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

PsychRights® Law Project for Psychiatric Rights, Inc.

Voices of the Heart

MFI

World Network of Users and Survivors of Psychiatry

International Disability Alliance

Repeal Mental Health Laws

Documenting and challenging forced psychiatric treatment

Suggestions to the Human Rights Committee for disability-related questions to consider for its List of Issues for the United States

The situation of people labeled with psychiatric disabilities in the United States raises questions under Articles 2, 6, 7, 9, 10, 16, 25 and 26 of the Covenant.

We use the term "people labeled with psychiatric disabilities" to refer to those who identify as having experienced madness, mental health problems or trauma, or as having been labeled with a psychiatric diagnosis. These individuals are covered as persons with disabilities under the Americans with Disabilities Act[2] and under the United Nations Convention on the Rights of Persons with Disabilities.[3] "From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves" was the title of a significant report issued in January 2000 by the U.S. National Council on Disability.[4]

We consider the "medical model of mental health," under which altered mental and emotional states are characterized as pathological medical conditions, to be incompatible with our human rights and dignity. The Committee on the Rights of Persons with Disabilities acknowledges that alternatives to the medical model of mental health, including peer support, need to be made available.[5]

This submission suggests questions to ask of the United States government, followed by a preliminary review of the current state of U.S. laws and practices.

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[1] For information on organizations submitting this report see Annex I.
[2] 42 USC chapter 126; see § 12102 Definition of disability.
[3] A/RES/61/106; see Article 1; see also CRPD/C/ESP/CO/1 para 20, recommending that discrimination based on "perceived disability" be prohibited.
[4] http://www.ncd.gov/publications/2000/Jan202000.
[5] CRPD/C/CHN/CO/1 para 36.

Recommended questions for the United States government:

Article 2:

- What steps are being taken to reconsider the reservations, understandings and declarations that have been attached to proposed ratification of the Convention on the Rights of Persons with Disabilities, which also violate provisions of the ICCPR (Articles 2, 7, 9, 10, 16 and 26), and to conform U.S. law to the standards of the CRPD as interpreted by its Committee of Experts in anticipation of ratification?

Articles 6 and 7:

- What steps are being taken to require independent evidence of safety and efficacy for electroshock machines and for all anticipated uses of psychiatric drugs, and to ensure that no treatment is prescribed unless such evidence has been satisfactorily provided?

- What is being done to ensure that physicians respect and adhere to individuals' reports of adverse effects from psychiatric treatments, and that safety and efficacy are periodically re-evaluated based on such evidence as well as formal research findings?

- What steps are being taken to ensure that people seeking mental health services are able to receive all types of desired services in their own homes and communities, without being confined in a psychiatric facility, including trauma-informed services and peer support among other alternatives to the medical model of mental health?

Articles 7, 16 and 26:

- What steps are being taken to inaugurate new federal laws and policies requiring free and informed consent by the person concerned with respect to all mental health services (including those provided to children)?

Articles 7, 9 and 26:

- What steps are being taken to repeal state laws authorizing civil commitment and compulsory treatment on an inpatient or outpatient basis in the mental health system?

Articles 9, 10 and 26:

- What steps are being taken to reform criminal law and procedure, and the policies and practices of correctional institutions, to eliminate discrimination against people labeled with psychiatric disabilities, including forced drugging in prison or as a condition for diversion or release from prison?

Article 26:

- What steps are being taken to remove the names of individuals "adjudicated as mentally ill" from the NCIC database?

- How will the United States ensure that gun control laws and policies are free from disability or other profiling?

- What steps will be taken to prevent stereotyping and discrimination against people labeled with psychiatric disabilities, or the retrogressive enactment of increased coercion in mental health services, when considering measures to reduce gun violence?

Review of U.S. Laws and Practices

1. Discrimination against people labeled with psychiatric disabilities (Articles 2, 16, 25, 26)

The Americans with Disabilities Act covers people labeled with psychiatric disabilities, but it does not explicitly address the forms of discrimination that are most oppressive to us, particularly commitment to psychiatric institutions and forced psychiatric interventions, practices that violate human rights and have been recognized as forms of torture and ill-treatment practiced against persons with disabilities.[6]

Discrimination that persists despite the ADA also includes legal provisions that breach the right to equal recognition before the law by authorizing incompetency determinations and substituted decision-making, and by incorporating discriminatory standards in areas such as child custody, voting rights and criminal liability.

