



**Joint Submission¹ to the Human Rights Committee
on upcoming General Comment on Right to Liberty and Security**

1. We welcome the initiative of the Human Rights Committee (*hereinafter* “the Committee”) to issue a General Comment on the right to liberty and security, Article 9 of the International Covenant on Civil and Political Rights (*hereinafter* “the Covenant”). Our organisations advocate for the rights of people with disabilities worldwide and in the present submission we would like to draw the Committee’s attention to particular areas of concern which the General Comment could cover to ensure enhanced protection of the human rights of persons with disabilities with a particular focus on the right to security of the person in the context of arbitrary detention. This second submission should be read together with the first joint submission sent in for the Committee’s Day of General Discussion.²
2. We believe that the General Comment presents an important opportunity for the Committee to address the widespread practices of forced treatment of persons with psychosocial disabilities and intellectual disabilities which consist in violations of their right to liberty and security of person, freedom from torture and cruel, inhuman and degrading treatment or punishment, the right to live in the community and the right to non-discrimination.
3. In order to assist the Committee in better understanding the lived experiences of survivors of arbitrary detention and torture and ill-treatment in the context of forced psychiatry, testimonies have been collected and can be read in Annex I below (p 10). International human rights standards on the rights of persons with disabilities, including children, and their protection from arbitrary detention, torture and cruel, inhuman or degrading treatment and punishment have been regrouped in Annex II below (p 15).

Forced treatment and international human rights law: Repeal and absolute ban on legislation allowing forced interventions including forced institutionalisation

4. Forced interventions, including forced psychiatric interventions, are one of the most common and severe human rights violations carried out against people with

¹ For more information on the organisations and contact persons, please see Annex III below (p 31)

² Submission on the application of Article 9 of the International Covenant on Civil and Political Rights to disability-based detention and institutionalisation, as informed by related provisions in the Convention on the Rights of Persons with Disabilities

disabilities. Forced commitment and treatment are violations of the right to liberty;³ forced treatment also violates the right to respect for integrity of the person concerned,⁴ the right to be free from torture and ill-treatment,⁵ and their right to health.⁶ The CRPD establishes that health care must be provided on the basis of “free and informed consent of the person concerned”,⁷ as reaffirmed by Manfred Nowak, by the Committee on the Rights of Persons with Disabilities and by the Committee against Torture.⁸ The right to full and free informed consent needs to be respected regardless of where services are provided for the person: in hospitals, psychiatric wards, residential institutions, or in the community: in prayer camps and traditional healing centers, as well as criminal detention settings.

5. However, despite these human rights standards, people with psychosocial disabilities are systematically subjected to forced interventions worldwide that are wrongfully justified by medicalization of emotions and behavior, and by theories of incapacity and best interest inconsistent with the CRPD and other human rights standards. These human rights violations are legitimated under national laws, and enjoy wide public support as they are viewed as being justified by the alleged “best interest” of the person concerned, despite inflicting severe harm and suffering.⁹
6. Civil commitment to any institution is the opposite of free and informed consent; it is the point at which coercion begins. Furthermore, permitting civil commitment makes it inevitable that some manner of forced interventions will be carried out in the name of treatment, or that the same prohibited measures will be rationalized as security measures. There is a continuum between civil commitment and forced interventions and they cannot logically or practically be separated.
7. The modalities used in forced interventions, such as electroshock, psychosurgery and the administration of neuroleptics and other mind-altering drugs, physically damage the brain and can cause both short-term and long-term, even permanent adverse effects on cognitive abilities, emotional and mental sensitivity, and the neurological, endocrine and metabolic systems.¹⁰ These modalities also cause

³ See Annex II: Committee on the Rights of Persons with Disabilities, Concluding Observations with respect to China, September 2012, paras. 25-26.; Concluding Observations with respect to Spain, September 2011, paras. 35-36.

⁴ CRPD, Article 17.

⁵ CRPD, Article 15; CAT Articles 1, 2 and 16; ICCPR Article 7.

⁶ CRPD, Article 25.

⁷ CRPD, Article 25; see Annex II: Committee on the Rights of Persons with Disabilities, Concluding Observations with respect to China, September 2012, paras. 37-38; Committee on the Rights of Persons with Disabilities, Concluding Observations with respect to Tunisia, April 2011, paras. 28-29; and Concluding Observations with respect to Spain, September 2011, paras. 35-36.

⁸ Nowak (2008), para. 44 “[...] involuntary treatment and involuntary confinement runs counter to the provisions of the CRPD” and Committee on the Rights of Persons with Disabilities, Concluding Observations with respect to China, September 2012, paras. 37-38.

⁹ Nowak (2008) paragraphs 38, 40, 41.

¹⁰ See PR Breggin, *Psychiatric Drugs: Hazards to the Brain* (New York, Springer, 1983); D Cohen, ‘A Critique of the Use of Neuroleptic Drugs’ in S Fisher and RP Greenberg (eds), *From Placebo to Panacea: Putting Psychiatric Drugs to the Test* (New York, John Wiley, 1997); GE Jackson, *Rethinking Psychiatric Drugs: A Guide for Informed Consent* (Bloomington, AuthorHouse, 2005); M Joukamaa, M Heliövaara, P Knekt, A Aromaa, R Raitasalo and V Lehtinen, ‘Schizophrenia, Neuroleptic Medication and Mortality’ (2006) 188 *British Journal of Psychiatry* 122. L Andre, *Doctors of Deception: What They Don’t Want You to Know About Shock Treatment* (Piscataway, Rutgers University Press, 2009) 1–12. See also, PR Breggin, ‘Electroshock: Scientific, Ethical and Political Issues’ (1998) 11 *International Journal of Risk and Safety in Medicine* 5, and HA Sackeim, J Prudic, R Fuller, J Keilp, PW Lavori and M Olfson, ‘The Cognitive Effects of Electroconvulsive Therapy in Community Settings’ (2007) 32 *Neuropsychopharmacology* 244.

enormous pain and suffering and long-term trauma after their cessation.¹¹ These effects, and the dubious benefits of the treatments, are well known to professional literature but are minimized by treatment providers, reflecting a callous attitude towards the health and well-being of persons with disabilities, as well as their autonomy and self-determination.

8. The retrograde and harmful nature of forced interventions is further brought home by the availability of effective alternatives that fully respect the autonomy and preferences of the person concerned. This includes, in particular, alternatives based on peer support. Such alternatives have yielded very positive results, confirmed by personal testimony¹² and evaluative studies.¹³
9. There is an intimate link between forced interventions and the deprivation of legal capacity. Legal capacity and equal recognition before the law is one of the core rights of the CRPD as established in Article 12, as well as Article 16 of the Covenant and Article 15 of the Convention on the Elimination of all forms of Discrimination against Women (CEDAW). Millions of people with disabilities are stripped of their legal capacity worldwide, due to stigma and discrimination, through judicial declaration of incompetency or merely by a doctor's decision that the person "lacks capacity" to make a decision about his or her treatment. Legislation and widespread hostile practices have affirmed perceptions where persons with disabilities are stigmatized, excluded, marginalized and 'overruled', which denies their role as the own moral agent over their own lives. The removal of legal capacity deprives people of many of the fundamental rights of personhood, prohibited from exercising the right to make independent decisions about their life including where and with whom they live or with respect to their treatment.¹⁴ Deprived of legal capacity, people are assigned a guardian or other substitute decision-maker, whose consent will be deemed sufficient to justify forced institutionalization and treatment,¹⁵ or their right to exercise free and informed consent may simply be denied, with doctors, or courts and tribunals, making decisions that by right should be within the sphere of control of the individual. The opinion of the person concerned is simply overruled, possibly in every aspect of life.
10. International human rights standards require governments to recognize the legal capacity of persons with disabilities and to replace substituted decision-making with supported decision-making, which respects the person's autonomy, will and preferences. They must ensure that accommodations and support are made available to persons with disabilities, with feedback mechanisms to ensure that such support meets the person's needs. However, in many countries there are no systems or standards for meeting the needs of people who seek a high level of support appropriately in accordance with the CRPD, and there is as yet no country that has fully recognized the legal capacity of persons with disabilities and their right to exercise it. Therefore it is common for people to be labeled with a psychosocial

¹¹ WNUSP and Bapu Trust, *First Person Stories of Forced Interventions and Deprivation of Legal Capacity* (2006).

¹² See Annex I (p 14-18)

¹³ Peter Lehmann and Peter Stastny, eds., *Alternatives Beyond Psychiatry* (2007). See also resources at www.madinamerica.com.

¹⁴ Art. 25, CRPD

¹⁵ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, 11 February 2005, E/CN.4/2005/51, para 79.

disability and treated without regard for their free and informed consent, or against the person's will.

11. The administration of non-consensual medication is often claimed as being a necessary treatment for the so-called "best interest" of the person concerned. Mr Nowak stated that forced medical treatment amounting to torture is often covered up by claims of good intentions. Mr Nowak specifically included non-consensual outpatient treatment as a human rights violation that can amount to torture. This is an area of rising concern given the skyrocketing use of community treatment orders (CTO)¹⁶ worldwide. In the UK, for example, a recent Care Quality Commission (CQC) report found that 4,220 people had been subjected to CTOs in 2012, a 10% increase on the previous year¹⁷. One survivor of this forced outpatient drugging reported "I became 'zombified' for nearly 12 months when I was forced to take mood stabilisers and anti-psychotic medication [...] I felt I had no control of my human rights."¹⁸
12. Forced psychiatric interventions are not only a violation of the CRPD, but are also forms of torture and ill-treatment, as first established by Peter Kooijmans, the first Special Rapporteur on Torture in 1986.¹⁹ Mr Nowak has followed this by devoting a report to these and other abuses perpetrated against persons with disabilities and setting out a more detailed analysis of forced psychiatric interventions under the framework of torture and ill-treatment. In particular, he recognized that psychiatric interventions such as electroshock and mind-altering drugs including neuroleptics are among the intrusive and irreversible medical treatments aimed at correcting or alleviating a disability that may constitute torture or ill treatment if enforced or administered without the free and informed consent of the person concerned.²⁰ Mr Nowak emphasized the discriminatory character of forced psychiatric interventions when committed against persons with psychosocial disabilities and called attention to the express prohibition of infliction of suffering for reasons based on discrimination under Article 1 of the Convention against Torture.²¹ He found that discrimination based on disability sufficed to demonstrate both intent and purpose required under CAT Article 1, notwithstanding the claims of "good intentions" on the part of medical professionals. This was a welcome advance in human rights standards sensitive to the reality of severe violations, including forced psychiatric interventions, practiced against persons with disabilities in the medical context.
13. The Committee on the Rights of Persons with Disabilities and the Committee against Torture have taken Mr Nowak's lead and condemned forced psychiatric

¹⁶ A community treatment order, also known as outpatient commitment, is court-ordered compulsory treatment in the community. It almost invariably includes compulsory use of psychiatric drugs such as neuroleptics (often in combinations known as polypharmacy, which exacerbate drug effects), and compulsory home visits from a team of mental health workers or compulsory attendance at a treatment setting for regular depot injections. People who do not comply with these terms face compulsory hospitalisation. CTOs can also include compulsory attendance at a psychiatric day program and compulsory residence in supervised housing

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http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mentalhealth_2011_12_main_final_web.pdf

¹⁸ <http://www.guardian.co.uk/society/2011/mar/15/mental-health-patients-forced-detention>

¹⁹ Special Rapporteur, *Report of the Special Rapporteur on the Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 119, U.N. Doc. E/CN.4/1986/15 (19 February 1986).

