Center for the Human Rights of
Users and Survivors of Psychiatry

Prohibition of Involuntary Hospitalization and Involuntary Treatment: Countering Misapprehensions

A briefing paper addressed to the Committee on the Rights of Persons with Disabilities and other stakeholders

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1. As the CRPD Committee is aware, there is still a great deal of misunderstanding about the standard applied to involuntary hospitalization and involuntary treatment under the CPRD. A large part of this misunderstanding is due to a failure to read closely the Committee's guidance on this subject, especially in General Comment No. 1 and the Guidelines on Article 12.

2. There are also proposals that misconstrue a statement in a report by the Office of the High Commissioner for Human Rights (A/HRC/10/48, paragraph 49), to permit 'disability-neutral' legislation that, while formally de-linking disability as a criterion, would perpetuate the practice of involuntary commitment and involuntary treatment in mental health settings. This cannot the standard under the CRPD, and the Committee should take every opportunity to insist on the absolute prohibition of impairment-based detention, both as arbitrary detention and as a violation of the right to legal capacity. All detention in mental health settings is impairment-based; as the Committee noted in its Concluding Observations to Spain (2019), all persons with (actual or perceived) mental health conditions are to be considered as persons with psychosocial disabilities.

3. It is worthwhile to explore the relationship of involuntary hospitalization to legal capacity, both in light of the 'Fusion Law' model for legislation that merges mental capacity assessment with involuntary hospitalization and treatment (all of which violate the Convention),[1] and in light of reforms of legal capacity that substantially comply with Article 12, such as those in Peru and Colombia,[2] but that have not carried through on

[1] For expositions of Fusion Law by proponents, see references contained in this presentation that takes a critical view of Fusion Law http://www.chrusp.org/file/359678/FusionLawWebinarMInkowitz061620.pptx.
[2] For Peru's Civil Code reform, see Decreto Legislativo No. 1384, https://busquedas.elperuano.pe/normaslegales/decreto-legislativo-que-reconoce-y-regula-la-capacidad-jurid-decreto-legislativo-n-1384-1687393-2/. For Colombia's legal capacity reform, see Ley 1996 de 2019,

the promise of Article 12 for abolishing involuntary hospitalization and treatment in mental health settings.[3]

4. In this briefing paper I set out my understanding of the logic of the Committee's standards as elaborated in General Comment No. 1 and the Guidelines on Article 14, as applied to involuntary hospitalization and involuntary treatment in mental health settings, supplemented by my views as a recognized expert on this topic. I offer the paper to the Committee and other stakeholders for their reference.

5. Involuntary hospitalization is contrary to the right to legal capacity, as hospital admission is a health care decision for which free and informed consent is required (Guidelines on Article 14, paragraph 10).

6. The criteria for substitute decision-making regimes that are contrary to Article 12 are given in General Comment No. 1, paragraph 27 as corrected in Corrigendum 1 – i.e. legal capacity is removed from a person, even in respect of a single decision, OR a substitute decision-maker is appointed by someone other than the person concerned, and can be done against the person's will, OR a substitute decision-maker acts based on what is believed to be in a person's 'best interests' and not based on the person's will and preferences.

7. Involuntary hospitalization removes legal capacity from a person in respect to the decision about hospital admission, and so it is substitute decision-making.

8. There is sometimes confusion about the meaning of 'substitute decision-making' because of two ways it is used in paragraph 27: as the prohibited regime which violates individual autonomy, and as the legitimate actions undertaken either when a supporter is specifically empowered to act on a person's behalf (as in a power of attorney) or when the criteria are met to apply a best interpretation of a person's will and preferences and a supporter, court or other intervenor acts in accordance with the standard in General Comment No. 1, paragraph 21.

9. Best interpretation of will and preferences cannot be applied when a person is actually expressing their will. Any theory of free will vs natural will, or will vs preferences,

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https://dapre.presidencia.gov.co/normativa/normativa/LEY%201996%20DEL%2026%20DE%20AGOSTO%20DE%202019.pdf.

[3] Peru's scheme is contained in Ley de Salud Mental https://busquedas.elperuano.pe/normaslegales/ley-de-salud-mental-ley-n-30947-1772004-1/ and its implementing regulations https://www.gob.pe/institucion/minsa/normas-legales/455147-007-2020-sa; Sodis responded to the Ley de Salud Mental in this article https://ius360.com/sin-categoria/la-nueva-ley-de-salud-mental-un-cambio-de-paradigma/. Colombia's Ley 1996 derogated certain provisions that authorized involuntary commitment and involuntary treatment based on incapacity that appeared in Ley 1306 de 2009, for reference see https://legislacion.vlex.com.co/vid/regimen-representacion-incapaces-emancipados-336257105; however, legal experts inform me that other provisions exist in Colombia that continue to allow these practices and there needs to be a comprehensive review and further reform.

advanced to legitimize the refusal to accept as valid a person's present expression of will amounts to a deprivation of legal capacity based on a functional approach, contrary to General Comment No. 1, paragraph 15.

