Submission to the Committee Against Torture
For its consideration of the report of the United States of America
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Subject: Coercive psychiatric interventions are a form of torture or cruel, inhuman or degrading treatment or punishment

The Convention Against Torture is an evolving instrument that is capable of an expansive definition to include practices that may not have been conceptualized as torture or cruel, inhuman or degrading treatment or punishment at an earlier time.

We wish to bring the Committee's attention to a practice that is widespread but has not been fully understood as being worthy of condemnation and cessation: coercive psychiatric interventions on people labeled with "mental illness" or to control the behavior of people with other kinds of disabilities. While such interventions on people who can claim some other reason for this persecution (e.g. as political prisoners) are roundly condemned, the majority of people who are locked away in institutions and forced or coerced into taking drugs or having electroshock done to them are labeled with mental illness and human rights defenders pass them by.[1]

We will then address the specifics of this situation in the United States of America.

1. Coercive psychiatric interventions cannot be a legitimate medical practice

Psychiatric interventions are not medical in the usual sense of the word, in several respects. First, they are paradigmatically done against the will of the person concerned, in contrast to medical treatment that is subject to free and informed consent. While some attempts have been made in recent years to extend free and informed consent to the mental health context, it is riddled with exceptions left over from the days of the asylum.

Secondly, psychiatric interventions blur the loyalties of the physician, who is not free to concentrate on serving the expressed needs of the patient, but has assumed a duty to third parties to control the "patient" which conflicts with the physician's primary loyalty.

Thirdly, psychiatric diagnosis, unlike medical diagnosis, is based in statistics rather than medicine or pathology. It is not based in natural science but in social science. From a philosophical point of view, psychiatry with its emphasis on biological solutions to

[1] See, for example, Uzbekhistan: Psychiatric Punishment Used to Quash Dissent, Human Rights News, http://hrw.org/english/docs/2005/10/20/uzbeki11905.htm

psychological and social problems is quite controversial, although its ideology has been gaining ground worldwide.

None of this is to deny the usefulness for many individuals of psychiatric diagnosis and treatment that they seek of their own free will. Psychological distress and anguish seeks healing and alleviation, and for many people psychiatric medications provide relief or a way to manage thoughts and feelings that can become disabling.

However, psychiatric interventions with these same medications against any person's will cannot be justified as a medical practice. Instead, these interventions should be understood as a profound violation of the physical and mental integrity of any person, performed for the purpose of changing the individual's personality.

2. Coercive psychiatric interventions are terrifying and cause both physical and psychological injury

> Your thoughts are broken, incoherent, you can't hold a train of thought for even a minute. You're talking about one subject and suddenly you're talking about another... Your mind is like a slot machine, every wheel spinning a different thought.[2]
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> I was horrified to see how I deteriorated intellectually, morally and emotionally from day to day. My interest in political problems quickly disappeared, then my interest in scientific problems, and then my interest in my wife and children.[3]
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> Statements such as 'It's a horrible feeling,' 'I can't describe it' or 'If this feeling continues, I'd rather be dead' were not unusual.[4]
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> What we have found is that most people with schizophrenia dislike taking the drugs they are being prescribed... [T]he negative parts [of the side effects] are perceived as quite often worse than the illness itself.... [I]n the anonymity of phone calls to SANELINE, even the most deluded person is often extraordinarily articulate and lucid on the subject of their medication.... "When I take my medication, I feel as though I am walking with lead in my shoes" one young man told me on the telephone. Another young man sent us a poem in which he compares the effects of the drugs with drowning - "i was always under the water gasping for air and sunshine," he writes.... Almost all of our callers report sensations of being separated from the outside world by a glass screen, that their senses are numbed, their willpower drained and their lives meaningless. It is these insidious effects that

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[2] Peter R. Breggin, M.D., Psychiatric Drugs: Hazardous to the Brain, 1983 p. 23.
[3] Breggin 1983, p. 25. These statements were quoted from former political prisoner Leonid Plyushch.
[4] Breggin 1983, p. 38.