²⁰ Nowak (2008), paras 40 and 47.

²¹ Nowak (2008), paras 39, 47, 48.

interventions under the framework of torture and ill-treatment.²² Despite Mr Nowak's report, however, and despite the jurisprudence of these Committees, the violations continue, requiring a redoubling of effort and an insistence that countries adhere to their human rights obligations toward persons with disabilities to stop torture and ill-treatment. WNUSP, ENUSP, CHRUSP and IDA consider forced drugging and other forced psychiatric interventions to amount to torture in all cases.²³

14. Children with (perceived)²⁴ disabilities are particularly affected by forced medical interventions as they are systematically denied their right to express their views and to make decisions about their treatment and placement. Instead, others make choices for them, supposedly in their best interest. Having a (perceived) disability should not diminish the weight given to the child's views in determining their best interest nor should it be the basis of substitution of determination and decision-making by parents, guardians, carers or the public authorities. In accordance with their evolving capacities, children with (perceived) disabilities, like all children, have valid insights into their well-being, valid solutions to their problems and a valid role in implementing those solutions.²⁵ Paternalistic attitudes often continue into adulthood and are based on the prejudicial perceptions that people with disabilities are childlike, therefore unable to make decisions about their own lives.
15. Women living with disabilities, and psychiatric labels in particular, are at risk of multiple forms of discrimination and other human rights violations related to liberty and security of the person. Women detained in psychiatric and social care institutions are subjected disproportionately to forced psychiatric interventions with electroshock and neuroleptic drugs, and also at increased risk of forced sterilization, forced abortions, sexual abuse, rape and other gender-based violence and exploitation. In addition to being deprived of their legal capacity and subjected to harmful and traumatic psychiatric interventions and detention, women and girls with psychiatric labels and those with intellectual disabilities are at times denied their sexual and reproductive rights, and their right to found a family and retain custody of their children.
16. Under the CRPD, there is an immediate obligation to abolish legislation and put an end to customs and practices that permit psychiatric interventions without the free and informed consent of the person concerned, and to provide remedies and redress for individuals who are deprived of their liberty based on a (perceived) disability in psychiatric institutions, prayer camps, jails and any setting, and subjected in any context to forced interventions. In addition, there is an immediate

²² See for instance the Committee's Concluding Observations on China, [CRPD/C/CHN/CO/1](#), September 2012, paras 27-28; Concluding Observations on Peru, [CRPD/C/PER/CO/1](#), April 2012, paras 34-35; CAT Committee Concluding Observations on Lithuania, June 2012, [CAT/C/CAN/CO/6](#), para 19(d); CAT Committee Concluding Observations on the Czech Republic, June 2012, [CAT/C/CZE/CO/4-5](#), para 21; Human Rights Committee Concluding Observations on Croatia, November 2009, [CCPR/C/HRV/CO/2](#), para 12.

²³ See T Minkowitz, The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions, *Syracuse Journal of Intl Law and Commerce* Vol 34 No 2 (2007).

²⁴ The characterization of psychosocial disability as "perceived" applies to adults as well, but it is particularly pertinent to the situation of children, who are developing mentally, physically and emotionally and can be especially harmed by being assigned a diagnostic label that limits their potential, and are being medicated, sometimes fatally, on the basis of spurious diagnoses.

²⁵ Boyden, J. and D. Levison, *Children as Economic and Social Actors in the Development Process*, Working Paper No. 1, Expert Group on Development Issues, Stockholm, 2000, cited in Lansdown, G., *The Evolving Capacities of the Child*, UNICEF Innocenti Research Centre, 2005 p. 23.

obligation to take positive steps to promote the enjoyment and exercise of the right to make one's own free and informed choices about mental health and other services, including legislation, policy, training and awareness-raising, and access to remedies, and to ensure that the exercise of legal capacity and decision-making by persons with psychosocial disabilities is respected.²⁶

17. Forced treatment and institutionalization need to be replaced with a wide range of services including peer support, with an emphasis on alternatives to the medical model of mental health that are available in the community and are free from coercion of any kind.²⁷ These services need to “respond to the needs expressed by persons with disabilities, and respect the person’s autonomy, choices, dignity and privacy”²⁸, otherwise they perpetuate the same treatment – in a different setting.
18. Further, the right to liberty under Article 14 must be read with Article 19 of the CRPD which secures “*the equal right of all persons with disabilities to live in the community*”.
19. This underscores that involuntary hospitalisation and institutionalisation should be eliminated, that supports and services should be provided for in the community and must respect the right to free and informed consent of the individual, and that the supports and services to be provided to support living in the community are not equivalent to health care, since disability is a social phenomenon and not a medical one. The right to live in the community does not mean the right to access medical-model services in the community, but rather the right to live freely with a wide range of supports of choices available, including the option to avail oneself of services for the general public that must be welcoming and accessible to persons with disabilities.

Recommendations:

Call on States to repeal legal provisions which allow forced and non-consensual medical interventions against persons with disabilities, including institutionalisation and the administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement and to recognize these practices and any forced interventions aimed at correcting or alleviating a disability as constituting torture and ill-treatment.

In accordance with Article 16, ICCPR, recognize that fully respecting each person’s legal capacity is an essential element in the prevention of arbitrary detention and torture and ill-treatment. Call on States to ensure the enjoyment and exercise of legal capacity on an equal basis with others by the repeal of laws allowing substituted decision-making, and to provide voluntary supports and accommodations that enable individuals to exercise their legal capacity and that fully respect their individual autonomy, will, and preferences.

Call on States to take effective steps to eliminate institutions and assist people in leaving them, and to develop community based supports and services that

²⁶ Nowak (2008) paras. 44, 50 and 73-74.

²⁷ See Annex II: Committee on the Rights of Persons with Disabilities, Concluding Observations with respect to China, September 2012, paras. 37-38

²⁸ *Id.*

meet needs expressed by persons with disabilities which respect the autonomy, choices, dignity, and privacy of the person concerned, including peer support.

Absolute ban on restraint and seclusion in all places of deprivation of liberty and in all programs and services designed to serve persons with disabilities.

20. Manfred Nowak's report during his tenure as Special Rapporteur on Torture recognized the link between solitary confinement and the harm caused by social isolation, a common feature affecting people with disabilities in *all* places of deprivation of liberty, including where deprivation of liberty is itself a violation of human rights. Such settings include psychiatric and social care institutions, psychiatric wards, emergency rooms, prayer camps or traditional healing centers.
21. Mr. Nowak stated that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions and said that both prolonged seclusion and restraint may constitute torture and ill-treatment.²⁹ This standard needs to be mainstreamed into the general discussion of solitary confinement, and it needs to be extended to restraint and solitary confinement of even short duration.
22. Restraint can include chemical³⁰, manual or physical/mechanical restraints which can for example be handcuffs, towels, leather straps³¹ or cage beds (these are beds with a netted or metal caging on the sides and on top to confine the person inside) and electroshocks.³² Caging in mental health facilities still exists. In a 2003 report, MDAC documented the routine use of cage beds in Hungary, the Czech Republic, Slovakia, and Slovenia.³³ MDAC found that cage beds were routinely being used as a substitute for adequate staffing or as a form of punishment against people with severe intellectual disabilities, elderly people with dementia, and people with psychosocial disabilities. People were placed in cage beds for hours, days, weeks, or sometimes months or years. A victim of such practices said, "You feel like you

²⁹ Nowak (2008), para 55-56.

³⁰ Forced, involuntary and non-consensual medication, such as forced injections, or medication mixed and concealed through food, are a fundamental breach of a person's right to integrity, which is the right to rule over one's own body. Often the administration of non-consensual medication is claimed as being a necessary treatment for the so-called best interest of the person concerned.

³¹ Straps and chains are still widely in use in many countries around the world, for example strapping persons to beds and chairs in general health care settings, mental health care institutions and social care homes, such as elderly homes, child care and homes for persons with intellectual disabilities. We note that many disabling furniture is in use, such as lockable chairs. Generally the victims of chaining and strapping are fully abandoned after being strapped/chained and are therefore fully disabled in all meaningful activities, including contact. In big parts of the world strapping/chaining still exists in prayer camps (often combined with praying and fasting), and throughout the community in family's homes. The practice often remains hidden.