These forms of discrimination are addressed in the Convention on the Rights of Persons with Disabilities, which the United States signed in 2009. The U.S. has not acknowledged that the CRPD prohibits involuntary treatment and involuntary confinement, or made any attempt to repeal legal provisions authorizing these practices. The Obama Administration's memorandum sending the CRPD to the U.S. Senate for ratification stated incorrectly that civil commitment to psychiatric facilities pursuant to U.S. federal and state law complies with CRPD Article 14,[7] and that a presumption of legal capacity to make decisions "until proven otherwise" satisfies CRPD Article 12;[8] both statements conflict with the text of the CRPD and with the Committee's interpretations (and also violate Articles 2, 9 and 16 of the Covenant). The ratification proposal under consideration by the Senate includes a number of reservations, understandings and declarations (RUDs), including a reservation limiting responsibility for matters under state

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[6] UN Special Rapporteur on Torture, A/63/175 see especially paras 38, 40, 41, 47, 49, 61-65; OHCHR A/HRC/10/48, paras 43-49; OHCHR Dignity and Justice for Detainees Week Information Note No. 4 on Persons with Disabilities (2007).

[7] http://www.gpo.gov/fdsys/pkg/CDOC-112tdoc7/pdf/CDOC-112tdoc7.pdf, pp 34-37. The Committee on the Rights of Persons with Disabilities interprets Article 14 to require states to repeal provisions authorizing deprivation of liberty based on psychosocial or intellectual disability, and to ensure that mental health services are based on free and informed consent of the person concerned, see CRPD/C/ESP/CO/1 para 36; CRPD/C/HUN/CO/1 para 28; CRPD/C/CHN/CO/1 para 26.

[8] http://www.gpo.gov/fdsys/pkg/CDOC-112tdoc7/pdf/CDOC-112tdoc7.pdf, pp 28-32. The Committee on the Rights of Persons with Disabilities interprets Article 12 to require replacement of substituted decision-making by supported decision-making. For the most detailed interpretation of Article 12, see CRPD/C/CHN/CO/1 para 22; see also CRPD/C/ESP/CO/1 para 34; CRPD/C/PER/CO/1 para 25; CRPD/C/ARG/CO/1 para 20; CRPD/C/HUN/CO/1 para 26.

jurisdiction, and a declaration that current U.S. law "fulfills or exceeds its obligations under the treaty."[9] Such a pre-emptive declaration is factually incorrect and contravenes the core obligation to conform U.S. law to the standards of the treaty,[10] rendering it incompatible with the object and purpose of the Convention and the prompting a letter of objection from the Center for the Human Rights of Users and Survivors of Psychiatry and other human rights defenders, including distinguished professors of law.[11]

Ratification of the CRPD is not the first opportunity the United States has had to consider a reversal in its approach to mental health policy and discriminatory laws. In January 2000, the National Council on Disability, a federal advisory agency, stated that involuntary treatment was incompatible with the principle of self-determination, and that federal policy should move in the direction of a totally voluntary mental health system.[12] No action has been taken that would suggest the NCD's recommendations are being followed.

We would like to highlight a particular form of discrimination that is currently the subject of news and debate, the inclusion of people who have been "adjudicated as a mental defective or committed to a mental institution" in a national registry of individuals who are not permitted to own guns, along with convicted criminals, that is maintained by the Federal Bureau of Investigation.[13] This registry further penalizes people with disabilities for having been subjected to discriminatory detention and incompetency proceedings; it is baseless profiling that stigmatizes our community[14] and deprives us of equal protection under U.S. law, which recognizes a constitutional right to bear arms.[15] The issue here is not the desirability of gun ownership, but the way that the stereotype of violence is being used against our community, as similar stereotypes have been used against racial and ethnic minorities. Following a terrible act of violence on December 14, 2012 in Newtown, Connecticut, by a young man who killed 20 children and 7 adults before taking his own life, we are facing the prospect of increased scrutiny, surveillance and coercion as politicians attempt to satisfy public demands for action by scapegoating this minority group that does not have significant political power.[16]

