



World Network of Users and Survivors of Psychiatry

WNUSP Submission to the Working Group on Arbitrary Detention for its Stakeholders consultation on remedies and procedures on the right to challenge the lawfulness of detention before court, 1-2 September 2014

The World Network of Users and Survivors of Psychiatry¹ is a global organization of self-identified users and survivors of psychiatry and persons with psychosocial disabilities. We are an organization of persons with disabilities with a global democratic structure and a member of the International Disability Alliance. WNUSP played an active role in the development of the Convention on the Rights of Persons with Disabilities, contributing substantially to the development of norms on legal capacity, liberty and security of the person, and freedom from torture and ill-treatment, among others. WNUSP members engage with human rights implementation and monitoring in their respective countries, based on the CRPD as well as other treaties.

This submission centers on the question of how to address the impermissible character of mental health detention under international law, in the context of court proceedings to determine the lawfulness of detention.

1. WNUSP position on the abolition of mental health detention and forced treatment

The background paper for this consultation cites the standard under the Convention on the Rights of Persons with Disabilities, Article 14. According to the Committee on the Rights of Persons with Disabilities, Article 14 prohibits detention in any kind of mental health facility and requires states to abolish legislative provisions that authorize detention in which mental health criteria are coupled with criteria such as “danger to self or others” or “need for care and treatment”.² Furthermore, under Articles 12 and 14 of the Convention, institutionalization without the free and informed consent of the person concerned amounts to arbitrary detention.³

¹ Website: www.wnusp.net; Contact: Tina Minkowitz, International Representative, tminkowitz@earthlink.net.

² Concluding Observations of the CRPD Committee under Article 14, CRPD/C/SWE/CO/1 paras 35-36; CRPD/C/AZE/CO/1 paras 28-29; CRPD/C/C/AUS/CO/1 paras 32(e) and 34; CRPD/C/AUT/CO/1 paras 29-30; CRPD/C/SLV/CO/1 para 32; CRPD/C/CHN/CO/1 paras 25-26; CRPD/C/HUN/CO/1 paras 27-28; CRPD/C/PER/CO/1 paras 28-29; CRPD/C/ESP/CO/1 paras 35-36; CRPD/C/TUN/CO/1 paras 24-25.

³ CRPD General Comment No. 1, Article 12: Equal recognition before the law, CRPD/C/GC/1 para 40.

WNUSP agrees with these conclusions and believes that a prohibition of mental health detention is required not only under the CRPD but also under ICCPR Article 9 in light of the principle of non-discrimination.⁴ There is no valid reason to distinguish between people with psychosocial disabilities and others with respect to the imposition of preventive detention for public safety reasons, or paternalistic detention said to be in the person's best interest. Such regimes are not typically imposed on the general population and would rightly be resisted as arbitrary, vague and detrimental to civil liberties and political participation. Their unfair and repressive character is not ameliorated but exacerbated when imposed on a segment of the population that is politically unpopular with dominant groups in society, particularly one, such as persons with psychosocial disabilities, that is guaranteed protection against discrimination under international human rights law.

Nor is the unfair character of mental health detention mitigated by the availability of court proceedings to make an individualized determination as to its lawfulness. Access to justice must be substantive as well as procedural. So long as courts are governed by a standard that authorizes mental health detention in any subset of cases, the rights of those individuals subjected to detention will be violated.⁵ Furthermore, all people with psychosocial disabilities experience a chilling effect on their exercise of civil, political, economic, social and cultural rights when they know that neighbors, family members, employers and police can at any time invoke a specialized detention regime against them and disrupt their lives temporarily if not for much longer periods of time. The collateral effects of psychiatric detention – including the imposition of forced treatment with addicting and harmful mind-altering drugs – are a huge loss to individuals and to society.⁶

a. CRPD social-construct model of disability

The CRPD enshrines a social-construct model of disability and rejects models of disability based on medical, charity and social welfare approaches, which diminish human dignity and equality of persons.⁷ On that basis, the CRPD provides for many kinds of support to be made available to persons with disabilities to enjoy and participate in all aspects of life and society to the extent desired by the individual. Examples of this

⁴ WNUSP, Submission to Human Rights Committee on its Draft General Comment No. 35, from the perspective of persons with disabilities, 9 September 2013, available at: <https://dk-media.s3.amazonaws.com/AA/AG/chrusp-biz/downloads/284703/WNUSPHRCmterresponseFINAL.pdf>.

