Comments of the U.S. NGO Disability Working Group
Related to Consideration of the

Second and Third Periodic Report of the United States

to the

Committee on Civil and Political Rights
17 March 2006

Submitted on behalf of:
Law Project for Psychiatric Rights
Mind Freedom International
National Association for Rights Protection and Advocacy
National Council on Independent Living
New York Organization For Human Rights and Against Psychiatric Assault
Public Interest Law Center of Philadelphia
Self Advocates Becoming Empowered

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Members of the Committee:

I am speaking on behalf of several disability rights organizations in the United States: Law Project for Psychiatric Rights, Mind Freedom International, National Association for Rights Protection and Advocacy, National Council on Independent Living, New York Organization For Human Rights and Against Psychiatric Assault, Public Interest Law Center Of Philadelphia and Self Advocates Becoming Empowered.

The disability perspective should be taken into account in reporting on every article of the Covenant, since the experiences of people with disabilities may not be visible otherwise. In some instances, discrimination occurs because of a failure to make reasonable accommodation for disability. In other instances, discrimination is embedded in law and policy, or in the structure of the legal system itself.

We had planned to bring several issues to your attention, reflecting the diversity of concerns affecting people with disabilities. However, at the present time only one is sufficiently developed; we hope to raise additional matters in a later written report.

I will speak today about nonconsensual psychiatric interventions, which harm people with psychosocial disabilities, otherwise referred to as people with mental

health problems, or who are labeled with mental health diagnoses. Such interventions violate several articles of the Covenant[1], most importantly article 7 and the non-discrimination provision of article 2.[2] Any nonconsensual medical intervention deprives an individual of autonomy in relation to his or her body and health choices, and can cause both psychological and physical harm. Psychiatric interventions, especially the use of mind-altering drugs and procedures such as electroshock, have come under special concern because they disrupt the personality.[3] For this to happen even once against a person's will can make a person feel terror and experience unwanted changes in consciousness. To undergo compulsory electroshock three times a week for a period of months, or to be drugged for years, can have devastating effects in a person's life.[4]

United States legal framework

United States law recognizes a right of any legally competent person to refuse medical treatment, even when treatment would be lifesaving.[5] This right, in theory, applies equally to people experiencing mental health problems or perceived as such.[6] However, there are many mechanisms by which people who are labeled with mental illness can be deprived of the right to refuse treatment. They include:

[1] Other relevant articles include articles 9, 18 and 26. We would argue that civil commitment of people labeled with mental illness violates the equality provision of article 2 with respect to the freedom from arbitrary detention guaranteed in article 9. Nonconsensual psychiatric interventions also implicate the freedom from coercion that would impair the ability to adopt a thought or belief, article 18(2). Legally-sanctioned practices that single out people with psychosocial disabilities for adverse treatment violate article 26.

[2] See also, World Network of Users and Survivors of Psychiatry, The Right to be Free from Forced or Coerced Interventions to Correct an Impairment – An Interpretation of an Existing Fundamental Right, at http://www.wnusp.org/wnusp%20evas/Dokumenter/freedom%20from%20force.doc

[3] See, e.g., J. Herman Burgers and Hans Danelius, The United Nations Convention against Torture: A Handbook on the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1988), p. 43 (in drafting the Convention Against Torture, Portugal had proposed a paragraph specifically identifying as torture the use of psychiatry for purposes prohibited in paragraph 1 of that Convention); Nigel S. Rodley, The Treatment of Prisoners under International Law (New York: Oxford University Press,1987), p. 235 (reflecting concern over psychiatric detention and treatment of both persons of sound mind and persons of unsound mind; we would argue that a lower standard of protection for persons of unsound mind is impermissible); Report by UN Special Rapporteur Mr. P. Kooijmans, 1985/33 E/CN.4/1986/15, 19 Feb. 1986, at http://ap.ohchr.org/documents/dpage_e.aspx?m=103, paragraph 119 (administration of drugs in psychiatric institutions is a form of physical torture).

[4] See, e.g., the personal testimonies and histories collected at http://www.mindfreedom.org/histories.shtml, http://www.psychrights.org, navigate to "Everyday Horrors of the Mental Health System," and http://www.ect.org/1stperson/about.html, and 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

[5] Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914), Cruzan v. Director, MDH, 497 U.S. 261 (1990).

[6] Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986).

