Torture and Cruel, Inhuman or Degrading Treatment

in Psychiatric Care

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CHECK AGAINST DELIVERY

I. I am very grateful to the German Association for Psychiatry, Psychotherapy and Psychosomatics, for inviting me to speak to this important meeting, and especially for the opportunity to discuss positions I have adopted in my capacity as the UN Special Rapporteur on Torture, in regards to practices in health care that may run afoul of the absolute prohibition of torture and cruel, inhuman or degrading treatment in international law. I hope this occasion will be a chance to explain my opinions on this matter, some of which have proven to be controversial.

II. Why should therapies of any kind be considered under the prohibition of torture?

Torture is defined under international law as any act by which severe pain and suffering, whether physical or mental, is intentionally inflicted by a State agent for such purposes as interrogation, obtaining confession, punishment or other objectives, or for any reason based on discrimination of any kind. Professionals who are employed in State hospitals, for example, fall under the "State agent" category. But the definition also covers torture perpetrated by non-State actors if it takes place at the instigation of or with the consent or acquiescence of State agents. The State has a duty of prevention of torture and of cruel, inhuman or degrading treatment or punishment; that duty is breached, for example, when the State fails to regulate and monitor certain therapeutic practices adequately. For these reasons, in circumstances in which State agencies are aware of or ought to be aware of treatment that crosses the line into torture or cruel, inhuman or degrading treatment, the practice constitutes a human rights violation under international law.

The requisite intent that the definition demands refers to the intentional infliction of pain and suffering, not to the purpose for which it is applied. In other words, knowledge that the treatment will inflict pain and suffering of a certain severity can constitute torture even if the purpose is not to obtain information or confession or to punish the victim, and even if the aim is therapeutic. On the other hand, many interventions of varying sorts, from a tooth extraction to various forms of surgery, involve a degree of pain and suffering, either immediately or as longer-term effects. If the patient is aware that the treatment will include a degree of pain and suffering and freely consents to it the matter does not constitute torture, because the intentional element is superseded by the patient's decision.

It must be noted that international law also contains an absolute prohibition on cruel, inhuman or degrading treatment (CIDT) that does not amount to torture. CIDT covers pain and suffering of certain severity but less serious or grievous than torture. In addition, CIDT does not have the requirement of intent associated with torture, so that pain and suffering – again of a lesser but still certain severity – that takes place because of negligence of State actors, still falls under the absolute prohibition. It bears repeating that the free and informed consent of the person who experiments pain and suffering in a health care setting also eliminates the possibility that the treatment can be considered CIDT under international law.

It follows, therefore, that some practices that take place in many countries can and do violate the absolute prohibition of torture and CIDT in international law even if the purpose is therapeutic, as long as some relationship can be found to a State responsibility for its prevention. Indeed, prevention of torture and of CIDT is a key feature of international law and an explicit duty of States under several human rights treaties.

My February 2013 report attempted to place a spotlight on practices observed around the world that may indeed cross the line into CIDT or even torture. I included examples of denial of painkillers, treatment of psychiatric or neurological disorders through fasting and prayer that includes long-term shackling, humiliating attitudes towards women who seek abortions in States where abortion is legally available, sex adjustment operations for children born with ambiguous sexual organs, sterilization of women without their consent for purposes of population control as well as of persons with disabilities or trans-sexuals, forcible treatment of drug addictions without access to alternatives, and so on. Several of my recommendations have elicited critical responses, on occasion from opposing points of view. I acknowledge that, due to editing problems, my report included references that were equivocal or could be understood as contradictory with each other. In that sense, I welcome this opportunity to clarify, to the extent possible, what I meant to say.

III. Evolving Standards: This discussion takes place against the backdrop of important changes in international law that have taken place in recent years, the importance of which cannot be overestimated. At the same time, those changes are in the process of being interpreted by authoritative organs, including international and domestic courts, and the exact contours of the new standards are, at this stage, unsettled. The adoption of the Convention on the Rights of Persons with Disabilities (CRPD) and its rapid ratification by numerous countries is the most salient development in international law for the purposes of our discussion today, but the Convention on the Rights of the Child (CRC) earlier on also introduced sweeping changes in applicable standards. Both of these treaties have expanded our understanding of the principle of equality and non-discrimination as it applies to new categories of persons. It is significant that the rule prohibiting adverse discrimination is a general rule of international law that admits no departure. The prohibition of racial discrimination is nowadays considered a norm of customary international law. Discrimination on other

grounds is a matter of treaty law, although the rapid adoption and ratification of treaties on elimination of discrimination against specific human groups suggest that the rule prohibiting discrimination on any basis is rapidly acquiring the status of a customary international law rule.