⁵ Minkowitz, Why Mental Health Laws Contravene the CRPD: An Application of Article 14 with Implications for the Obligations of States Parties (2011), available at: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1928600.

⁶ Minkowitz, The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions (2007), available at: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1481512.

⁷ CRPD Preamble, Article 1, and Article 3.

are support in exercising legal capacity,⁸ support to live in the community and prevent isolation,⁹ peer support,¹⁰ habilitation and rehabilitation,¹¹ support to recognize and report instances of abuse and exploitation,¹² support in performance of childrearing responsibilities,¹³ support to facilitate their effective education in the general education system,¹⁴ programs to facilitate access to work and employment,¹⁵ financial assistance with disability-related expenses,¹⁶ access to poverty-reduction programs,¹⁷ and measures to enable the development and utilization of creative, artistic and intellectual potential.¹⁸ Services and supports must be made available – they are obligatory as a matter of right and not charity¹⁹ – and they must not infringe on personal autonomy and integrity but instead meet the individual on her/his own terms to create relations of mutual respect, learning and growth.²⁰

This vision was created by and for people with psychosocial disabilities as much as any other sector of the disability community.

b. Mental health detention as disability-based discrimination

In the context of human rights advocacy, WNUSP uses the term “persons with psychosocial disabilities” interchangeably with “users and survivors of psychiatry,” defined in our statutes to mean individuals who experience or have experienced madness or mental health problems, who use or have used mental health services, or who are currently being subjected to or have survived mental health services. Persons with psychosocial disabilities may experience long-term, short-term or intermittent impairments, or may experience no subjective impairment at all yet experience disability and discrimination because others perceive them to be impaired. Our perspective as global representative of a significant sector of the disability community was welcomed throughout the drafting and negotiation of the CRPD, and mental health detention was clearly explained as disability-based detention to be prohibited under Article 14.²¹

⁸ CRPD Article 12.3; also support for children with disabilities to express their views to be taken into account in matters concerning the child, CRPD Article 7.3.

⁹ CRPD Article 19(b).

¹⁰ CRPD Article 26.1.

¹¹ CRPD Article 26.

¹² CRPD Article 16(b).

¹³ CRPD Article 23.2.

¹⁴ CRPD Article 24.2(e).

¹⁵ CRPD Article 27.1(d), (e), (f), (h), (j), (k).

¹⁶ CRPD Article 28.2(a) and (c).

¹⁷ CRPD Article 28.2(b).

¹⁸ CRPD Article 30.2.

¹⁹ With respect to the obligation to provide support in the exercise of legal capacity, see CRPD General Comment No. 1 paras 16, 28, 29, 30, 34, 50(b) and throughout.

²⁰ CRPD General Comment No. 1 paras 17, 18, 19, 26, 29, 42, 46, 50(b).

²¹ See materials in the CRPD Negotiation Archives pertaining to liberty and security of the person (originally enumerated as Article 10, later as Article 14), including

Subsequent to the adoption of the CRPD, various actors have contended that detention based on mental health status, either alone or in combination with an assessment of risk to the person and to others, is something other than disability-based detention. This results from a misunderstanding of the scope of disability as understood under the CRPD.

While the CRPD does not define disability, it makes clear that it is an evolving concept and that persons with “long term mental impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” are among those included as persons with disabilities.²² It should be noted that this does not mean persons with short term or intermittent impairments are excluded, but that the Convention emphasizes those whose impairments are long-term. Obligations of non-discrimination, in particular, cannot depend on the duration of an impairment. The CRPD Committee has made it known that discrimination based on disability includes acts based on actual or perceived disability,²³ and has emphasized this particularly in its recommendations for the prohibition of mental health detention.²⁴

Another error is committed when it is contended that disability-based detention is prohibited only when disability is the sole criteria for detention. This was argued and rejected during the negotiations of the CRPD, when certain governments proposed language for article 14 that would prohibit detention based “solely” or “exclusively” on disability.²⁵ That formulation was rejected, as noted by OHCHR and by the Special Rapporteur on Torture.²⁶ The CRPD Committee has explicitly clarified that criteria such as “likelihood of harm to the person or to others” or “need for care and treatment” do not change the fundamental character of discriminatory detention that targets a particular sector of persons with disabilities, and has called for repeal of legislation authorizing mental health detention on these grounds.²⁷

c. Torture and ill-treatment

submissions by WNUSP and by the International Disability Caucus, available at: <http://www.un.org/disabilities/default.asp?id=1423>.