appear to trouble our callers much more than the dramatic physical ones, such as muscular spasms.[5]

Recognized today as the most frequent (5% to 76% incidence) and distress EPS [extra-pyramidal syndrome, a type of adverse effect of neuroleptic drugs], akathisia was relatively ignored by researchers until recently (Sachdev & Loneragan, 1991). This may be partly because the problem is often subjective, described differently by patients: inability to sit still, a sense of gloom and anxiety originating in the abdomen, restless legs, and so forth (Lavin and Rifkin, 1992). In "mild" cases, the individual may show no visible movement (especially if there is a co-occurring akinesia) but nevertheless feel significant psychic agitation or muscular tension. When visible, the motor agitation typically takes the form of shifting weight from foot to foot or walking on the spot, inability to keep legs still, shifting of body position while sitting (Sachdev & Kruk, 1994). Akathisia usually appears within hours or days of the start of NLPs [neuroleptics] and is often mistaken for psychotic agitation; this may result in a NLP dose increase, which worsens the akathisia (Lavin & Rifkin, 1991). In one study (Hermesh, Shalev, & Munetz, 1985), akathisia was reported to contribute to 3.4% of emergency hospital admissions. In extreme cases, it has led to suicide and homicide.

Akathisia is frequently accompanied by a dysphoric mental state, described by some normal subjects as a "paralysis of will" (Belmaker & Wald, 1977). A medical student who received 1 mg of HPL described the sensation of an external force forcing him to move (Kendler, 1976). Vaughan, Oquendo, and Horwath (1991) described the case of a 34-year-old man on fluphenazine who developed a severe akathisia and attributed his agitation to an external force, described by Vaughan et al. as a "psychotic delusion." Manos, Gkiouzepas, and Logothetis (1981) described patients who experienced psychotic flare-ups, making statements such as "A woman tried to strangle me last night," "I burn inside," and "A pair of pliers squeezed my body and throat." However, the authors stressed that the symptoms were subjective accounts of objective manifestations of disturbing EPS. Commenting on these cases, Lavin and Rifkin (1991) believe, "It is likely that [they] occur more frequently than is usually recognized" (p. 1615).[6]

The above descriptions relate to the most common type of coercive psychiatric intervention: administration of neuroleptic drugs.

The first UN Special Rapporteur on Torture, P. Kooijmans, included among the forms of physical torture, “administration of drugs, in detention and psychiatric institutions” and

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[5] David Cohen, “A Critique of the Use of Neuroleptic Drugs in Psychiatry,” in Fisher and Greenberg, eds., From Placebo to Panacea: Putting Psychiatric Drugs to the Test, 1997, p. 202.

[6] Cohen p. 206.

specified three types of drugs, including "neuroleptics, that cause trembling, shivering and contractions, but mainly make the subject apathetic and dull his intelligence."[7]

There is a great deal of information that is available if the Committee wishes to look into the subject further.[8]

3. Coercive psychiatric interventions are torture or cruel, inhuman or degrading treatment or punishment

We would submit that the purpose of changing an individual's personality or consciousness is similar to the purposes listed in article 1 of the Convention and should be addressed as a purpose of torture.

The extent of suffering caused by coercive psychiatric interventions can be extreme and devastating to a person's future life. The modern movement against psychiatric abuse arose as people transformed the experience of victimization into survival and resistance. Our movement, in the USA and worldwide, has documented individual stories as well as collective advocacy reflecting the pain and trauma that affects us constantly and gives impetus to our commitment to create change.[9]

We believe that coercive psychiatric interventions can meet the requirements of the definition in Article 1. It has been said that the intent required for torture is not specific intent that the individual should suffer; a general intent to do the proscribed act, with the knowledge that intense suffering will result, for a prohibited purpose, will suffice. Mainstream psychiatric literature has acknowledged the mind-destroying effects of its interventions since their inception.[10] Mainstream psychiatric organizations acknowledge

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[7] Report by UN Special Rapporteur Mr. P. Kooijmans, 1985/33 E/CN.4/1986/15, 19 Feb. 1986, para. 119, http://ap.ohchr.org/documents/dpage_e.aspx?m=103