³² Recent studies have shown that ECT causes irreparable brain damage; the region of the brain that is damaged is the same area assaulted by surgical lobotomy. This documented consequence of ECT is almost never mentioned to individuals who "consent" to the treatment, let alone to those who are forcibly and repeatedly electroshocked - in some countries without anaesthetic. See for instance Dr Peter Breggin, "New study shows ECT causes brain damage", Huffington Post, 4 September 2009. http://www.huffingtonpost.com/dr-peter-breggin/electroshock-treatment_b_1373619.html

³³ Mental Disability Advocacy Center, *Cage Beds: Inhuman and Degrading Treatment or Punishment in Four EU Accession Countries*, (Budapest: MDAC, 2003). Subsequent to the campaign, cage beds were banned in Hungary, and in Slovakia they were banned in social care institutions. In Slovenia we believe their use has considerably diminished. These are not the only countries where cage beds are used, however.

would rather kill yourself than be in there for several days.”³⁴ In May 2012, ENUSP, WNUSP and IDA made a submission on cage beds and other forced psychiatric interventions for the review of the Czech Republic in the Committee against Torture. A survivor of cage bed confinement shared his experiences with Committee, saying, “I felt, it was truly a poker game with death, I have to admit, I felt it kind of close.”³⁵ In January 2012, a woman in a Czech psychiatric hospital hanged herself in a cage bed after only hours of being confined there. Similar deaths in cage beds have been reported in the Czech Republic in recent years. These deaths often remain without proper investigation and no one is held accountable.³⁶ The CAT Committee this year told the Czech government to put a total ban on these beds, which should be reaffirmed by your report.

23. The Dutch government has recently introduced new high-tech forms of solitary confinement in mental health settings with touchscreens and toilets claiming that these are more humane: “high-tech isolation cells, which are cells with a touch-screen, a toilet and coloured lights, are euphemistically called “sensory support rooms”. These developments are dangerous, because it’s basically misleading and covering up the real abuse: the person is still locked up, but now it’s an expensive cell, so it doesn’t seem so inhumane, but it still is”.³⁷ Urgent action is needed against developments like these, especially since the tech lobby is so well-resourced. It is timely to call for a universal worldwide ban.
24. All services in the context of social or health care need to be provided through the full and informed consent of the person receiving treatment, as established by Article 25(d) of the CRPD. Any use of restraint and seclusion is in clear violation of this right, as well as of the right to liberty (Article 14) and the right to respect for physical and mental integrity (Article 17). It is essential that a ban on restraint and solitary confinement be part and parcel of a ban on all coercive and nonconsensual measures; otherwise, the motivations that led to the use of restraint and seclusion will lead to increased use of nonconsensual medication and electroshock, which are equally violative of integrity and human rights. The Committee on the Rights of Persons with Disabilities has emphasized the principle of free and informed consent of the person concerned in mental health services and other health care provided to persons with disabilities, under each of these provisions.³⁸

Recommendation:

We urge the Committee to address the issues of solitary confinement and restraint in light of these standards, and to call for an absolute ban on both prolonged and short term restraint and seclusion in *all* places of deprivation of liberty.

³⁴ Interview conducted with a cage bed survivor in the Czech Republic in 2003. Cage Beds: Inhuman and Degrading Treatment Punishment in Four EU Accession Countries. Mental Disability Advocacy Center. 2003. page 34

³⁵ To read the testimony of his experience being locked in a cage bed for ten days and forcibly medicated, see Annex I below (p ____).

³⁶ The Committee’s stated that the government needs to “[t]ake all necessary measures to ensure, in practice, the prohibition of the use of cage-beds, in conformity with the prohibition enshrined in the Act on Medical Services (Act No. 372/2011). In addition, the Committee recommends that the Act be amended to include the prohibition of the use of net-beds since their effects are similar to those of cage-beds.” UN Committee against Torture, Concluding Observations of the Committee: Czech Republic, 13 July 2013, CAT/C/CZE/CO/4-5, para 21(c).

³⁷ Jolijn Santegoeds, “European situation”. Blog entry of 20 October 2012. <http://punkertje.waarbenijj.nu/>

³⁸ See the section on informed consent in Annex II (p xx)

Forensic psychiatry and rights of prisoners with psychosocial disabilities

25. People with psychosocial disabilities who have committed a crime are often placed in forensic psychiatric settings and forcibly treated for indefinite periods - without knowing when they will be released. This goes against the CRPD, which implies abolishing a defence based on insanity as reaffirmed by the UN Office of the High Commissioner for Human Rights.³⁹ People with psychosocial disabilities are often transferred to forensic institutions if they resist civil psychiatric commitment and forced interventions. In these places, inmates are subjected to abuses typical of prison as well as those typical of psychiatric institutions; they experience double discrimination and severe violations of their human rights.⁴⁰
26. Under the CRPD, persons with psychosocial disabilities have equal guarantees as others when deprived of their liberty in law enforcement and criminal detention settings, and have the right to be treated in conformity with the objectives and principles of the CRPD, including provision of reasonable accommodation.⁴¹ This standard is based on formal plus substantive equality, rather than the uncritical paternalistic approach of the Mental Illness Principles.⁴² It is essential that in investigating the conditions and treatment to which persons with psychosocial disabilities are subjected in prisons, that the principles of individual autonomy, non-discrimination, and respect for difference be kept in mind, along with rights guaranteed in the CRPD such as the freedom from unwanted mental health services and the right to live in the community, which in the prison setting translates into the right to be housed in general population and not to be transferred against the person's will to mental health units within or outside the prison.⁴³

Recommendation:

Call on States to ensure the right to be free from forced psychiatric and medical interventions applies in all detention settings, including prisons. Further, call on States to ensure that mental health services in prisons, and transfer and placement into mental health units in prison, or mental health facilities outside of prison, can only be provided based on the free and informed consent of the person concerned, and that a wide range of services including peer support must be made available to prisoners with psychosocial disabilities, along with reasonable accommodation as defined in the CRPD.

³⁹ "In the area of criminal law, recognition of the legal capacity of persons with disabilities requires abolishing a defence based on the negation of criminal responsibility because of the existence of a mental or intellectual disability" *Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities*. Human Rights Committee. Distr. GENERAL A/HRC/10/48 26 January 2009, para 47.

⁴⁰ See first-person story of Tristano Ajmone, in Annex I (p 17-19).

⁴¹ CRPD Article 14.2.

⁴² See Annex II for references on the superseding nature of the CRPD over the Mental Illness Principles

⁴³ CRPD Articles 3, 12, 14, 15, 17, 25 and 19. See also WNUSP Discussion Paper on Prison and Mental Health Systems – available at <http://www.chrusp.org/media/AA/AG/chruspbiz/downloads/200273/WNUSPDiscussionPaperPrisonsMH.doc>.

ANNEX I: Personal testimonies of users/survivors of forced psychiatry

1) Personal testimony provided to ENUSP regarding detention, forced treatment and caging in a psychiatric clinic in Brno, Czech Republic, circa 2000 :

"This second time, I was brought there, more or less, involuntarily by some of my family members. The clinic's staff made me sign the voluntary admission, because it was beneficial to them for sure (no headaches with any legal processing) as well as to me as they described the situation to me.

They blocked the doors and there I was just calmly sitting, waiting... Before I had realized what happened, I was taken down by a bunch of staff, the security officers included, harshly injected with some kind of tranquilizer and wound up in a cage (cage bed – a regular sized bed with netting or metal bars all around and above it locked with a padlock) entirely confused, hopeless, helpless. I thought back then that they were trying to get rid of me... plus the injected stuff kicked in and with all these thoughts and emotions I was getting unconscious or worse... I was locked there for around 10 days.

The only thing I remember was that they frequently opened the cage and injected me again and again and because I was blanked out, I just woke up to take a leak through the bars... The whole time, at least when I needed something, there was nobody around and even the door of the room was constantly closed, except other patients staring at you through the door's window – very humiliating. I lost back then around 7 kilos and was so thirsty, I even attempted to wet my cracked lips with my own urine. Despite all this, I managed to open the cage bed and run away a couple of times, but no farther than to the nearest locked door, where I collapsed... I felt, it was truly a poker game with death, I have to admit, I felt it kind of close..."⁴⁴

Personal testimony of HL provided to We Shall Overcome, a Norwegian DPO, member of WNUSP. HL was subjected to psychiatric interventions over a period of 7 years, and had invasive side effects caused by the medication, including excessive weight gain from 55 kg to 97 kg.

"The consequences of the use of coercion are large and overwhelming. You are deprived of all rights pertaining to your life, You lose your freedom, which is the bedrock of everything with the capacity to grow. You lose the opportunity to stay in your home, which is the basis from which you can work and which can be your sanctuary for both safety, rest and peace. You can only eat and get fresh air when others allow you to. You cannot sleep without others coming into your room up to three times every night. You feel invaded in all possible ways and develop an intense need to be left alone. You cannot cry even when it is quiet, because then they come to you with their medicine. Subsequently they send you home with more afflictions than you suffered from initially. (...) The medication works in such a way that they add to your disability. They cut short your nerve impulses, causing motor and sensory disorders like those of an old man, making you extremely tired/dulled, or robbing you of the ability to speak."

2) Excerpts from First Person Stories of Forced Interventions and Being Deprived of Legal Capacity, published in 2006 by WNUSP and Bapu Trust. These excerpts are from the story of Elena in Peru:

After my first electroshock, I decided not to allow anybody either to touch or talk to me about pills. That experience was terrible, I felt like an animal tied to the stretcher, like a furious animal. Happy moment from the picnics of my childhood passed through my mind and body shake, they subjected me and I wanted to return to my garden, the

⁴⁴ See also: http://news.bbc.co.uk/2/hi/programmes/crossing_continents/3873123.stm

garden of the picnic of my childhood, and then, I did not understand what they were doing to me or why they did it. I only understood that if I could get free from that, I would not die, and I would never allow them to drive me crazy. I was January; I had finished High School a month before.

When I was 18, they gave me this alternative: either we declare you insane and you go to the madhouse, or you enter the Convent where the nuns of your old school love you. At my 18's, my second stage of joys ended within that Convent. The exorcisms, the lighted candles around my 18 years, I was on the floor, I still shake, it seems that I still hear the chorus of nuns, I wanted to die at each session. Why I did not die at each session? Why did I go through that torture? Until now I do not understand it. But those exorcisms did not have good results.

I think that happened to me for me to be able to speak for our little brothers and sisters, who are stolen away from their 13-14 year old happiness... their 18-19 year old happiness, the happiness of the best years of life.