²² CRPD Article 1.

²³ CRPD Concluding Observations under Article 4, CRPD/C/ESP/CO/1 paras 19-20.

²⁴ CRPD Concluding Observations under Article 14, CRPD/C/SWE/CO/1 para 36; CRPD/C/AUT/CO/1 para 29; CRPD/C/CHN/CO/1 paras 25-26; CRPD/C/PER/CO/1 paras 28-29; and under Article 15, CRPD/C/CHN/CO/1 paras 27-28.

²⁵ See negotiation archives, in particular the unofficial daily summary of discussion on 19 January 2006, available at:

<http://www.un.org/esa/socdev/enable/rights/ahc7sum19jan.htm>.

²⁶ OHCHR Thematic Study on CRPD, A/HRC/10/48 paras 48-49; Special Rapporteur on Torture Interm Report on torture and persons with disabilities A/63/175 para 44; Special Rapporteur on Torture Report on torture in the context of health-care A/HRC/22/53 para

²⁷ CRPD Concluding Observations under Article 14, CRPD/C/SWE/CO/1 para 35-36; CRPD/C/AUT/CO/1 paras 29-30; CRPD/C/SLV/CO/1 para 32.

WNUSP has consistently argued that forced psychiatric interventions amount to torture whether they are performed for allegedly therapeutic purposes or otherwise.²⁸ Part of the justification for this assertion lies in the character of such interventions as causing severe pain and suffering as well as constituting a profound invasion of the consciousness, will and personality such that even with a therapeutic purpose acting without the person's consent cannot be justified.²⁹ The statements of people who have endured psychiatric coercion overwhelmingly describe the severe pain and suffering, both mental and physical, that these practices entail. Furthermore, all ostensible purposes for psychiatric intervention are founded on discriminatory intent: the intent to alter a person's consciousness, will or personality in the belief that it is defective and that such impairment cannot be tolerated but must be changed or destroyed.³⁰ As such, forced psychiatric interventions discriminate against persons with disabilities with respect to both the right to legal capacity and the right to physical and mental integrity. Our bodily autonomy is viewed as less worthy of protection than that of others, such that treatments harmful to both physical and mental well-being are deemed necessary to eradicate or control a supposed mental illness; and our personal and legal autonomy is trampled on as we are viewed as incapable of making legally valid choices.

The Committee on the Rights of Persons with Disabilities has affirmed in General Comment No. 1 that legal capacity cannot be deprived on the basis of a person's actual or perceived mental capacity or decision-making skills.³¹ Forced and non-consensual psychiatric treatment violates the right to legal capacity and infringes the right to be free from torture and ill-treatment.³² The Special Rapporteur on Torture has similarly recognized that intrusive and irreversible medical treatment aimed at correcting or alleviating a disability, such as electroshock and mind-altering drugs including neuroleptics, may constitute torture if enforced or administered without the free and informed consent of the person concerned,³³ and has called for an absolute ban on such interventions.³⁴

²⁸ Statement of WNUSP for Meeting of Experts in Mexico City, 11-14 June 2002, IDC Information Note on Forced Interventions as Torture (2005), and WNUSP Kampala Declaration (2009), available at: [http://www.chrusp.org/home/flyers; ENUSP/IDA/MDAC/WNUSP Submission to Special Rapporteur on Torture \(2012\)](http://www.chrusp.org/home/flyers;ENUSP/IDA/MDAC/WNUSP%20Submission%20to%20Special%20Rapporteur%20on%20Torture%20(2012).pdf), available at: https://dk-media.s3.amazonaws.com/AA/AG/chrusp-biz/downloads/281595/2012_11_06_TortureInHealthcare_submission.pdf.

²⁹ See Minkowitz, Forced interventions and institutionalization as torture/CIDT from the perspective of persons with disabilities (presentation), Annex III to Final report on OHCHR expert seminar on freedom from torture and persons with disabilities, available at: <http://www.ohchr.org/EN/Issues/Disability/Pages/UNStudiesAndReports.aspx>; see also Minkowitz 2007 (citation as in footnote 6).

³⁰ Id. See also Special Rapporteur on Torture A/63/175 paras 40, 47-49; A/HRC/22/53 para 32.

