (and pathologized) bodies and identities, and the right to personal and bodily autonomy.

3. Persons with psychosocial disabilities and persons with psychosocial disabilities have different concerns, perspectives and life situations. It should never be assumed that what holds true for one group holds true for the other. Self-representative DPOs (disabled peoples organizations) of both groups must be consulted to understand their lived experiences and what they need to be done differently than in the current circumstances.

4. The CRPD is relevant to a discussion of torture and ill-treatment of persons with disabilities because it changes the earlier paradigm that was epitomized in the MI Principles. Forced psychiatric interventions particularly with neuroleptic drugs have been recognized since 1986 as a form of torture. However, until the CRPD entry into force and the clarifying interpretations made by the CRPD Committee, as well as by Mr Nowak and OHCHR, the human rights regime treated these same interventions as legitimate when done by medical professionals to persons whom they had diagnosed as having a mental illness. The CRPD removes that exception; therefore it is really unjustified to hold back from identifying all forced psychiatric interventions, particularly neuroleptics and other drugs, electroshock (electroconvulsive "therapy") and psychosurgery, as torture. We have analyzed these practices as meeting the elements of the definition of torture. It would be helpful if the report would make explicit was what implicit in Mr Nowak's report, that they always constitute at least inhuman and degrading treatment. (See my presentation to the 2007 expert meeting on torture and persons with disabilities, and also IDC Advocacy Note on Forced Interventions as Torture and my 2007 law review article.) There can be no discussion of forced psychiatric interventions and detention under the torture prevention framework that allows them under any "exceptional" situations. To do so would be a reversion to the MI Principles, contrary to the CRPD, the jurisprudence of the CRPD Committee, Mr Nowak's report, and the thematic study by OHCHR (A/HRC/10/48).

5. Forced psychiatric interventions are never an emergency. Medical interventions to save a person's life have nothing to do with psychiatric interventions per se.

Persons attempting suicide could be medically saved when it is unknown whether they made an actual choice to die, and society needs an open discussion about suicide that doesn't discriminate based on disability either by devaluing the lives of persons with disabilities or by pathologizing a choice to die as a psychiatric "symptom". Good practices exist for dealing with suicide and self-harm with respect for the person's "autonomy, choices, dignity and privacy." (See David Webb, thinkingaboutsuicide.com and http://studymore.org.uk/harmmin.htm.) Similarly, a person threatening violence to others is a law enforcement problem. Medical professionals and mental health professionals have no legitimate role in social control, rather law enforcement personnel need to be trained so as to respond constructively to persons in situations of extreme stress, and supports and services (that respect the person's "autonomy, choices, dignity and privacy") need to be made available to people during encounters with law enforcement, criminal detention and judicial proceedings. (See also CRPD Article 13 access to justice).

6. There is no justification for restraint or solitary confinement in the mental health setting. This should be reflected in the report. Restraint, solitary confinement and deprivation of liberty are all coercive measures contrary to the obligation (emphasized by the CRPD Committee in several Concluding Observations) to ensure all mental health services are based on free and informed consent of the person concerned.

7. It is essential to call for repeal or abolition of the legal provisions that allow detention on mental health grounds or in mental health facilities, guardianship and substituted decision-making, and any coercive interventions or treatments in the mental health setting without the free and informed consent by the person concerned. The language of the CRPD Committee Concluding Observations on China is a good source for up to date standards and interpretation on needed reforms in the area of legal capacity as well as abolition of psychiatric detention and forced interventions and creation of alternative supports and services.