10. The duty to respect legal capacity exists at all times including in emergency and crisis situations (General Comment No. 1, paragraphs 18 and 42, and Guidelines on Article 14, paragraphs 22 and 23).

11. It must not be assumed that a crisis or emergency situation equates to meeting the criteria to make a best interpretation. In psychosocial crisis situations, on the contrary, this is precisely when support and accommodations are required both to empower the person to satisfyingly make decisions with legal effect, and also to make everyday decisions and long-term decisions that such a crisis by definition may disrupt and make difficult. In physical health emergencies as well as psychosocial crisis, those responding have an obligation to respect the person's decision including a decision to refuse treatment and/or to refuse support.

12. Best interpretation is limited to those situations where it has not been possible, despite significant effort including the provision of support and accommodations, and using accessible communication, to determine the person's will and action or inaction will prejudice important rights. (See Peru's Legislative Decree No. 1384, Article 659-E, as an example elaborating the best interpretation standard.) The obligation should be in the following order, to adhere to an advance directive, to follow known general preferences the person expressed in the past about a class of situations, to be guided by known values and beliefs expressed in the past, to draw conclusions based on lifestyle and activities and the opinions of close associates about the person's most likely wishes in such a situation, any other information known about this individual.

13. The process of applying a best interpretation of will and preferences should include communication of the proposed decision to the person in plain language, even though the person may appear to be unaware of their surroundings, and giving them the opportunity to reject or confirm this interpretation of their will and preferences. If the person indicates rejection, there must be a renewed attempt to determine their will and preferences for any further decision-making, and, if necessary, to proceed a second time to best interpretation according to the criteria and standard.

14. To sum up: both involuntary hospitalization and involuntary treatment are decisions about health care that correspond to the right to exercise legal capacity; these decisions must be respected at all times including in crisis situations; the best interpretation of will and preferences, strictly applied, respects the individual's autonomy, will and preferences in situations where their will and preferences have proven impossible to determine.

15. For the reasons advanced in this paper, it is impossible to justify under the CRPD any hospital admission or treatment that is involuntary in the sense of being against the person's presently expressed will. Free and informed consent can be approximated by best interpretation when the person has not expressed their will, it is not possible to determine through diligent efforts, and action or inaction is essential to avoid prejudicing important rights.

16. Decisions that affect a person's physical or mental integrity, such as those concerning psychiatric treatments, require heightened vigilance and protection, according to General Comment No. 1, paragraph 42. Since neuroleptic drugs, other psychiatric medications, electroshock and psychosurgery, are all known to have severely disruptive effects on consciousness, brain functioning and structure, and other bodily systems, they should only be given when the person explicitly consents after disclosure of unbiased, accurate and relevant information in an accessible form and manner designed to empower the person to assess the information and reach a decision in light of their own self-knowledge, values and beliefs. These modalities, if used at all, should never be administered based on a tacit manifestation of will or by applying a 'best interpretation of will and preferences'.

17. Any legislation that is designed to authorize involuntary hospitalization or involuntary treatment, including those characterized as Fusion Law (which merges involuntary hospitalization and treatment with interventions based on mental incapacity assessment), must be denounced as contrary to Articles 12, 14 and 15.

18. There should be no room left open for involuntary hospitalization or involuntary treatment that is said to be disability-neutral, either in mental health settings or in any context other than a public health emergency requiring concerted action of the entire population. It is impossible to have disability-neutral legislation that violates the right to legal capacity based on status, function or outcome approaches. Denial of the right to exercise legal capacity with respect to a hospital admission or to treatment, if not based on disability as such (status), is based on function (mental incapacity) or outcome (refusal of hospitalization that health care providers believe is needed). Involuntary hospitalization and treatment in mental health settings, furthermore, are absolutely prohibited as they are disability-based by definition, and cannot be disability-neutral.

19. The CRPD Committee should use every opportunity to ensure that states parties, as well as other UN mechanisms and agencies, and other stakeholders, understand the absolute prohibition of involuntary psychiatric interventions under the CRPD and provide them with appropriate recommendations and resources to implement this human rights obligation.