I don't know if this testimony is useful at all. Perhaps I did not tell the hardest part. If you expected something harder, something that can make people to respect our right to exist, the right to be different, the right to assume our identity on our own best terms, to look for and decide about how we feel and experience, what is the best for us, I believe that the strongest story would be that you, states, families, community, acknowledge that when you exclude us or when you make decisions on our behalf, about each step in our lives, without giving the option to speak on our own behalf, to talk to you, like siblings within a family talk to each other, then this is the strongest thing of this story, the story of you, the one that must be changed, oriented, not to continue to violate our right to be recognized as equal persons with the same rights and obligations.

'The crazy one' is just a product of the fears of a competitive society where only the material exists.

These excerpts are from the story of "Noah" in India:

In the morning it happened. I had a premonition when I heard the sharp rap on my door at 7'o clock. I opened the door. Immediately, two burly men dressed in police uniforms overpowered me. The third (a medical social worker) whispered to me in a voice palpably radiating joy: "So, you think you are Mr. Know all." I was not allowed to go to either the WB or dress up but immediately bundled into the car and driven off to a government psychiatric facility. A long and unending night of torture in the name of treatment awaited me.

The story I was forced to tell the psychiatrists was the same that I had earlier told. But strangely, these psychiatrists gave me a diagnosis of SCHIZOPHRENIA. I repeatedly told them that though I might be under an episode of psychosis I am not in need of either medicines or involuntary hospitalization. No one listened to me.

After the first hospitalization the subsequent ones have all been on the ground of non-compliance. The issue was not whether I was psychotic or not but that I had stopped taking the medicine. I have stopped medication for two reasons. Firstly, I believe that medicines are not the cure. Secondly, I have discontinued the medicines because these have severe and highly discomfoting side effects. I suffered from slurred speech, prolonged constipation, tardive dyskinesia, akinesia (slowness of movement of limbs and hands), salivation, difficulty in passing urine and a dozen other grave side effects.

In August 2000 I was again forcibly readmitted and discharged after 2 1/2 months. I had been staying in Delhi alone, cooking, washing my clothes, going to the library for reading, interacting with people and doing activities, which a "schizophrenic" is supposed to find difficult to do. My medicine was changed. if earlier I had the responsibility of taking the medicine, this time that option has been withdrawn from me. My parents are giving me medicine under the strictest supervision. I am not allowed to

travel outside my city. I was not able to go for my honeymoon when I got married. My freedom is compromised in addition to suffering from untold misery because of the anti-psychotic medicines.

Since India is a patriarchal society, family centered with parents the bosses, the law pertaining to the people suffering mental agony is also overtly patriarchal. Such being the case, the onus of treatment has been directly placed in the hands of the parents. Even if the mental law legislates voluntarism, the parents won't balk at forceful treatment. The courts will see the tears of the parents, and over-rule voluntarism, the judges will cozy up with the parents and the Indian civil society, and adjudicate the case as a "family matter" between the suffering person and his family.

These excerpts are from the story of Tristan Ajmone in Italy:

My name is Tristano Jonathan Ajmone, I'm 34 years old, I live in Italy and, between 1998 and 2003, I have been subjected to a forensic-psychiatric regime for a period of five and a half years following a court sentence that declared me "partly incapable of intending and willing" - which is the juridical means by which an offender is denied moral agency for the acts of which he is accused.

The court decided that I was mentally insane based on a five minute meeting with the court's psychiatric expert who visited me in prison. We didn't exchange many words, yet he decided that I was a psychotic and insane.

Anyhow, my state of mind was such that ordinary prison personnel did not manage to cope with me, so I was moved to a special psychiatric branch inside the prison facility of Le Vallette, in Turin.

In this special branch (at the time, called "Settima Sezione blocco A" "7th Branch of Block A"), I was locked in a very small cell. The cell was about 9 square meters; it had bars on the windows and on the inner cell door; the outer cell door was an iron door filled with cement, and in the middle it had a big three-layered soundproof glass window that made it possible to see inside the cell, but sound would not escape the cell, nor could I hear what was going on outside when the door was closed; the toilet was in an open space, so that I would always be visible to the prison guards; there was a small sink with no hot water; the bed was a metal cot cemented to the floor....

In the 7th Branch there were no four-point-restraints, the punishment system was ritual beating.

So, after four months of pain and horror in the Seventh Branch I was moved to a civilian hospital, as a convict under a regime of home arrests. The place was an ordinary private psychiatric institution which happened to house, from time to time, convicts for treatment.

Even though the place was comfortable and clean, and we were not subjected to any particular harassment, one thing was clear: the fee we had to pay for all this "paradise as an alternative to hell" was to take all drugs without protesting. The institute did not tolerate any questioning about the drugs they gave us, we only had to swallow and "rest". We were not even allowed to ask the nurses what drugs we were given.

I remember those 18 months as the period of my life in which I was most sedated. I gradually slipped in a state which was quite close to mental vegetation. Side effects were really harsh to cope with, my limbs would shiver all the time, and I got fatter and fatter, my mind confused, and I soon wasn't able to read a novel. Any disobedience to the staff would result in a forensic report to the custody judge, who would revoke the benefit of home arrests and send us to a prison facility. So I had to shut up and swallow all that I was requested from the staff, which mainly consisted of taking the neuroleptic injections without complaining.

After a year at the Catholic psychiatric facility I was moved to a private "community" (comunità, as they are defined in Italian Mental Health System), which was a villa in the countryside (far away from my home and family).

The day I arrived I was immediately body searched and all of my luggage was thoroughly searched.

All of our money was handled by the staff, and they would give us the fags according to the psychiatrists' dispositions. So, despite the fact that it was a relatively open place, it had many prison-like rules of conduct.

The people in charge of our rehabilitation program (psychologists and educators) would force us to participate in a lot of activities, most of which were childish in nature. For example, we had to play hide-and-peek in group, or organize treasure hunts, and other games of the type that carry out during early childhood in school. So the experience was like being in Alice in Wonderland, and we all were quite disoriented about our external life and the problems that caused us to be there; but there was not much time to think since our daily life was scheduled in a detailed manner that left little time gaps to rethink our situation. It was like a kindergarten for adults, and was something quite odd since a few of the residents were there following serious offenses, like murder. Also, we were forcibly given strong psychiatric drugs in huge quantities (some people took up to six or seven drugs at the same time).

After a few months, I left the facility asking to go back to ordinary prison, because I could no longer stand the working rhythms, the massive drugging, and the endless sequence of false promises they would feed me regarding my social rehabilitation program and its coming steps. Since they didn't allow us to use or possess phones, and I was denied access to a fax machine to contact the judge or phone the police, I climbed the fence and ran to the nearest police station and asked them to take me back to ordinary prison. For my leaving the facility I was further charged with jailbreaking.

Shortly after going back to jail, my prison sentence expired and my period of Cure and Custody began in OPG. I was thus moved to the OPG of Montelupo Fiorentino, near Florence.

There are five OPGs prisons in Italy (Montelupo Fiorentino, Aversa Castiglione dell Stiviere, Barcellona Pozzo di Gotto, and Sant'Eframò). Only one of them has no bars and police guards (Castiglione dell Stiviere), the others are prison facilities. If it weren't for the fact that they give lots of drugs you wouldn't think that they are hospitals, yet they are called hospitals.

Life was really miserable there; most people lived in a state of total self-abandonment and simply lost any hope of getting free again. Young and old people alike were heavily drugged and had such strong side effects that you could notice them from a far distance. The place was really filthy and stinky. It took me a good amount of time to get used to its stench.

It's hard to describe how an inmate feels when his sentence is linked with a cure program which could last forever (indeed many people enter OPG with a 2 years period of cure and end up dying there after a whole life of "prorogations"). Unlike the man sentenced to death, a psychiatric hostage is tortured between the promise of imminent freedom and the risk of the request for another six months of cures. In such a state of uncertainty, it is very difficult to invest on anything. It's like trying to build a house on quicksand.

Violence was a normal part of our everyday life in OPG.

A man over 65 years old was put in a 5-point restraint for four days and four nights in a row, even though he had a bad lung disease. He was restrained because he insulted a doctor. Sometimes bed-restraining could last weeks.

My experience in the above mentioned psychiatric facilities has left an undeletable scar of sufferance in my soul, and for this reason I am always sad and unable to cope with life. Often I wake up in the middle of the night overwhelmed by the nightmares of memory: I dream of the tortures to which were subjected the people in psychiatric forensic facilities. I hear their desperate screams. Even though years have gone by, at times it still happens that I wake up frightened, screaming for the help of a security guard or a nurse. Then I resurface from the maze of dreams and realize that I am in my flat alone, and that there is no longer any security guard or nurse in the corridor... I'm alone with my fears. The only cell that now restrains me is that of the alienation that follows the dehumanization I underwent in psychiatry. I hope that such places will be soon locked down and that they will never exist again.

3) Excerpts from NOUSPR -Ubumuntu Advocacy Report for Persons with Psychosocial Disabilities in Rwanda - 2011 :

“Many people are not well informed about psychosocial problems, and they often misinterpret us. Their listening skills need to be improved; they make quick, and often wrong, conclusions about our situation. am a graduate with masters in electrical engineering, and am well experienced as a mature person expect any body to treat me with respect and dignity. how come a psychiatric nurse treat me like a young kid in a kindergarten?” Batiste.

“Many people in the medical services still assume they know what services we need and how to provide those “good services” to us without even seeking our consent. We are the ones using the services they give to us but we have no power to change them; we can’t even go to other services. Many mental health services continue to treat us without respect, equality and protection of our rights - especially our right to informed consent is suppressed.” Venuste.

Involvement of Traditional and Spiritual Healers and Doctors

Persons with psychosocial disability are often taken, with or without their consent, to traditional healers or “diviners” who are asked to identify the illness and provide a “cure”. The traditionalists provide “medication” for the specific illness they have diagnosed. Representatives from a spiritual church may examine “the patient” and order him/her to fast and pray “until God cures” their “problem”. Both churches and traditional healers keep people confined in isolated places where there are no facilities for someone who is unwell.

Medical practitioners often act as if they “own” persons with psychosocial disabilities in their care. This attitude often exacerbates psychosocial disability, because it can result in orders about what and when to eat/ drink, which can be harmful.