³¹ CRPD General Comment No. 1 paras 13-15.

³² CRPD General Comment No. 1 para 42.

³³ Special Rapporteur on Torture A/63/175 paras 40 and 47.

³⁴ Special Rapporteur on Torture A/HRC/22/53 para 89(b).

Both the CRPD Committee and the Special Rapporteur on Torture delineate the positive measures respecting individual autonomy that must be undertaken to provide supports and services to persons with disabilities on the basis of free and informed consent of the person concerned.³⁵ The absence of such supports, however, can in no way justify continuation of forced and coercive measures in mental health services. As noted by the Special Rapporteur, the obligation to end forced psychiatric interventions is of immediate application and scarce financial resources cannot justify a delay in its implementation.³⁶

d. Criminal responsibility and detention

People with disabilities as persons with equal status as others before and under the law,³⁷ have duties to the community, as well as rights, on an equal basis with others.³⁸ Mental health detention is not a legitimate disposition for individuals who are subject to criminal proceedings – not at any stage of the proceedings, whether pre-trial or following either acquittal or conviction.³⁹ The problem is not whether a particular mental health facility has better or worse conditions than a particular prison, rather that the form of detention subjects the person to medical authority and control instead of (or in addition to) the authority and control of the penal system. Medical authority and control treats the disability as the problem rather than (or in addition to) the criminal behavior, so that detention is predicated on the person's status rather than conduct. This sustains false and prejudicial stereotypes of persons with psychosocial disabilities as being uniquely undeterrable by criminal punishment, and casts us as dangerous outsiders to society and to humanity. Such a regime is plainly contrary to the CRPD.⁴⁰

Beyond the abolition of mental health detention, measures can be adopted to ensure that substantive and formal justice is done towards persons with psychosocial disabilities in criminal proceedings, under CRPD Article 13 on access to justice. Persons with psychosocial disabilities must be given the opportunity to promptly stand trial, with support and accommodations as may be needed, rather than declaring the person

³⁵ CRPD Concluding Observations under Article 14, CRPD/C/SWE/CO/1 para 36; CRPD/C/AZE/CO/1 para 29; CRPD/C/AUT/CO/1 paras 30-31 CRPD/C/CHN/CO/1 para 27; CRPD/C/HUN/CO/1 para 38; CRPD/C/ESP/CO/1 para 36; under Article 15, CRPD/C/PER/CO/1 para 31; under Article 19, CRPD/C/AZE/CO/1 paras 32-33; CRPD/C/CRI/CO/1 paras 39-40; CRPD/C/AUT/CO/1 paras 38-39; CRPD/C/SLV/CO/1 paras 41-42; CRPD/C/PRY/CO/1 paras 47-48; under Article 25, CRPD/C/CHN/CO/1 para 38; Special Rapporteur on Torture A/HRC/22/53 para 89(c).

³⁶ Special Rapporteur on Torture A/HRC/22/53 para 89(b).

³⁷ CRPD Articles 5 and 12.

³⁸ Universal Declaration of Human Rights Article 29.

³⁹ CRPD Concluding Observations under Article 13, CRPD/C/AUS/CO/1 para 29.

⁴⁰ See Special Rapporteur on Torture Report on the Standard Minimum Rules on the Treatment of Prisoners, A/68/295 para 72; see also WNUSP Submission on Revision of the Standard Minimum Rules on the Treatment of Prisoners (2011), available at: <http://www.chrusp.org/home/resources>.

incompetent.⁴¹ CRPD Article 14 furthermore requires that persons with disabilities under any (legitimate) form of detention have a right to guarantees on an equal basis with others, must be afforded reasonable accommodation, and must be treated in accordance with the objectives and principles of the Convention as a whole. For further information, please see WNUSP position papers and submissions in the context of the review of the Standard Minimum Rules on the Treatment of Prisoners.⁴²

2. How to address mental health detention in court proceedings

The right to challenge any detention before a court pertains with equal if not greater force to detention that is by its nature contrary to standards of international law. However, international norms should take care not to frame the right to have access to such proceedings in any way that legitimizes the prohibited detention. Thus, it is suggested that any normative discussion of court proceedings related to mental health detention begin by stating clearly that the detention is contrary to standards of international law.