- Involuntary admission to psychiatric institutions or hospitals[7]
- Conversion of voluntary status to involuntary upon a person's refusal of treatment[8]
- Court ordered outpatient treatment (in 43 out of 50 states)[9]
- Court authorization of compulsory treatment of a person found incompetent to make the decision to refuse treatment[10]
- Police power of state said to justify "emergency" compulsory treatment in inpatient setting to prevent harm to self or others[11]
- Compulsory treatment in the criminal justice context[12]
- Placing a person under guardianship, which deprives him or her of the right to make a wide spectrum of decisions[13]
- Contingent services, such as government-funded housing programs that are permitted to require psychiatric treatment as a condition of housing tenure[14]

Central to many of these mechanisms (but not all) is the concept of legal capacity and a determination of incapacity based on mental illness. While incapacity has traditionally been thought of as a protective measure, the modern movement of people with disabilities can no longer accept paternalism and instead have developed a new model of legal capacity based on facilitating the self-determination of all adult individuals[15], and of children to the extent of their evolving capacities (as provided in the Convention on the Rights of the Child[16]). While a full discussion of this model is beyond our scope here, we would urge the Committee to consider it further, especially with respect to its relevance as a protection against nonconsensual psychiatric interventions.[17]

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[7] Governed by law in all 50 states, see, e.g., N.Y. Mental Hygiene Law Article 9.
[8] N.Y. Mental Hygiene Law § 9.13.
[9] See, 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).
[10] Rivers v. Katz, supra note 6.
[11] Id.
[12] See Washington v. Harper, 494 U.S. 10 (1990) and Sell v. United States, 539 U.S. 166 (2003).
[13] See, e.g., N.Y. Mental Hygiene Law § 81.02.
[14] NYCRR § 595.10 (broad leeway to set terms of residency agreements in certain housing programs).
[15] Self-determination is understood here in the individual sense.
[16] Convention on the Rights of the Child, article 12.
[17] See IDC MODIFICATION: Article 12, Draft EU Position elaborated together with Canada, Australia, Norway, Costa Rica, USA, Liechtenstein, at http://www.un.org/esa/socdev/enable/rights/ahc7docs/ahc7idcmodart12e.doc; Amita Dhanda, Advocacy Note on Legal Capacity, at http://www.wnusp.org/wnusp%20evas/Dokumenter/LegalCapacityNote.doc, Amita Dhanda, How Should Legal Capacity be incorporated in the Disability Rights Convention? A Legal Design Concept Note, to be posted at http://www.wnusp.org/wnusp%20evas/Dokumenter/Disability%20Convention%20Resources.html. The model was most fully developed in a practical schema in Report of the C.A.C.L. Task Force on Alternatives to Guardianship, at http://www.worldenable.net/rights/adhoc3meet_guardianship.htm.

We would further point out that procedural safeguards are not adequate to address a human rights violation involving integrity of the person. Procedural safeguards are also inappropriate to mitigate the results of discrimination. The discrimination itself must be ended. There is no legitimate reason to deny equal rights and responsibilities to people with psychosocial disabilities. The evidence is clear that mental illness bears no particular relationship to violence[18] and preventive detention or nonconsensual treatment of individuals labeled with mental illness cannot be justified as a violence prevention measure.[19]

A new policy that has never been implemented

The United States government has designated the National Council on Disability, an independent federal agency, as its coordinating mechanism on disability policy matters, as required by the Standard Rules on the Equalization of Opportunities for Persons with Disabilities[20].[21] The Standard Rules can be viewed as a guide to interpreting obligations with respect to some aspects of discrimination based on disability.

In January 2000, the National Council on Disability issued a ground-breaking report based on the testimony of people labeled with psychiatric disabilities.[22] The report made ten key recommendations, the first of which was to move towards a totally voluntary mental health system that safeguards dignity and respects autonomy. This recommendation by the agency designated to coordinate disability policy has been ignored and marginalized.

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[18] Steadman, H., Mulvey, E., Monahan, J., Robbins, P., Appelbaum, P., Grisso, T., Roth, L., & Silver, E. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry*, 55, 393-401. Summarized at http://www.macarthur.virginia.edu/violence.html. On the other hand, people labeled with mental illness were found more likely than others to be victims of violence. Linda A. Teplin, Gary M. McClelland, Karen M. Abram, Dana A. Weiner, Crime Victimization in Adults With Severe Mental Illness: Comparison With the National Crime Victimization Survey, Arch. Gen. Psychiatry 2005;62:911-921, abstract at http://archpsyc.ama-assn.org/cgi/content/abstract/62/8/911

[19] Nonconsensual medical treatment cannot be justified as a measure to prevent violence in any case, since it is contrary to medical ethics to perform treatment for reasons unrelated to the health of the person. Subsuming behavior to a mental health problem is suspect and illustrates the extent to which ethics are compromised by authorizing medical professionals to act as arbiters of preventive detention.

[20] United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities, U.N. General Assembly Resolution 48/96, Annex, of 20 December 1993, at http://www.un.org/esa/socdev/enable/dissre00.htm.

[21] 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.

[22] National Council on Disability, From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves, January 20, 2000, at http://www.ncd.gov/newsroom/publications/2000/pdf/privileges.pdf

We would urge the Committee to inquire into what the United States government is doing to implement the recommendation of the National Council on Disability report “From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves,” to move national policy in the direction of a totally voluntary mental health system.

We would further urge the Committee to consider a disability perspective when examining the United States’ compliance with each article of the Covenant.

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