The rules are new and unsettled, at least in the sense that they may lend themselves to varying interpretations. In considering what some authors consider a veritable paradigm shift, one must not ignore the jurisprudence of the specific organs of implementation of the new treaties. Those treaty organs may not be the ultimate arbiters of how new norms must be applied or interpreted, but their views must certainly be taken into account.

Even if international law is changing before our eyes, practices that appear inconsistent with the new standards continue unabated in many countries and, more importantly, domestic law and regulation provide cover to such practices. As in other aspects of international human rights law, States that sign and ratify human rights treaties are obliged to amend and adapt their domestic law to reflect treaty standards, and yet domestic laws and regulations in most countries are still not in line with the new international norms.

In sum, we need to analyze existing practices in health care in the light of profound changes in the framework of international human rights law, especially those norms designed to offer additional protections to vulnerable persons from mistreatment and from discrimination on the basis of their very vulnerability.

At the risk of oversimplification, the new framework of international law applicable to our topic is as follows:

1. Every person has a right to be free from torture and from cruel, inhuman or degrading treatment or punishment;
2. Every person has a right to the enjoyment of the highest attainable standard of physical and mental health;
3. That highest standard must be dispensed without discrimination on the basis of race, ethnicity, national origin, religion, political or other opinion, social status, birth, property, age, gender, sexual orientation or gender identity, or any other status.
4. In particular, medical care must not be dispensed in a manner that discriminates against persons with disabilities *on the basis of such disabilities*.
5. Every person – including members of all communities that are protected against discrimination as mentioned above – must enjoy respect for his or her inherent dignity, personal liberty, individual autonomy and independence.

IV. <u>Autonomy and Capacity in the light of this changing legal framework:</u>

Full, free and informed consent is the norm that gives effect to the principle of autonomy. The rule, therefore, should be that any intervention should be agreed upon between patient and therapist, after a careful and complete discussion of all its advantages and disadvantages, its potential for cure or alleviation as well as for unwanted side effects, including the degree of pain and suffering that may be

involved. Every patient, and especially those with mental or psycho-social disabilities, must be the ultimate decision-maker on what therapies to undergo, on the basis of full information provided by specialists.

A critical moment happens when the patient is not able to provide consent for different reasons and the treatment is nonetheless deemed critical for his or her well-being, to prevent harm to the patient or to others, or even to save lives. A growing current of opinion, based mostly on the CRPD and its interpretations by the Committee on the Rights of Persons with Disabilities, postulates that under no circumstance should involuntary interventions be allowed; indeed, that such non-consensual interventions constitute a human rights violation and – because of pain and suffering inherent in the very denial of the patient's agency – it constitutes torture or CIDT. According to this posture, the patient is under all circumstances entitled to alternatives to support autonomous consent, including assisted decision-making, community-based treatment, and so on. It goes without saying that all of these alternatives support the idea that the ultimate decision lies with the patient and no one else.

At the other extreme, some believe that the new international law framework simply restates the obvious: that patients should be informed and should be able to make up their own minds about treatment, *if and when their decisions are reasonable and as long as their thinking is not impaired by a mental disability.* The problem with ignoring the legal changes brought about by the CRPD is that too often the very diagnosis of a mental disability carries with it an assumption of incapacity to make decisions. In fact, most domestic laws about capacity and guardianship (though not all, certainly) implicitly make that assumption: it is enough that someone has been diagnosed with a mental or psycho-social disability for the law to strip them of all ability to decide, and for the responsibility for those decisions to be transferred to a guardian. The guardian is expected to act in the best interest of the person, but in fact the guardian's decisions are made mostly on the basis of the rights or wishes of relatives and on the advice of a medical professional. More often than not, even when acting in good faith the guardian assumes that the patient is incapable of making decisions. When the guardian is in fact a hospital director, decisions are made on the same basis for hundreds of patients, without any significant attention to specialized needs of individuals.

I believe that domestic laws and regulations need to be amended so that full, free and informed consent is clearly established as the norm and observed in practice. It would be important also for the law to establish the narrow exceptions under which non-consensual treatment can be legally dispensed. For example, if the patient is unconscious and a life-saving operation is necessary, it makes no sense to prohibit treatment because of lack of consent from the patient.

There are probably other scenarios for which an absolute prohibition of non-consensual treatment would yield absurd results. But I believe very strongly that the law must define those exceptional circumstances with precision in order to uphold the

principle of full, free and informed consent and not let the exceptions swallow the rule.