These people put persons with psychosocial disabilities in a very vulnerable position, where they often become more accepting of human rights violations against them and less likely to seek redress. There should be more effort on part of Government to protect the safety and welfare of persons with psychosocial disabilities, so they can receive appropriate and effective treatment.

ANNEX II: International standards with respect to torture and other cruel, inhuman or degrading treatment or punishment in the context of detention and forced treatment of persons with disabilities

- **Recognition as forms of torture and ill-treatment (see also throughout)**
- **Informed consent**
 - **Involuntary treatment**
 - **Legal capacity**
 - **Children**
- **Involuntary detention**
- **Restraints**
- **Forced medication, electroshock and other psychiatric interventions**
- **Medical experimentation**
- **The right to live in the community; community based health services and alternatives to medical model**

- **Forced psychiatric interventions as torture and ill-treatment**

For those involuntarily committed persons with actual or perceived intellectual and psychosocial impairments, the Committee is concerned that the “correctional therapy” offered at psychiatric institutions represents an inhuman and degrading treatment.

The Committee urges that the state party cease its policy of subjecting persons with actual or perceived impairments to such therapies and abstains from involuntarily committing them to institutions.

(**CRPD Committee Concluding Observations on China**, [CRPD/C/CHN/CO/1](#), September 2012, paras 27-28)

The Committee is concerned at consistent reports of the use of continuous forcible medication, including neuroleptics, and poor material conditions in psychiatric institutions, such as the hospital Larco Herrera, where some persons have been institutionalized for more than ten years without appropriate rehabilitation services.

(**CRPD Committee Concluding Observations on Peru**, [CRPD/C/PER/CO/1](#), April 2012, paras 34-35)

The author alleges that in 1976 he was subjected to psychiatric experiments (giving the name of the doctor) and that for three years, against his will, he was injected with tranquilizers every two weeks. He alleges in this connection that in May 1976 when he put up resistance to the injections, Captain X (name is given) ordered a group of soldiers to subdue him forcibly in order to inject the drug and that he was subsequently held incommunicado in a punishment cell for 45 days. He further claims, without providing any detail, that on 14 and 15 April 1977 he was interrogated and subjected to torture at Libertad prison, that on 22 November 1978 he was again subjected to torture (giving the names of his torturers in both instances), that he started a hunger strike protesting against this ill-treatment and that in retaliation he was held incommunicado in a punishment cell for 45 days without any medical attention. He claims that in April 1980 he was again held incommunicado because he had spoken with members of the International Red Cross visiting Libertad prison. The author lists the names of several Uruguayan officials who allegedly practised torture.

The Human Rights Committee, acting under article 5 (4) of the Optional Protocol to the International Covenant on Civil and Political Rights, is of the view that the facts as found by the Committee, in so far as they continued or occurred after 23 March 1976 (the date on which the Covenant and the Optional Protocol entered into force for Uruguay), disclose violations of the International Covenant on Civil and Political Rights, with respect to: articles 7 and 10 (1) because Antonio Viana Acosta was subjected to inhuman treatment.

(Views on communication No. 110/1981, *Viana Acosta v. Uruguay*, adopted by the **Human Rights Committee**, on 29 March 1984, CCPR/C/21/D/110/1981, paras. 2.7, 14 and 15.)

Persons with disabilities are often segregated from society in institutions, including prisons, social care centres, orphanages and mental health institutions. They are deprived of their liberty for long periods of time including what may amount to a lifelong experience, either against their will or without their free and informed consent. Inside these institutions, persons with disabilities are frequently informed consent. Inside these institutions, persons with disabilities are frequently subjected to unspeakable indignities, neglect, severe forms of restraint and seclusion, as well as physical, mental and sexual violence.

Persons with disabilities are exposed to medical experimentation and intrusive and irreversible medical treatments without their consent (e.g. sterilization, abortion and interventions aiming to correct or alleviate a disability, such as electroshock treatment and mind-altering drugs including neuroleptics).

The Special Rapporteur is concerned that in many cases such practices, when perpetrated against persons with disabilities, remain invisible or are being justified, and are not recognized as torture or other cruel, inhuman or degrading treatment or punishment. The recent entry into force of the Convention on the Rights of Persons with Disabilities and its Optional Protocol provides a timely opportunity to review the anti-torture framework in relation to persons with disabilities. (**Special Rapporteur on Torture, A/63/175, paras 38, 40, 41**)

Assessing the level of suffering or pain, relative in its nature, requires considering the circumstances of the case, including the existence of a disability, as well as looking at the acquisition or deterioration of impairment as result of the treatment or conditions of detention in the victim. Whereas a fully justified medical treatment may lead to severe pain or suffering, medical treatments of an intrusive and irreversible nature, when they lack a therapeutic purpose, or aim at correcting or alleviating a disability, may constitute torture and ill-treatment if enforced or administered without the free and informed consent of the person concerned. (**Special Rapporteur on Torture, A/63/175, para 47**)

Furthermore, the requirement of intent in article 1 of the Convention against Torture can be effectively implied where a person has been discriminated against on the basis of disability. This is particularly relevant in the context of medical treatment of persons with disabilities, where serious violations and discrimination against persons with disabilities may be masked as "good intentions" on the part of health professionals. Purely negligent conduct lacks the intent required under article 1, and may constitute ill-treatment if it leads to severe pain and suffering. (**Special Rapporteur on Torture, A/63/175, para 49**)

The use of psychiatry as a means of torture or ill-treatment for the purpose of political repression, in the context of the fight against terrorism and, to a lesser extent, in treatment inflicted in order to attempt to suppress, control and modify the sexual

orientation of individuals has been well documented. However, the Special Rapporteur notes that abuse of psychiatry and forcing it upon persons with disabilities, and primarily upon persons with mental or intellectual disabilities, warrants greater attention. (**Special Rapporteur on Torture, A/63/175, para 62**)

The administration in detention and psychiatric institutions of drugs, including neuroleptics that cause trembling, shivering and contractions and make the subject apathetic and dull his or her intelligence, has been recognized as a form of torture. In *Viana Acosta v. Uruguay*, the Human Rights Committee concluded that the treatment of the complainant, which included psychiatric experiments and forced injection of tranquilizers against his will, constituted inhuman treatment. The Special Rapporteur notes that forced and non-consensual administration of psychiatric drugs, and in particular of neuroleptics, for the treatment of a mental condition needs to be closely scrutinized. Depending on the circumstances of the case, the suffering inflicted and the effects upon the individual's health may constitute a form of torture or ill-treatment. (**Special Rapporteur on Torture, A/63/175, para 63**)

There are two main types of torture: physical and psychological or mental. In physical torture, pain is inflicted directly on the body; in the psychological or mental torture the aim is to injure the psyche. The two types are interrelated and ultimately both have physical and psychological effects.

The following list, which is not exhaustive, refers to some methods of physical torture:

Electric shocks

Shocks of variable intensity to any part of the body causing intensive muscular contractions

Administration of drugs, in detention or psychiatric institutions

neuroleptics, that cause trembling, shivering and contractions, but mainly make the subject apathetic and dull his intelligence

(**Special Rapporteur on Torture, E/CN.4/1986/15, paras 118, 119**)

- **Informed consent**

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)

The Committee is concerned with the imposition of rehabilitation and habilitation measures on persons with disabilities, especially persons with psychosocial or intellectual disabilities, without their informed consent.

The Committee recommends that rights based approach to rehabilitation and habilitation be put in place and ensure that such programmes promote the informed consent of individuals with disabilities and respects their autonomy, integrity, will and preference. (**CRPD Committee Concluding Observations on China, [CRPD/C/CHN/CO/1](#), September 2012, paras 39-40**)

Igualmente, le recomienda adoptar protocolos que garanticen el consentimiento libre e informado de todas las personas con discapacidad para recibir cualquier tratamiento médico. **(CRPD Committee Concluding Observations on Argentina, [CRPD/C/ARG/CO/1](#), September 2011, paras 41-42)**

The Committee recommends that the State party: review its laws that allow for the deprivation of liberty on the basis of disability, including mental, psychosocial or intellectual disabilities; repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability; and adopt measures to ensure that health-care services, including all mental-health-care services, are based on the informed consent of the person concerned. **(CRPD Committee Concluding Observations on Spain, [CRPD/C/ESP/CO/1](#), September 2011, paras 35-36)**

The Committee is concerned about the lack of clarity concerning the scope of legislation to protect persons with disabilities from being subjected to treatment without their free and informed consent, including forced treatment in mental health services.

The Committee recommends that the State party incorporate into the law the abolition of surgery and treatment without the full and informed consent of the patient, and ensure that national law especially respects women's rights under article 23 and 25 of the Convention. **(CRPD Committee Concluding Observations on Tunisia, [CRPD/C/TUN/CO/1](#), April 2011, paras 28-29)**

Notwithstanding the changes in legislation announced by the delegation of the State party, the Committee is concerned about the reports of frequent placement of persons with intellectual or psychosocial disabilities in social, medical and psychiatric institutions without their informed and free consent; the continued use of cage-beds and net-beds as well as the use of other restraint measures such as bed strapping, manacles, and solitary confinement, often in unhygienic conditions and with physical neglect. The Committee is also concerned about the absence of investigations into the ill-treatment and deaths of institutionalized persons confined to cage and net-beds, including suicides (arts. 11 and 16, CAT).

The Committee recommends that the State party:

(a) Allocate appropriate funding for the implementation of the national plan on the transformation of psychiatric, health, social and other services for adults and children with intellectual or psychosocial disabilities to ensure a speedy process of deinstitutionalization to more community-based services and/or affordable housing.