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[9] http://thomas.loc.gov/cgi-bin/thomas, Treaty number 112-7.
[10] A/RES/61/106, Article 4.
[11] http://www.chrusp.org/media/AA/AG/chrusp-biz/downloads/254973/LtrSenate120312.pdf.
[12] "From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves," http://www.ncd.gov/publications/2000/Jan202000.
[13] Brady Law, P.L. 103-159, Title I; 107 Stat. 1536; see http://www.fbi.gov/about-us/cjis/nics/general-information/fact-sheet.
[14] Research shows there is no greater risk of violence by individuals labeled with psychiatric disabilities compared with others in their communities, see http://www.macarthur.virginia.edu/violence.html.
[15] District of Columbia v Heller, 554 U.S. 570 (2008).
[16] See for example remarks by Representative Sensenbrenner quoted in http://www.nytimes.com/2012/12/20/us/politics/obama-to-give-congress-plan-on-gun-control-within-weeks.html; the White House has blocked a petition requesting investigation of a link between violence and psychiatric drugs while calling for increased access to mental health services, http://www.madinamerica.com/2012/12/white-house-petition-seeks-investigation-into-school-shootings-and-psychiatric-drugs/. The disability community has responded; see http://repealmentalhealthlaws.org/?page_id=88; http://www.madinamerica.com/wp-comments-post.php; http://www.madinamerica.com/2012/12/a-reflection-on-mothers-children-and-mental-

These and other discriminatory laws enacted and enforced by United States federal, state and local governments violate the rights of persons with psychosocial disabilities under Articles 2, 16 and 26 of the Covenant.

2. Forced and nonconsensual psychiatric interventions and civil commitment (Articles 2, 7, 9, 10, 16, 26)

U.S. state and federal law allows the administration of mind-altering drugs and electroshock to people labeled with mental disorders without the person's free and informed consent and against his or her will.[17] For purposes of such "treatment" the law permits civil commitment and involuntary admission to designated facilities.[18] Physical and chemical restraint and solitary confinement are also practiced in psychiatric facilities.[19]

These treatments are known to cause serious pain and suffering and adverse consequences for individuals' health both short- and long-term,[20] including a shortened lifespan.[21] Psychiatric drugs are commonly prescribed for unapproved uses and as polypharmacy (prescribing several such drugs at the same time), without findings of safety and efficacy pertaining to such uses. It is also common that physicians reject individuals' reports of adverse effects from these drugs, even when the effects are listed in official prescribing information. Electroshock machines have never been evaluated by the Food and Drug Administration to determine safety and efficacy,[22] and proponents of this treatment have acknowledged that it causes brain damage.[23] The reality of psychiatric treatment amounts to a vast uncontrolled and unacknowledged experiment that disregards the lives and human worth of people labeled with psychiatric disabilities.

In New York State, compulsory treatment can be practiced on persons confined against their will in psychiatric facilities, under the parens patriae power of the state, based on a determination that

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illness-2/; http://www.advocacymonitor.com/an-injury-to-one-an-injury-to-all/#more-1049; http://autisticadvocacy.org/2012/12/asan-statement-on-media-reports-regarding-newtown-ct-shooting/ among others.

[17] Youngberg v Romeo, 102 S.Ct. 2452 (1982); Mills v Rogers, 102 S.Ct. 2442 (1982); Rennie v Klein, 102 S.Ct. 3506 (1982); Sell v United States, 539 U.S. 166 (2003).

[18] O'Connor v Donaldson, 422 U.S. 563; Addington v Texas, 441 U.S. 418.

[19] http://www.napas.org/en/issues/abuse-and-neglect/restraint-and-seclusion/277-restraint-and-seclusions-statutes-and-regulations.html.

[20] James B (Jim) Gottstein, Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course, 25 Alaska L Rev 51 (2008) pp 59-68; Peter R Breggin, M.D., Brain Disabling Treatments in Psychiatry (2008); Robert Whitaker, Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs and the Astonishing Rise of Mental Illness (2010); Linda Andre, Doctors of Deception: What They Don't Want You to Know about Shock Treatment (2009).