[8] See Loren R. Mosher, M.D., The Biopsychiatric Model of Mental Illness: A Critical Bibliography, http://www.moshersoteria.com/litrev.htm, for references on brain damage caused by neuroleptics and studies showing equal or better outcomes from non-somatic treatments undercutting the "medical" rationale for forced treatment; Robert Whitaker, "Anatomy of an Epidemic: see also Psychiatric Drugs and the Astonishing Rise of Mental Illness in America," Ethical Human Psychology and Psychiatry 7:1, Spring 2005, http://psychrights.org/Articles/EHPPPsychDrugEpidemic(Whitaker).pdf on evidence that psychiatric drugs are causing an "epidemic" of neurological disorders.

[9] See, for example, http://www.mindfreedom.org/histories.shtml, http://www.psychrights.org, http://www.ect.org/1stperson/about.html, Vanessa Jackson, In Our Own Voice: African American Stories of Oppression, Recovery and Survival in Mental Health Systems, at http://www.mindfreedom.org/pdf/inourownvoice.pdf, http://www.wnusp.org, and http://www.narpa.org. See also, Statement of Principles of the 10th International Conference on Human Rights and Psychiatric Oppression, May, 1982, and Deborah E. Reidy, "Stigma is Social Death": Mental Health Consumers/Survivors Talk About Stigma In Their Lives, Education for Community Initiatives 1993.

[10] Breggin 1983, p. 12-32; Cohen p. 179-181.

that psychiatric interventions performed on political prisoners will destroy the personality and cause frightening changes in consciousness.[11] Yet they persist in performing these same interventions against the will of people whom they label with "mental illness". This indicates knowledge, and also that discrimination (based on imputed disability) may be a factor in the ordinary practice of coercive psychiatry.[12]

Furthermore, acting against a person's will usually means that the person acted on will suffer. People who are locked in psychiatric institutions are aware that resistance will be met with punishment, often in the form of the same interventions (more neuroleptic drugs, or being scheduled for electroshock). Under these coercive conditions, it may be difficult for some people to express refusal, and there should be a heightened scrutiny even of apparent consent, to discover whether intimidation has taken place.

Public officials are involved through laws and immunities authorizing coercive psychiatric interventions, some of which require judicial approval, and when psychiatrists and others ordering psychiatric interventions are employees of public institutions.

We believe that the definition in article 1 can be met, however, at the least, coercive psychiatric interventions should be condemned as cruel, inhuman or degrading treatment or punishment, and the obligations of article 16 applied.

4. The situation in the United States of America

An agency of the United States government, the National Council on Disability, issued a groundbreaking report in January 2000, "From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves,"[13] which recommended that public policy should move towards a totally voluntary mental health system; that mental health treatment should be about healing, not punishment; and that people labeled with psychiatric disabilities should be given the central role in designing policies and services. The National Council on Disability is an advisory body which the U.S. has also claimed functions as the coordinating committee on disability matters, satisfying its obligations

[11] See, "WPA, Chinese Psychiatrists Agree on Psychiatry Abuse Charges," http://pn.psychiatryonline.org/cgi/content/full/39/15/2, APA Committee Calls for Investigation of Chinese Psychiatric Abuses, http://www.psych.org/pnews/00-06-16/chinese.html.

[12] For the scope of modern understanding of disability, see the proposed definition of disability for the forthcoming Convention on the Rights of People with Disabilities, at http://www.un.org/esa/socdev/enable/rights/ahc7pddisability.htm, which builds on the older definitions in the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, U.N. GAOR 48/96, 20 December 1993, at http://www.un.org/esa/socdev/enable/dissre00.htm, and in the Inter-American Convention on the Elimination of All Forms of Discrimination Against People with Disabilities, at http://www.oas.org/Juridico/english/treaties/a-65.htm, article 2.