(b) Establish close supervision and monitoring by judicial organs of any placement in institutions of persons with intellectual or psychosocial disabilities, with appropriate legal safeguards and visit by independent monitoring bodies. **Institutionalization and treatment should be based on free and informed consent and that the persons concerned should be informed in advance about the intended treatment.**

(CAT Committee Concluding Observations on the Czech Republic, June 2012, [CAT/C/CZE/CO/4-5](#), para 21)

Whereas a fully justified medical treatment may lead to severe pain or suffering, medical treatments of an intrusive and irreversible nature, when they lack a therapeutic purpose, or aim at correcting or alleviating a disability, may constitute torture and ill-treatment if enforced or administered without the free and informed consent of the person concerned. **(Special Rapporteur on Torture, A/63/175, para 47)**

States should issue clear and unambiguous guidelines in line with the Convention on what is meant by “free and informed consent”, and make available accessible complaints procedures. **(Special Rapporteur on Torture, A/63/175, para 74)**

Such policies and programmes should be developed in close partnerships with women and girls with disabilities and with disability organizations, including those providing services for survivors, and encompass:

(e) Prohibiting compulsory/forced treatment of persons with disabilities and ensuring adequate procedural safeguards to protect the right to prior informed consent;
(OHCHR Thematic study on the issue of violence against women and girls and disability March 2012, [A/HRC/20/5](#), para 53(d), (e))

- **Involuntary treatment**

Thus, in the case of earlier non-binding standards, such as the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (resolution 46/119), known as the MI Principles, the Special Rapporteur notes that the acceptance of involuntary treatment and involuntary confinement runs counter to the provisions of the Convention on the Rights of Persons with Disabilities. **(Special Rapporteur on Torture, A/63/175, para 64)**

- **Legal capacity**

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 recommends that the State party use effectively the current review process of its Civil Code and related laws to take immediate steps to derogate guardianship in order to move from substitute decision-making to supported decision-making, which respects the person's autonomy, will and preferences and is in full conformity with article 12 of the Convention, including with respect to the individual's right, on their own, to give and withdraw informed consent for medical treatment, to access justice, to vote, to marry, to work, and to choose their place of residence. The Committee further recommends the State party to provide training, in consultation and cooperation with persons with disabilities and their representative organizations, at the national, regional and local levels for all actors, including civil servants, judges, and social workers on the recognition of the legal capacity of persons with disabilities and on mechanisms of supported decision-making.

(CRPD Committee Concluding Observations on Hungary, [CRPD/C/HUN/CO/1](#), September 2012, para 26)

The Committee welcomes the fact that Act 26/2011 amends regulations to contain provisions to reflect the right to accessibility when granting informed consent to medical treatment. It however regrets that guardians representing persons with disabilities deemed “legally incapacitated” may validly consent to termination or withdrawal of medical treatment, nutrition or other life support for those persons. The Committee wishes to remind the State party that the right to life is absolute, and that substitute decision-making in regard to the termination or withdrawal of life-sustaining treatment is inconsistent with this right.

The Committee requests the State party to ensure that the informed consent of all persons with disabilities is secured on all matters relating to medical treatment, especially the withdrawal of treatment, nutrition or other life support. (CRPD Committee Concluding Observations on Spain, [CRPD/C/ESP/CO/1](#), September 2011, paras 29-30)

Torture, as the most serious violation of the human right to personal integrity and dignity, presupposes a situation of powerlessness, whereby the victim is under the total control of another person. Persons with disabilities often find themselves in such situations, for instance when they are deprived of their liberty in prisons or other places, or when they are under the control of their caregivers or legal guardians. In a given context, the particular disability of an individual may render him or her more likely to be in a dependant situation and make him or her an easier target of abuse. However, it is often circumstances external to the individual that render them “powerless”, such as when one’s exercise of decision-making and legal capacity is taken away by discriminatory laws or practices and given to others.

(Special Rapporteur on Torture, [A/63/175](#), para 50)

The Special Rapporteur notes that State acquiescence with regard to violence against persons with disabilities may take many forms, including discriminatory legislative frameworks and practices such as laws depriving them of their legal capacity or failing to ensure equal access to justice of persons with disabilities, resulting in impunity for such acts of violence.

(Special Rapporteur on Torture, [A/63/175](#), para 69)

In keeping with the Convention, States must adopt legislation that recognizes the legal capacity of persons with disabilities and must ensure that, where required, they are provided with the support needed to make informed decisions. (Special Rapporteur on Torture, [A/63/175](#), para 73)

In the area of criminal law, recognition of the legal capacity of persons with disabilities requires abolishing a defence based on the negation of criminal responsibility because of the existence of a mental or intellectual disability. (Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities, [A/HRC/10/48](#) 26 January 2009)

- **Children**

The Committee emphasizes that article 12 imposes no age limit on the right of the child to express her or his views, and discourages States parties from introducing age limits

either in law or in practice which would restrict the child's right to be heard in all matters affecting her or him. In this respect, the Committee underlines the following:

- First, in its recommendations following the day of general discussion on implementing child rights in early childhood in 2004, the Committee underlined that the concept of the child as rights holder is "... anchored in the child's daily life from the earliest stage". Research shows that the child is able to form views from the youngest age, even when she or he may be unable to express them verbally. Consequently, full implementation of article 12 requires recognition of, and respect for, non-verbal forms of communication including play, body language, facial expressions, and drawing and painting, through which very young children demonstrate understanding, choices and preferences.
- Second, it is not necessary that the child has comprehensive knowledge of all aspects of the matter affecting her or him, but that she or he has sufficient understanding to be capable of appropriately forming her or his own views on the matter.
- Third, States parties are also under the obligation to ensure the implementation of this right for children experiencing difficulties in making their views heard. For instance, children with disabilities should be equipped with, and enabled to use, any mode of communication necessary to facilitate the expression of their views. Efforts must also be made to recognize the right to expression of views for minority, indigenous and migrant children and other children who do not speak the majority language.

(CRC Committee General Comment no 12, the right of the child to be heard, [CRC/C/GC/12](#), July 2009, para 21)

Ensure that all health services provided to children and adolescents with disabilities, including mental health services and, in particular, the administration of psychotropic substances, are based on the free and informed consent of the children concerned, according to their evolving capacities.

(CRC Committee Concluding Observations on Costa Rica, August 2011, [CRC/C/CRI/CO/4](#), para 56(d))

Enact non-discriminatory legislation that prohibits non-therapeutic sterilization of all children, regardless of disability; and ensure that when sterilisation that is strictly on therapeutic grounds does occur, that this be subject to the free and informed consent of children, including those with disabilities;

(CRC Committee Concluding Observations on Australia, June 2012, [CRC/C/AUS/CO/4](#), para 57(f))

In the case of children, States must ensure that health professionals carry out such interventions only if they serve a therapeutic purpose, are in the best interests of the child, and are based on the free and informed consent of the parents (though parental consent must be disregarded if the treatment is not in the best interest of the child). Otherwise, the Special Rapporteur notes that such treatments may constitute torture, or cruel, inhuman or degrading treatment. **(Special Rapporteur on Torture, A/63/175, para 59)**

▪ **Involuntary detention**

The Committee notes with appreciation that the State party is dedicated to undertaking measures to provide reasonable accommodation to persons with disabilities that are deprived of their liberty. It also notes with appreciation that "personal liberty is assured by making use of the services voluntarily" (paragraph 87 of the State party's report: CRPD/C/HUN/1). However, the Committee is concerned about the situation faced by persons under guardianship, where the decision of institutional care is made by the

guardian instead of the person him/herself, and guardians are authorised to give consent to mental health care services on behalf of their ward. The Committee further regrets that disability, in some cases, can be the ground for detention.

The Committee recommends that the State party review provisions in legislation that allow for the deprivation of liberty on the basis of disability, including mental, psychosocial or intellectual disabilities, and adopt measures to ensure that health care services, including all mental health care services, are based on the free and informed consent of the person concerned. **(CRPD Committee Concluding Observations on Hungary, [CRPD/C/HUN/CO/1](#), September 2012, paras 27-28)**

The Committee recommends the abolishment of the practice of involuntary civil commitment based on actual or perceived impairment. In addition, the Committee asks the state party to allocate more financial resources to persons with intellectual and psychosocial disabilities who require a high level of support, in order to ensure social support and medical treatment outside their own home when necessary. **(CRPD Committee Concluding Observations on China, [CRPD/C/CHN/CO/1](#), September 2012, para 26)**

The Committee notes with concern that article 11 of the General Health Law No. 26842 permits involuntary detention for people with "mental health problems", defined to include people with psychosocial disabilities as well as persons with a "perceived disability" (persons with a drug or alcohol dependence).

The Committee calls upon the State party to eliminate Law 29737 which modifies article 11 of the General Health Law, in order to prohibit the deprivation of liberty on the basis of disability, including psychosocial, intellectual or perceived disability. **(CRPD Committee Concluding Observations on Peru, [CRPD/C/PER/CO/1](#), April 2012, paras 28-29)**

The Committee takes note of the legal regime allowing the institutionalization of persons with disabilities, including persons with intellectual and psychosocial disabilities ("mental illness"). It is concerned at the reported trend of resorting to urgent measures of institutionalization which contain only ex post facto safeguards for the affected individuals. It is equally concerned at the reported abuse of persons with disabilities who are institutionalized in residential centres or psychiatric hospitals.

The Committee recommends that the State party: review its laws that allow for the deprivation of liberty on the basis of disability, including mental, psychosocial or intellectual disabilities; repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability; and adopt measures to ensure that health-care services, including all mental-health-care services, are based on the informed consent of the person concerned. **(CRPD Committee Concluding Observations on Spain, [CRPD/C/ESP/CO/1](#), September 2011, paras 35-36)**

The Committee recommends that the State party repeal legislative provisions which allow for the deprivation of liberty on the basis of disability, including a psychosocial or intellectual disability.

The Committee further recommends that until new legislation is in place, all cases of persons with disabilities who are deprived of their liberty in hospitals and specialized institutions be reviewed, and that the review include the possibility of appeal. **(CRPD Committee Concluding Observations on Tunisia, [CRPD/C/TUN/CO/1](#), April 2011, paras 24-25)**

The Convention radically departs from this approach by forbidding deprivation of liberty based on the existence of any disability, including mental or intellectual, as discriminatory. Article 14, paragraph 1 (b), of the Convention unambiguously states that “the existence of a disability shall in no case justify a deprivation of liberty”. (**Thematic study of the High Commissioner for Human Rights on implementation on key legal measures for the ratification and implementation of the Convention on the Rights of Persons with Disabilities**, [A/HRC/10/48](#), para 48)

Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished. This must include the repeal of provisions authorizing institutionalization of persons with disabilities for their care and treatment without their free and informed consent, as well as provisions authorizing the preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness. (**Thematic study of the High Commissioner for Human Rights on implementation on key legal measures for the ratification and implementation of the Convention on the Rights of Persons with Disabilities**, [A/HRC/10/48](#), para 49)

Key human rights standards on the detention of persons with disabilities state that:

- The existence of a disability shall in no case justify a deprivation of liberty.
- Persons with disabilities have the right to live in the community
- Persons with disabilities are recognized to have legal capacity on an equal basis with others in all aspects of life.
- Those with disabilities who are detained have the right to be treated humanely.