[21] Joukamaa et al, Schizophrenia, neuroleptic medication and mortality, British Journal of Psychiatry (2006) 188, 122-127.

[22] Andre, Doctors of Deception.

[23] Sackeim et al, The Cognitive Effects of Electroconvulsive Therapy in Community Settings, Neuropsychopharmacology (2007) 32, 244-254.

the individual lacks the capacity to make a reasoned decision about treatment.[24] It can also be conducted in institutions on an "emergency" basis without court approval, under the police power of the state.[25] Court-ordered treatment in the community can be imposed on individuals who have in the past refused to comply with mental health services and whose subsequent admission to psychiatric facilities, or subsequent act of violence, is attributed to such lack of compliance.[26] As a result of these laws and practices, people labeled with psychiatric disabilities are deprived of equal enjoyment of the right to free and informed consent in healthcare that is guaranteed to others under U.S. federal and state law.[27]

Alternatives to intrusive medical model "treatments" are growing in number and reputation,[28] including peer support, but they are often not readily available or affordable, or they become co-opted as an adjunct to medical model services rather than a true alternative.

A person can be involuntarily admitted and retained in a psychiatric facility in New York for an initial period ranging from 72 hours to two months without court involvement; longer retention must then be prospectively approved by a court.[29] The standard is that a person must be deemed dangerous to him/herself or others as a result of a mental disorder. There is no requirement of any overt act threatening violence, and behavior deemed likely to lead to the person's victimization by others is considered sufficient to demonstrate danger to self. The stereotype of "mental illness" as being associated with violence is here enshrined in a legal standard that applies loose criteria for preventive detention targeted uniquely to people labeled with psychiatric disabilities,[30] which deprives us of equal enjoyment of the right to liberty enshrined in Article 9 of the Covenant, thus also violating Article 2.

Such confinement causes physical and mental suffering because it is indefinite and based on prediction of future behavior that the individual is powerless to refute, and because it is

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[24] Rivers v Katz, 67 N.Y.2d 485 (1986).
[25] Id.
[26] NY Mental Hygiene Law, § 9.60.
[27] Cruzan v Director, MDH, 497 U.S. 261 (1990); In re Storar, 52 N.Y.2d (1981). Limitation of the exercise of free and informed consent and the right to refuse treatment to individuals deemed "competent" discriminates based on disability; see IDA letter on Functional Capacity, and IDA CRPD Forum Principles for the Implementation of CRPD Article 12, both available at http://www.chrusp.org/home/resources. Human rights requires the replacement of substituted decision-making regimes with supported decision-making that respects the autonomy, will and preferences of the individual; see also CRPD/C/CHN/CO/1 paragraph 22.
[28] For example, Intentional Peer Support, http://intentionalpeersupport.org, Hearing Voices Network, http://www.intervoiceonline.org, Soteria, http://www.moshersoteria.org, Trauma-Informed Care, http://www.samhsa
[29] NY Mental Hygiene Law Article 9. While the law requires a court hearing within five days if requested by an individual held under one of the shorter term provisions, it is not uncommon for hearings to be postponed and merged into the prospective request for a longer commitment required after 60 days.
[30] See James B (Jim) Gottstein, Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course, 25 Alaska L Rev 51 (2008), pp 90-93.

discriminatory and therefore stigmatizing.[31] Intense suffering amounting to torture is also caused by forced interventions with neuroleptics and other mind-altering drugs and electroshock, and by the use of restraint and solitary confinement in psychiatric facilities.[32]

The United Nations Special Rapporteur on Torture has recognized that forced psychiatric drugging and electroshock, as well as the continuing use of restraints and solitary confinement in psychiatric facilities, are forms of torture and ill-treatment,[33] and this Committee has recognized the injection of tranquilizers as a component of ill-treatment.[34] These practices violate Article 7, and can cause deaths violating Article 6. The administration of treatments for which there is no independent research demonstrating safety or efficacy, and which are known to cause serious adverse effects, also violates Article 7. Indefinite discriminatory detention violates Article 7 as well as Articles 9 and 10. In addition, the singling out of persons labeled with psychiatric disabilities for adverse treatment is discrimination violating Articles 2 and 26. The use of a "capacity" test to deprive individuals of personal and bodily autonomy violates Article 16 on equal recognition before the law.