[13] http://www.ncd.gov/newsroom/publications/2000/pdf/privileges.pdf.

under Rule 17 of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities.[14]

The recommendations in "From Privileges to Rights" have never been implemented. Instead, we continue to see expansion of coercive psychiatry through enactment of outpatient commitment laws, which authorize judges to impose court-ordered psychiatric interventions on people who are not institutionalized but living in the community. Forty-two out of the 50 states now have such laws, with varying criteria for their use. [15]

The hazards of outpatient commitment can include death. Ricky Herron, a 35-year-old African American man in Lane County, Oregon, died after his physical complaints related to force-drugging with clozapine (a neuroleptic) were ignored. An autopsy ruled that his death may have been caused by neuroleptic malignant syndrome.[16] While the county mental health agency settled a lawsuit by Herron's family, everyone under an outpatient commitment order requiring administration of neuroleptic drugs continues to be at risk.

In addition, screening of schoolchildren for "mental illness" has been initiated in some states and is being promoted by the federal agency in charge of mental health policy.[17] Such screening uses a broad survey questionnaire as the basis for more intrusive questioning by mental health professionals, with the goal of prescribing psychiatric medications.[18] It is especially disturbing that this is being done to children who lack the

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[14] Dmitris Michailakis, Government Action on Disability Policy: A Global Survey (1997) (prepared on the basis of information made available by governments responding to a questionnaire of the Special Rapporteur on Disability of the Commission for Social Development), p. 96.

[15] Bazelon Center for Mental Health Law, Involuntary Commitment: Summary of State Statutes, at http://www.bazelon.org/issues/commitment/moreresources/iocchart.html (chart summarizing outpatient commitment laws in 37 states as of April 2000). Since that time, laws have been passed in Alaska, California, Florida, New Hampshire and Wisconsin.

[16] News alert posted on Mind Freedom website, http://www.mindfreedom.org/mindfreedom/ioc/herron2.shtml.

[17] See Alliance for Human Research Protection, SAMHSA Promotes Infant and Child Screening and Drugging, January 27, 2006, http://www.ahrp.org/cms/content/view/53/31/.

[18] The Alliance for Human Research Protection described the development of TeenScreen, in TeenScreen – "Under Intense Criticism Nationally", March 11, 2006, http://www.ahrp.org/cms/content/view/106/31/ as follows:

Mental screening programs for children were developed by the DISC Development Group at Columbia University, Division of Child and Adolescent Psychiatry, whose director is Dr. David Shaffer. (DISC = Diagnostic Interview Schedule for Children modeled on the DSM IV) See: Columbia DISC depression scale, a 22-item questionnaire: http://www.connecticare.com/Provider/Communications/CDDSTeen.pdf.

power to refuse on their own, but must depend on their parents to assert their rights. The safety and efficacy of such medications on children is quite controversial, and has included “black box warnings”. A recent report found that 2.5 million children in the U.S. were being prescribed neuroleptic drugs.[19]

Advocates in New York are concerned that the rate of forced electroshock appears to be steadily increasing.[20] In a highly publicized case in 2001, Paul Henri Thomas, a Haitian immigrant and former human rights activist, was forced to undergo as many as 60 electroshocks, and it was only through the dedication of expert attorneys and supporters that he was finally released from the facility and freed from the threat of further shocks.[21] During a court hearing, Thomas said, "After the treatment, it is just as if I came back from nowhere. I am surprised I am myself... It is not a pleasant experience."[22]

Increased coercion builds on the system that is already in place, which makes “mental illness” into a threshold determination that puts a person at risk of detention, restriction of legal capacity, and, as is the focus of this report, administration of drugs, electroshock or other procedures against the person’s will. Inpatient commitment laws exist in all 50 states, and all states also permit the forced administration of drugs or electroshock through some mechanism.