([OHCHR Information Note no 4 on Detention: Persons with Disabilities](#))

The Special Rapporteur recalls that article 14 of CRPD prohibits unlawful or arbitrary deprivation of liberty and the existence of a disability as a justification for deprivation of liberty. (**Special Rapporteur on Torture, A/63/175, para 64**)

In certain cases, arbitrary or unlawful deprivation of liberty based on the existence of a disability might also inflict severe pain or suffering on the individual, thus falling under the scope of the Convention against Torture. When assessing the pain inflicted by deprivation of liberty, the length of institutionalization, the conditions of detention and the treatment inflicted must be taken into account. (**Special Rapporteur on Torture, A/63/175, para 65**)

▪ Restraints and seclusion

The State party should take all necessary measures to ensure that detention conditions in all places of deprivation of liberty are in conformity with the UN Standard Minimum Rules for the Treatment of Prisoners, adopted by the Economic and Social Council in its resolutions 663 C (XXIV) and 2076 (LXII). It should, inter alia:

d) Abolish the use of solitary confinement for persons with serious or acute mental illness. (**CAT Committee Concluding Observations on Lithuania**, June 2012, [CAT/C/CAN/CO/6](#), para 19(d))

Notwithstanding the changes in legislation announced by the delegation of the State party, the Committee is concerned about the reports of frequent placement of persons with intellectual or psychosocial disabilities in social, medical and psychiatric institutions without their informed and free consent; the continued use of cage-beds and net-beds as well as the use of other restraint measures such as bed strapping, manacles, and solitary confinement, often in unhygienic conditions and with physical neglect. The Committee is also concerned about the absence of investigations into the ill-treatment and deaths of institutionalized persons confined to cage and net-beds, including suicides (arts. 11 and 16, CAT).

The Committee recommends that the State party:

(a) Allocate appropriate funding for the implementation of the national plan on the transformation of psychiatric, health, social and other services for adults and children with intellectual or psychosocial disabilities to ensure a speedy process of deinstitutionalization to more community-based services and/or affordable housing.

(b) Establish close supervision and monitoring by judicial organs of any placement in institutions of persons with intellectual or psychosocial disabilities, with appropriate legal safeguards and visit by independent monitoring bodies. Institutionalization and treatment should be based on free and informed consent and that the persons concerned should be informed in advance about the intended treatment.

(c) Provide a clear legal basis for the use of all forms of restraint measures in institutional settings. It urges the **prohibition of the use of restraint measures such as cage-beds and net-beds.**

(d) Ensure the effective monitoring and independent assessment of the conditions in institutions, including hygiene and instances of neglect. It should establish a complaints mechanism, ensure counsel and provide training to medical and non-medical staff on how to administer non-violent and non-coercive care. All cases of ill-treatment and deaths, including those of 30 year-old Vera Musilova in 2006 and the suicide of a 51 year-old woman on 20 January 2012, should be effectively investigated and prosecuted and redress provided to the victims and their families, including compensation and rehabilitation.

(CAT Committee Concluding Observations on the Czech Republic, June 2012, [CAT/C/CZE/CO/4-5](#), para 21)

While noting the State party's statement concerning its commitment to abolish the use of enclosed restraint beds (cages/net beds) as a means to restrain mental health patients, including children, in institutions, the Committee is concerned about the current use of such beds. The Committee recalls that this practice constitutes inhuman and degrading treatment. (arts. 7, 9, 10 of the Covenant) The State party should take immediate measures to abolish the use of enclosed restraint beds in psychiatric and related institutions.

(Human Rights Committee Concluding Observations on Croatia, November 2009, [CCPR/C/HRV/CO/2](#), para 12)

Poor conditions in institutions are often coupled with severe forms of restraint and seclusion. Children and adults with disabilities may be tied to their beds, cribs or chairs for prolonged periods, including with chains and handcuffs; they may be locked in "cage" or "net beds" and may be overmedicated as a form of chemical restraint. It is important to note that "prolonged use of restraint can lead to muscle atrophy, life-threatening deformities and even organ failure", and exacerbates psychological damage. The Special Rapporteur notes that there can be no therapeutic justification for the prolonged use of restraints, which may amount to torture or ill-treatment. **(Special Rapporteur on Torture, A/63/175, para 55)**

Within institutions, persons with disabilities are often held in seclusion or solitary confinement as a form of control or medical treatment, although this cannot be justified for therapeutic reasons, or as a form of punishment. In December 2003, the Inter-American Commission on Human Rights approved precautionary measures to protect 460 individuals detained in the State-run Neuro-psychiatric Hospital in Paraguay, including two teenage boys who had been detained in solitary confinement for over four years in isolation cells, naked and in unhygienic conditions. In *Victor Rosario Congo v. Ecuador*, the Inter-American Commission on Human Rights considered that the solitary confinement to which Mr. Congo (who had a mental disability) was subjected in a social rehabilitation centre constituted inhuman and degrading treatment in terms of article 5, paragraph 2, of the American Convention on Human Rights. The Special Rapporteur notes that prolonged solitary confinement and seclusion of persons may constitute torture or ill-treatment. (**Special Rapporteur on Torture, A/63/175, para 55**)

▪ **Forced medication, electroshock and other psychiatric interventions**

For those involuntarily committed persons with actual or perceived intellectual and psychosocial impairments, the Committee is concerned that the “correctional therapy” offered at psychiatric institutions represents an inhuman and degrading treatment. The Committee urges that the state party cease its policy of subjecting persons with actual or perceived impairments to such therapies and abstains from involuntarily committing them to institutions.

(**CRPD Committee Concluding Observations on China**, [CRPD/C/CHN/CO/1](#), September 2012, paras 27-28)

The Committee is concerned at consistent reports of the use of continuous forcible medication, including neuroleptics, and poor material conditions in psychiatric institutions, such as the hospital Larco Herrera, where some persons have been institutionalized for more than ten years without appropriate rehabilitation services. (**CRPD Committee Concluding Observations on Peru**, [CRPD/C/PER/CO/1](#), April 2012, paras 34-35)

It also recommends that the State party incorporate into the law the abolition of violent and discriminatory practices against children and adults with disabilities in the medical setting, including deprivation of liberty, the use of restraint and the enforced administration of intrusive and irreversible treatments such as neuroleptic drugs and electro convulsive therapy (ECT). In addition, the Committee recommends that existing legal provisions allowing for the complete removal or suspension of legal capacity for persons with mental, intellectual or other disabilities be amended in order to avoid abuse. Furthermore, the Committee recommends that provisions for assisted decision-making be developed and implemented without delay.

(**CESCR Committee Concluding Observations on Moldova**, [E/C.12/MDA/CO/2](#), 2011, para 24)

Carefully monitor the prescription of psycho-stimulants to children and take initiatives to provide children diagnosed with ADHD and ADD, as well as their parents and teachers, with access to a wider range of psychological, educational and social measures and treatments; and, consider undertaking the collection and analysis of data disaggregated according to the type of substance-and age with a view to monitoring the possible abuse of psycho-stimulant drugs by children. (**CRC Committee Concluding Observations on Australia**, June 2012, [CRC/C/AUS/CO/4](#), para 65(e))

Investigate the phenomenon of over-prescription of psycho-stimulants to children and take initiatives to provide children diagnosed with ADHD, as well as their parents and teachers, with access to a wide range of psychological, educational and social measures and therapies. (**CRC Committee Concluding Observations on Belgium**, June 2010, 59(e); **on Norway**, [CRC/C/NOR/CO/4](#), March 2010, para 43; **on Spain**, [CRC/C/ESP/CO/3-4](#), November 2010, para 49)

The use of electroshocks on prisoners has been found to constitute torture or ill-treatment. The use of electroshocks or electroconvulsive therapy (ECT) to induce seizures as a form of treatment for persons with mental and intellectual disabilities began in the 1930s. CPT has documented instances in psychiatric institutions where unmodified ECT (i.e. without anaesthesia, muscle relaxant or oxygenation) is administered to persons to treat their disabilities, and used even as a form of punishment. The Special Rapporteur notes that unmodified ECT may inflict severe pain and suffering and often leads to medical consequences, including bone, ligament and spinal fractures, cognitive deficits and possible loss of memory. It cannot be considered as an acceptable medical practice, and may constitute torture or ill-treatment. In its modified form, it is of vital importance that ECT be administered only with the free and informed consent of the person concerned, including on the basis of information on the secondary effects and related risks such as heart complications, confusion, loss of memory and even death.

Special Rapporteur on Torture, A/63/175, para 61)

Inside institutions, as well as in the context of forced outpatient treatment, psychiatric medication, including neuroleptics and other mind-altering drugs, may be administered to persons with mental disabilities without their free and informed consent or against their will, under coercion, or as a form of punishment. The administration in detention and psychiatric institutions of drugs, including neuroleptics that cause trembling, shivering and contractions and make the subject apathetic and dull his or her intelligence, has been recognized as a form of torture. In *Viana Acosta v. Uruguay*, the Human Rights Committee concluded that the treatment of the complainant, which included psychiatric experiments and forced injection of tranquillizers against his will, constituted inhuman treatment. The Special Rapporteur notes that forced and non-consensual administration of psychiatric drugs, and in particular of neuroleptics, for the treatment of a mental condition needs to be closely scrutinized. Depending on the circumstances of the case, the suffering inflicted and the effects upon the individual's health may constitute a form of torture or ill-treatment. (**Special Rapporteur on Torture, A/63/175, para 63)**

- **Medical experimentation**

The Committee is concerned that Act CLIV of 1997 on Healthcare provides for a legal framework for subjecting persons with disabilities whose legal capacity is restricted to medical experimentation without their free and informed consent, as consent may be given by their legal guardians. The Committee is also notes with concern that there is no independent medical examination body mandated to examine alleged victims of torture and guarantee respect for human dignity during the conduct of medical examinations, as stated by the Human Rights Committee (CCPR/C/HUN/CO/5). The Committee urges the State party to amend Act CLIV on Healthcare and abolish its provisions that provide a legal framework for subjecting persons with disabilities with restricted legal capacity to medical experimentation without their free and informed consent. The Committee

recommends the State party to implement the recommendation made by the Human Rights Committee in 2010 (CCPR/C/HUN/CO/5) to “establish an independent medical examination body mandated to examine alleged victims of torture and guarantee respect for human dignity during the conduct of medical examinations.”