To begin with, a diagnosis of a mental disability should not by itself be enough to take away the patient's autonomy and capacity. As all of you know better than me, there are multiple conditions that amount to a mental or psychosocial disability, and not all of them impair the person's ability to receive information, process it, understand it and adopt rational decisions on its basis. As I stated in my report, the current state of international law establishes clearly that an involuntary intervention that is made solely on the basis of the disability of the patient is a human rights violation because it is intrinsically discriminatory. For that reason, interventions without the full, free and informed consent of the patient, conducted solely on the basis of his or her disability, are absolutely prohibited. If they carry with them a degree of pain and suffering of either a physical or a mental nature, including humiliation or degradation, they are absolutely prohibited as well as either torture or CIDT.

I would suggest that non-consensual intervention can only be justified to save the patient's life when he or she is not in a position to decide, or to prevent him or her from hurting self or others. Any intervention in cases of this nature must necessarily be proportional to the risk to be averted and for a duration strictly limited to conjure that risk.

In addition, some forms of involuntary treatment should be avoided because of their very nature and because they inflict pain and suffering of an intolerable gravity. In particular, solitary confinement should be avoided for persons with mental or psychosocial disabilities, because deprivation of meaningful social contact causes grievous pain and suffering that aggravates the condition of persons with disabilities. If separation of a person from others is necessary to prevent harm, some temporary segregation may be justified, but it should not result in complete isolation of any duration. Precisely because it is an emergency measure, temporary segregation must be accompanied with close therapeutic attention and contact with families and friends and associates who are not at risk or do not contribute to the risk.

Similarly, physical restraints should only be used exceptionally and under the same rules mentioned above. Restraints are implicitly demeaning and humiliating, in addition to depriving a person of ambulatory freedom.

Laws and regulations should require that these emergency interventions be governed by due process safeguards, including full reporting and recording of the facts and of the treatment dispensed, so that judicial bodies can eventually and on a timely basis monitor them and establish accountability for any violation of the rights of the disabled person.

There are human rights specialists who believe that, in addition to emergency treatment as outlined above, the law must make some room for non-consensual interventions when the patient is afflicted by such an acute disorder that he or she is incapable of making rational decisions about treatment. This would cover cases of some chronic disorders of that level of acuteness. It seems to me, however, that this

open-ended exception to free and informed consent brings us back to the status quo and ignores the evolution in human rights law that I have been mentioning. In this stance, it is precisely the diagnosis of a mental disorder that by itself is deemed to justify taking away the patient's autonomy and even his or her dignity.

Domestic law and regulation and norms of professional ethics must explicitly incorporate the full, free and informed consent of the patient standard as the governing principle of all medical interventions. As stated above, they should also carefully craft the legitimate exceptions that are admissible. Domestic standards on legal capacity and on guardianship must also be overhauled with a view to respecting the patients' human dignity, personal liberty, autonomy and self-determination to the maximum extent possible. The role of the appointed guardian should also be carefully delineated in line with this principle, to promote and to foster autonomous decision-making and not to substitute for it. Finally, it could be good to have domestic legal standards regulating the concept of "medical necessity," especially in regard to the availability of less painful and less intrusive alternatives to treatment.

V. Conclusion

Due to the changes in international legal standards, there is now a vibrant debate going on among human rights practitioners, advocacy groups and health care specialists about the exact limits the new standards place on therapeutic practices. An important locus of the debate is with the various organs of human rights protection and promotion set up by international treaties and by the UN Charter-based machinery. My 2013 report has prompted the Committee Against Torture and the Subcommittee on the Prevention of Torture to initiate internal discussions about the matter, and to begin a dialogue with members of the Committee on the Rights of Persons with Disabilities and the Committee on the Rights of the Child. In addition, regional bodies like the European Court of Human Rights, and the African and Inter-American Commissions and Courts have also entered the debate. The ongoing character of these conversations prevent me from attributing positions to any of these organs or even to individual members of them. I do, however, wish to disseminate my own views as the UN Special Rapporteur on Torture. I note, in that respect, that my predecessor in that role had already staked a position on the matter. In deciding to write a thematic report and present it to the Human Rights Council in March of 2013, I chose to conduct consultations with specialists on the matter, and to make them as extensive as limited resources allowed. Evidently, there are many voices that could also have been requested, as post-report reactions attest to. But I stress that my report was meant to be a contribution to a larger debate and by no means to close the discussion. That is why my team and I have also published a book with contributions obtained before and after my report, and containing opposing views on some subjects.

The debate is therefore open and lively. I continue to shape my views on this matter by having enlightened conversations with various stakeholders and experts, and that is why I eagerly look forward to your comments. Your experience, your standards of

professional ethics and your scientific knowledge are key components of this debate and I hope you will take the opportunity to contribute to our common understanding of these vital issues.

Thank you very much for your attention.