To take one example, in New York State Article 9 of the Mental Hygiene Law governs all “admissions” to mental health facilities. The statute states a preference for “voluntary” or “informal” admissions[23], but several avenues to “involuntary” admissions

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... DISC begat TeenScreen and BSAD (Brief Screen for Adolescent Depression). These mini-versions of the DISC questionnaire were developed by Dr. Shaffer and the DISC Development Group and they are used to screen America's school children. TeenScreen is a 14 item questionnaires competed in 10 minutes, that is aggressively promoted by Columbia and the Bush Administration in schools across America. BSAD is an 8 item questionnaire completed in 5 minutes used by Screening for Mental Health, Inc, who conduct an annual mass Depression Screening Day. [See: http://www.ahrp.org/cms/content/view/97/29/]
Mental screening is not backed by any scientific evidence of a benefit for those screened. The screening instrument that is used falsely identifies children as depressed and suicidal 84% of the time. In his published report, Dr. Shaffer acknowledges that "in practice a specificity of 0.83.could reduce the acceptability of a school-based prevention program."

[19] AHRP, 2.5 Million US Children Prescribed Antipsychotics_ FDA ADHD--ADR Review, http://www.ahrp.org/cms/content/view/112/28/.

[20] Personal communication.

[21] Thomas’s case and other cases of forced electroshock are described at http://www.ect.org/news/forced.shtml.

[22] “His New Battle: Patient Takes Fight Against Electric Shock Treatment to Court,” Newsday, March 3, 2001, http://www.ect.org/news/newsday.html.

[23] N.Y. Mental Hygiene Law § 9.13, 9.15, 9.17, 9.19, 9.21, 9.23 and 9.25. “Voluntary” status can be transformed to “involuntary” on application of the hospital, but “informal” means that a person can leave at will.

are also prescribed.[24] An outpatient commitment law, euphemized as "assisted outpatient treatment" is also included.[25] New York recognizes a right to refuse treatment as a matter of state constitutional law as well as common law, but in relation to people on involuntary status in psychiatric units, there is a special procedure allowing a court to authorize treatment despite the person's objection.[26] For people under outpatient commitment, there is no presumption of a right to refuse treatment at all.[27] The primary criterion for exercising the right to refuse treatment is "capacity to make a rational decision", but in practice judges accept the assessment of psychiatrists despite evidence that the person is using rational processes to make the decision to refuse. Furthermore, the criterion that a decision must be "rational" is weighted against people who base their decision on feelings or intuition, or who are intimidated by disparagement of their reasons for refusing. It is rare for the hospital's application for an order for "treatment over objection" to be denied.[28]

5. Conclusion

Here is a "human rights emergency" that has gone for a long time without meaningful response. It is only since users and survivors of psychiatry have generated a critique based on discrimination, and created nonviolent alternatives to the existing mental health system, that society can begin to understand madness in a different way. This has been assisted by the development of a disability rights movement that understands disability in general as a social rather than a medical phenomenon, and puts the onus on society to challenge intolerance and accommodate people with diverse needs, in ways that respect individual dignity, integrity and self-determination.

We call on the United States to affirm the policy recommendations of its agency that is mandated to lead the way on matters related to disability, reflecting the "considerable influence" of organizations of people with disabilities. The recommendations of the NCD Report "From Privileges to Rights" should be taken as the starting point for dismantling the coercive mental health system, which violates our right to be free from torture and/or cruel, inhuman or degrading treatment or punishment, and create healing alternatives based in respect and equality.

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[24] N.Y. Mental Hygiene Law § 9.27, 9.31, 9.33, 9.37, 9.39, 9.40, 9.41, 9.43, 9.45, 9.55, 9.57 and 9.58. In addition § 9.49, 9.51 and 9.53 govern admission of children and youth.
[25] N.Y. Mental Hygiene Law § 9.60.
[26] Rivers v. Katz, 67 N.Y.2d 485 (1986).
[27] K.L. v. Martin, N.Y. Court of Appeals, Slip Opinion 2 No. 6, Feb. 16, 2004, http://www.courts.state.ny.us/CTAPPS/decisions/feb04/6opn04.pdf.
[28] Mental Hygiene Law Court Monitoring Project, Do Psychiatric Inmates in New York State Have the Right to Refuse Drugs? An Examination of *Rivers* Hearings in the Brooklyn Court, http://www.courts.state.ny.us/CTAPPS/decisions/feb04/6opn04.pdf.