(**CRPD Committee Concluding Observations on Hungary**, [CRPD/C/HUN/CO/1](#), September 2012, paras 29-30)

For those involuntarily committed persons with actual or perceived intellectual and psychosocial impairments, the Committee is concerned that the “correctional therapy” offered at psychiatric institutions represents an inhuman and degrading treatment. Further, the Committee is concerned that not all medical experimentation without free and informed consent is prohibited by Chinese law. The Committee urges that the state party cease its policy of subjecting persons with actual or perceived impairments to such therapies and abstains from involuntarily committing them to institutions. Further it urges the state party to abolish laws which allow for medical experimentation on persons with disabilities without their free and informed consent. (**CRPD Committee Concluding Observations on China**, [CRPD/C/CHN/CO/1](#), September 2012, paras 27-28)

Under article 15 of CRPD medical or scientific experimentation on persons with disabilities, including testing of medicines, is permissible only when the person concerned gives his or her free consent and when the very nature of the experiment cannot be deemed torture or cruel, inhuman or degrading treatment. (**Special Rapporteur on Torture**, [A/63/175](#), para 58)

- **The right to live in the community; community based health services**

The Committee recommends to take immediate steps to phase out and eliminate institutional-based care for people with disabilities. Further, the Committee recommends State party to consult with organisations of persons with disabilities on developing **support services for persons with disabilities to live independently in accordance with their own choice. Support services should also be provided to persons with a high level of support needs. In addition, the Committee suggests that the state party undertake all necessary measures to grant people with leprosy the medical treatment needed and to reintegrate them into the community**, thereby eliminating the existence of such lepers’ colonies. (**CRPD Committee Concluding Observations on China**, [CRPD/C/CHN/CO/1](#), September 2012, para 32)

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)

The Committee urges the MSAR to prioritize the implementation of this right and shift from institutionalization to in-home or residential living as well as provide other community support services. (**CRPD Committee Concluding Observations on China**, [CRPD/C/CHN/CO/1](#), September 2012, para 93)

The Committee calls upon the State party to ensure that an adequate level of funding is made available to effectively enable persons with disabilities to: enjoy the freedom to choose their residence on an equal basis with others; access a full range of in-home, residential and other community services for daily life, including personal assistance; and enjoy reasonable accommodation with a view to supporting their inclusion in their local communities.

(CRPD Committee **Concluding Observations on Hungary**, [CRPD/C/HUN/CO/1](#), September 2012, para 34)

The Committee urges the State party to initiate comprehensive programmes to enable persons with disabilities to access a whole range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community, especially in rural areas. (CRPD Committee **Concluding Observations on Peru**, [CRPD/C/PER/CO/1](#), April 2012, para 33)

The provisions of article 19 of the Convention carry far-reaching implications for all forms of institutionalized care of persons with disabilities. The recognition of the right of persons with disabilities to independent living and community inclusion requires the shift of government policies away from institutions towards in-home, residential and other community support services. The key element of any intervention aimed at giving effect to the right to independent living and community inclusion is the explicit legal recognition of the right of persons with disabilities to determine where and with whom to live. This recognition should also openly reflect the unlawfulness of arrangements for residential care made against the wishes of a person with disabilities.

De-institutionalization is necessary but not sufficient to achieve the goal of independent living. In most cases, a national strategy that integrates interventions in the area of social services, health, housing and employment, at a very minimum, will be required. For the effective implementation of such strategies it is necessary that the independent living principle be rooted in a legislative framework which clearly establishes it as a legal right and in turn places duties on authorities and service providers, while also allowing for recourse in case of violation. Such legislative frameworks shall include the recognition of the right to access the support services required to enable independent living and inclusion in community life, and the guarantee that independent living support should be provided and arranged on the basis of the individual's own choices and aspirations, in line with the principles of the Convention.

(**Thematic study of the High Commissioner for Human Rights on implementation on key legal measures for the ratification and implementation of the Convention on the Rights of Persons with Disabilities**, [A/HRC/10/48](#), paras 50-51)

The Committee recommends that the State party:

(a) Allocate appropriate funding for the implementation of the national plan on the transformation of psychiatric, health, social and other services for adults and children with intellectual or psychosocial disabilities to ensure a speedy process of deinstitutionalization to more community-based services and/or affordable housing.

(b) Establish close supervision and monitoring by judicial organs of any placement in institutions of persons with intellectual or psychosocial disabilities, with appropriate legal safeguards and visit by independent monitoring bodies. **Institutionalization and treatment should be based on free and informed consent and that the persons concerned should be informed in advance about the intended treatment.** (CAT

Committee Concluding Observations on the Czech Republic, June 2012, [CAT/C/CZE/CO/4-5](#), para 21)

The Committee notes the State party's acknowledgement that poor and inadequate treatment takes place in some institutions and remains concerned at the reports of treatment of children and adults with mental or physical disability, especially at the forceful internment and long-term restraint used in institutions that amount to torture or cruel, inhuman and degrading treatment or punishment in social-protection institutions for persons with mental disability and psychiatric hospitals. The Committee is concerned that no investigation seems to have been initiated with respect to treatment of persons with disability in institutions amounting to torture or inhuman or degrading treatment (arts. 2, 12, 13 and 16).

The State party should:

- (a) Initiate social reforms and alternative community-based support systems in parallel with the ongoing process of de-institutionalization of persons with disability, and strengthen professional training in both social-protection institutions for persons with mental disability and in psychiatric hospitals; and
- (b) Investigate reports of torture or cruel, inhuman or degrading treatment or punishment of persons with disability in institutions. (**CAT Committee Concluding Observations on Serbia, [CAT/C/SRB/CO/1](#), 2008, para 16**)

Increase human, technical and financial resources allocated to children with disabilities, focusing on the development of community-based services which could better reach families with children with disabilities in all areas, and provide basic education, social and health services. (**CRC Committee Concluding Observations on Cameroon, [CRC/C/CMR/CO/2](#), 2010, para 52(c)**)

Undertake efforts to establish and to implement alternatives to the institutionalization of children with disabilities, including community-based rehabilitation programmes and home-based care; (**CRC Committee Concluding Observations on Latvia, [CRC/C/LVA/CO/2](#), 2006, para 40(c)**)

The Committee recommends that the State party, taking into account the Committee's General Comment No. 9 (2006) on the rights of children with disabilities (CRC/C/GC/9), take all necessary measures to:

- (d) Continue and increase the provision of community-based programmes and services in order to allow children with disabilities to stay at home with their families; (**CRC Committee Concluding Observations on Malaysia, [CRC/C/MYS/CO/1](#), 2007, para 61(d)**)

The Committee recommends that the State party: (c) Undertake greater efforts to make available the necessary professional (i.e. disability specialists) and financial resources, especially at the local level and to promote and expand community-based rehabilitation programmes, including parent support groups to ensure that all children with disabilities receive adequate services; (**CRC Committee Concluding Observations on Bolivia, [CRC/C/BOL/CO/4](#), 2009, para 52(c)**)

The Committee recommends that the State party: (a) Reduce the large number of children placed in alternative care by parents by developing a comprehensive policy for the provision of assistance to families and a complimentary community-based service and protection system; (**CRC Committee Concluding Observations on Timor Leste, [CRC/C/TLS/CO/1](#), 2008, para 49(a)**)

Field Code Changed

Provide all children with disabilities with access to adequate social and health services, including community-based support and services, inclusive quality education, the physical environment, information and communication, and continue its efforts to standardize the service provision. (**CRC Committee Concluding Observations on Oman**, [CRC/C/OMN/CO/2](#), 2006, para 44(d))

The Committee recommends that the State party make greater efforts to implement alternatives to the institutionalization of children with disabilities, including community-based rehabilitation programmes and reunification of children with their parents. (**CRC Committee Concluding Observations on Kyrgyzstan**, [CRC/C/15/ADD.127](#), 2000, para 42; on Armenia, [CRC/C/15/ADD.225](#), 2004, para 44; on Estonia, [CRC/C/15/ADD.196](#), 2003, para 39(c))

ANNEX III- About the organisations

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.⁴⁵ 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 **European Network of (Ex-) Users and Survivors of Psychiatry (ENUSP)** is the grassroots, independent representative organisation of mental health service users and survivors of psychiatry at a European level. ENUSP's members are regional, national and local organisations and individuals across 39 European countries. Since its foundation in 1991, ENUSP has campaigned for the full human rights and dignity of mental health service users and survivors of psychiatry and the abolition of all laws and practices that discriminate against us. ENUSP is currently a consultant to the European Commission, the European Union Fundamental Rights Agency, and the World Health Organization-Europe. ENUSP is a member of European Disability Forum (EDF) and European Patients' Forum (EPF) and part of the World Network of Users and Survivors of Psychiatry (WNUSP). Through WNUSP, our members were active in the drafting and negotiation of the CRPD.

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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 **Mental Disability Advocacy Center (MDAC)** is an international human rights organisation which is based in Budapest, Hungary. It advances the rights of children and adults with intellectual disabilities and those with psycho-social (mental health) disabilities. MDAC does this through a combination of strategic litigation, research, advocacy and capacity-building, and the organisation has participatory status at the Council of Europe and special consultative status at the UN Economic and Social Council. MDAC is a member organisation of the OPCAT Contact Group, a network of NGOs, which assists the work of the UN Subcommittee on Prevention of Torture (SPT).

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⁴⁵ 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.

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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