Second, such a document should call for the effective incorporation into domestic law of the international prohibition of mental health detention and forced treatment (treatment without the free and informed consent of the person concerned). This means repeal or nullification of any legal provisions that allow mental health detention and forced treatment, whether by a legislative act of repeal, judicial decision, enactment of a superseding law, or other effective means. It should be recalled that access to justice has a substantive as well as a procedural component; if the substantive law is defective and violates human rights, it cannot be ameliorated by good procedures.

Third, there needs to be a discussion of procedures by which individuals who are currently detained in mental health facilities and/or subjected to forced treatment, or who may be so detained or forcibly treated in the future, can effectively and promptly secure their release. Such detention can be expected to continue if domestic laws continue to authorize such detention in violation of international standards or if facilities and medical personnel violate a prohibition contained in domestic law. Use by individuals of the remedy of habeas corpus can serve this purpose but is inefficient in a situation where there are a large number of instances of similar violations. (Individuals could also seek to raise arguments under international law in the context of proceedings under existing mental health laws that allow for review of detention, but given that the legislative framework legitimizes such detention, it is even more inefficient as a strategy to secure release of all those who are detained.) Class action lawsuits and the use of injunctive and declaratory remedies with large-scale impact are a better alternative. Injunctive relief should consist of measures such as requiring mental health facilities to unlock their doors and inform people of their right to leave, and establishing a public authority to provide for access to housing, means of subsistence and other forms of economic and social support in order to facilitate re-entry into the community. Such assistance programs

⁴¹ CRPD Concluding Observations under Article 13, CRPD/C/AUS/CO/1 para 30.

⁴² See materials on Prison Reform/Abolition and CRPD, <http://www.chrusp.org/home/resources>.

should not be centered on the provision of mental health services or treatment, but free or affordable mental health services and treatment, including alternatives that are free from medical-model diagnosis and interventions, as well as both access to medications and assistance in withdrawing from medications, should be made available for those who desire them.

Fourth, it would be helpful to remind governments of the obligation to provide for the subsistence and well-being of individuals who lack other resources, without depriving them of their liberty. Institutionalization is not a legitimate means of realizing economic, social and cultural rights in any sense. Under CRPD Articles 19 and 28 in particular, persons with disabilities have an equal right as others to an adequate standard of living and to live independently in the community, with equal opportunity to choose where and with whom to live. CRPD Article 14 (liberty and security of the person, corresponding in part to ICCPR Article 9) also has a positive component, requiring governments to shift resources from institutions to community-based supports.

Fifth, while urging governments to ratify the CRPD and to implement the abolition of mental health detention, the document should discuss the obligations of judges when required to adjudicate cases under current domestic laws that regulate but do not prohibit mental health detention. Governments should ensure that judges have the power to take into account standards of international law that contravene provisions of domestic law, when ruling on the lawfulness of detention. Judges should also be addressed directly as relevant actors who can use discretionary power available to them to rule in the interests of justice based on international law standards that they find persuasive. An example of innovative practice is found in Moldova, where judges in a few cities including the capital Chisinau, have begun to reject applications for guardianship and require the use of a provision of the Civil Code that provides for a form of supported decision-making instead, as required by Article 12 of the CRPD. Through their professional associations, judges and legal professionals should be encouraged to inform themselves about international law standards prohibiting mental health detention and forced treatment, and to apply those standards in their practice. Lawyers, lay advocates and people with psychosocial disabilities participating in court proceedings should also be encouraged to familiarize themselves with the standards and raise them in argument so as to educate the judiciary.

Sixth, the remedy of habeas corpus must always remain available to people who may voluntarily enter a mental health facility or utilize outpatient mental health services, but then find themselves prevented from leaving or being treated with medication, electroshock or other interventions against their will or without their free and informed consent. Notices in plain language alerting service users of the right to make choices at all times about hospitalization and treatment, including the right to discontinue any hospitalization or treatment, and informing them in detail of how to enforce these rights, should be posted prominently in all offices and facilities of service providers. In keeping with CRPD Article 16, mental health facilities and services should continue to be monitored independently to prevent abuse even after domestic laws authorizing detention and forced treatment have been repealed. Further under Article 16, mental health

detention and forced treatment should be viewed as forms of violence, exploitation and abuse to be prevented, reported and prosecuted. Victimized persons should be provided with remedies, including assistance to recover from trauma and re-establish one's life and livelihood, and access to desired services and supports including both medications and support to withdraw from medications, according to the person's preferences.