> 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 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;
(**CRPD Committee Concluding Observations on China**, CRPD/C/CHN/CO/1, September 2012, para 22)

The Committee advises the state party to adopt measures to ensure that all health care and services provided to persons with disabilities, including all mental health care and services, is based on the free and informed consent of the individual concerned, and that laws permitting involuntary treatment and confinement, including upon the authorisation of third party decision-makers such as family members or guardians, are repealed. It recommends the state party to develop a wide range of community-based services and supports that respond to needs expressed by persons with disabilities, and respect the person's autonomy, choices, dignity and privacy, including peer support and other alternatives to the medical model of mental health.
(**CRPD Committee Concluding Observations on China,** CRPD/C/CHN/CO/1, September 2012, para 38)

8. It's essential to recall that Mr Nowak rightly characterized neuroleptics and other mind-altering drugs, and electroshock, as intrusive and irreversible treatments aimed at correcting or alleviating a disability. The brain-damaging effects of these treatments cannot be ignored, nor can the subjective suffering they inflict on people. (See Peter Breggin 2008 Brain Disabling Treatments in Psychiatry.) Even with fully free and informed consent, these treatments should be considered dangerous because of significant adverse effects from neurological disorders and cognitive impairment to exacerbation of extreme mental and emotional states, to metabolic disorders and a seriously reduced lifespan. It is essential that these treatments be used only with the free and informed consent of any person concerned, including children according to their evolving capacities. Electroshock and neuroleptic drugs should never be used on children because of the damage to their developing brains. (In the U.S., Texas and California ban the use of electroshock on minors.) (See references in my 2007 law review paper and also in my article Abolishing Mental Health Laws to Comply with CRPD.)

9. In light of the work under way to revise the Standard Minimum Rules on the Treatment of Prisoners, it would be helpful for the report to reiterate that the requirement that mental health services be based on free and informed consent by the person concerned applies to mental health services in the prison context, and that segregation against a person's will in mental health units is similarly prohibited.

10. A number of good approaches for alternatives in mental health, in addition to Jolijn's work, include: Intentional Peer Support www.intentionalpeersupport.org, Hearing Voices Networks www.intervoiceonline.org, Soteria www.moshersoteria.com and the Personal Ombudsperson program as

implemented in Skåne, Sweden http://www.po-skane.org/ombudsman-for-psychiatric-patients-30.php.

11. The law reform proposal coming out of NALSAR University in India is recommended as coming close to full compliance with CRPD. I am supplying that separately together with my paper analyzing that proposal and another paper dealing with abolition of mental health laws.

12. Reparations need to be understood as in the CAT General Comment and the UN Basic Principles and Guidelines (A/RES/60/147), including satisfaction and guarantees of non-repetition, restitution, compensation and rehabilitation, and the right to a remedy for victims. Access to justice itself needs to be the subject of reparations when legal capacity poses an obstacle. (i.e. deprivation or restriction of legal capacity is itself a violation of human rights that needs to be the subject of reparation.) Also, the right to a remedy is denied where the legal standards of country maintain that acts of torture and other ill-treatment (or other human rights violations) are lawful, and so confer impunity on offenders. (That is the case obviously with psychiatric detention and forced interventions.)

13. We reject the insanity defense as being incompatible with legal capacity, which entails responsibility for one's own actions. (OHCHR A/HRC/10/48 para 47 agrees with this, see also recent WNUSP submissions to review of the Standard Minimum Rules on the Treatment of Prisoners on UNODC website http://www.unodc.org/unodc/en/justice-and-prison-reform/expert-group-meetings5.html.) Furthermore security measures imposed on a person who has been acquitted by reason of insanity amount to disability-based detention in violation of CRPD Article 14.

14. It was welcome to hear the Special Rapporteur say that he does not intend to carve out exceptions permitting acts that "may constitute" torture and ill-treatment in certain circumstances, but rather that he is seeking a basis on which to characterize them as acts of torture and ill-treatment per se. I hope that my presentation to the 2007 expert meeting on torture and persons with disabilities satisfies this request, and if additional response from me is needed I am happy to oblige.

15. Core suggestions to frame these issues in the report:
    a. Amplify the CRPD Committee's recommendations for abolition of psychiatric detention and forced interventions, and for repeal of the legal provisions allowing these violations, as obligations under the torture prevention framework as well as under the CRPD.
    b. Make explicit that forced psychiatric interventions amount to torture and ill-treatment per se, including detention, restraint, solitary confinement and intrusive and irreversible treatment with neuroleptics, other mind-altering drugs, electroshock or psychosurgery, without the free and informed consent of the person concerned.