3. People labeled with psychiatric disabilities in the prison system (Articles 2, 7, 9, 10, 16, 26)

A significant number of people in prisons are labeled with psychiatric disabilities, and there is also a system of forensic psychiatric institutions where people are confined if they are considered "incompetent" to defend themselves in a criminal trial or adjudicated not guilty by reason of insanity.[35] People in the forensic institutions are detained on an indeterminate basis, dependent on the judgment of medical professionals, rather than receiving a determinate sentence. Such detention, and the incompetency determinations on which it is based, are acts of adverse treatment based on the individual's disability and as such constitute discrimination in violation of human rights standards.[36]

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[31] Minkowitz, Forced interventions and institutionalization as torture/CIDT from the perspective of persons with disabilities (2007), Annex III to Final Report of the OHCHR expert seminar on freedom from torture and persons with disabilities, http://www.ohchr.org/EN/Issues/Disability/Pages/UNStudiesAndReports.aspx.

[32] Id; see also Minkowitz, The UN CRPD and the Right to be Free from Nonconsensual Psychiatric Interventions, Syracuse J of Intl L & Commerce (2007) Vol 34 No 2; and ENUSP/MDAC/IDA/WNUSP Submission to Special Rapporteur on Torture on his upcoming thematic report on torture in the context of healthcare, available at http://www.chrusp.org/home/resources.

[33] Special Rapporteur on Torture A/63/175, paras 38, 40, 41, 47, 55-57, 61-65; Special Rapporteur on Torture E/CN.4/1986/15, paras 118, 119.

[34] Human Rights Committee, views on communication No. 110/1981, Viana Acosta v. Uruguay, adopted on 29 March 1984 (CCPR/C/21/D/110/1981), paras 2.7, 14 and 15; see also Committee on the Rights of Persons with Disabilities, Concluding Observations on Peru (CRPD/C/PER/CO/1) paras 30-31.

[35] In New York State, see http://www.omh.ny.gov/omhweb/forensic/BFS.htm.

[36] See OHCHR A/HRC/10/48 para 47, interpreting CRPD Article 12 to preclude the insanity defense; see also WNUSP submissions to the review of the Standard Minimum Rules on the Treatment of Prisoners, available at http://www.chrusp.org/home/resources.

Forced drugging and involuntary segregation in a psychiatric unit within a prison are common and are permitted by law,[37] and a coercive medical model of mental health "treatment" predominates although there are some initiatives of good practice offering trauma-informed services.[38] Discriminatory policies make people labeled with psychiatric disabilities ineligible for certain programs in prison such as work release and New York State's "Shock Incarceration" early release program.[39]

Some states have special "mental health courts" and "drug treatment courts" that divert people labeled with psychiatric disabilities into the mental health system.[40] The penalties imposed by these courts for noncompliance with treatment violate the right to respect for physical and mental integrity by requiring an individual to prospectively waive the right to refuse treatment, especially when the program requires an individual to plead guilty as a condition of participation, so that the consequence of noncompliance is to serve the designated term in prison. In New York State people being released from prison can be required to undergo court-ordered psychiatric treatment, including forced drugging and compulsory attendance at programs amounting to institutionalization without walls in the community.[41]

The discriminatory laws, policies and practices applied to people labeled with psychiatric disabilities in the prison system violate Articles 2, 7, 9, 10, 16 and 26.

[37] Washington v Harper, 494 U.S. 210; Riggins v Nevada, 504 U.S. 127; Sell v United States, 539 U.S. 166 (2003).
[38] http://www.samhsa.gov/nctic/healing.asp.
[39] http://www.doccs.ny.gov/Directives/0086.pdf.
[40] https://www.bja.gov/publications/mhc_primer.pdf.
[41] NY Mental Hygiene Law § 9.60.

Annex I: Information about Organizations

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.

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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.

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Voices of the Heart mission: To promote and defend the rights and interests of people who have been labeled “mentally ill.”

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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.

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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.

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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.[42] 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.

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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.

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[42] 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.