Center for the Human Rights of
Users and Survivors of Psychiatry

Center for the Human Rights of Users and Survivors of Psychiatry

Submission to the Special Rapporteur on Torture Thematic Report on survivor experiences and perspectives

22 September 2025

1. Forced psychiatric interventions amount to torture

The Center for the Human Rights of Users and Survivors of Psychiatry has engaged in anti-torture since its inception in 2009. In this submission, we draw on our collective experience and knowledge as well as published sources, and our own advocacy positions as well as the standards we have helped to create.

CHRUSP president and co-founder Tina Minkowitz is herself a survivor, and our current and former board members and wider networks include numerous survivors of involuntary psychiatric interventions throughout the world.[1] Before founding CHRUSP, Minkowitz represented the World Network of Users and Survivors of Psychiatry in the process to create the Convention on the Rights of Persons with Disabilities, including serving on its drafting group. Her conceptualizations in those early years laid the groundwork for the current standard in human rights law that prohibits involuntary psychiatric interventions, including the administration of mind-altering drugs, as a form of disability-based torture and other ill-treatment.[2]

---

[1] In this submission, the terms 'involuntary,' 'forced,' 'nonconsensual' are used interchangeably, to refer to psychiatric interventions against the will of the person concerned or without their personal, prior, affirmatively expressed free and informed consent.

[2] Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free From Nonconsensual Psychiatric Interventions,' Syracuse J. Law & Intl Com. 34:405 (2007); Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions: An Update on Its Interpretation by UN Mechanisms,' in Cantú, Maisel and Ruby, eds., Institutionalized Madness: The Interplay of Psychiatry and Society's Institutions (2024), available at: https://ethicspress.com/products/institutionalized-madness?INTEGRITY; see also Minkowitz, Forced interventions and forced institutionalization as torture/CIDT (cruel, inhuman and degrading treatment) from perspective of PWD (slides presented to expert meeting with Special Rapporteur on Torture Manfred Nowak that informed his 2008 report), and Minkowitz, Advocacy Note: Forced Interventions Meet International Definition of Torture Standards (circulated during CRPD negotiations).

This standard has been articulated by the Committee on the Rights of Persons with Disabilities and by several Special Rapporteurs on Torture.[3] The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa, Article 10 on Freedom From Torture or Cruel, Inhuman or Degrading Treatment or Punishment includes a binding obligation on states to 'ensure that persons with disabilities, on an equal basis as others, are not subjected without their free, prior and informed consent to any medical experimentation *or intervention* [italics added].'

The characterization of involuntary psychiatric interventions as torture entails the following premises:

- The administration of mind-altering drugs and procedures (such as electroshock or psychosurgery) against a person's will or without their free and informed consent is inherently an act that unjustifiably causes objective harm to the body and mind, as well as subjectively experienced pain and suffering.[4] Neuroleptic drugs in particular (the class of drugs most commonly administered without consent) were classified as a form of physical torture in 1986 by then-Special Rapporteur on Torture P. Kooijmans, due to their signature effects of psychic apathy and a movement disorder called akathisia that is characterized by 'trembling, shivering and contractions.'[5]

- Persons with disabilities have a right to be equally protected as others against the administration of mind-altering drugs and procedures. A defense of medical

---

[3] CRPD General Comment No. 1, CRPD/C/GC/1 (2014) para 42; CRPD Guidelines on liberty and security of the person of persons with disabilities, adopted in 2015, published as Annex I to A/72/55; CRPD Guidelines on deinstitutionalization, including in emergencies, CRPD/C/5 (2022), paras 10, 13, 55, 58, 76 and Section IX; Reports of Special Rapporteur on Torture: prior to CRPD: E/CN.4/1986/15, para 119; after CRPD: A/63/175 (2008); A/HRC/22/53 (2013), paras 85 and 89; A/HRC/43/49 (2020), para 37.

[4] See Minkowitz 2007 (cited in footnote 2 above); Center for the Human Rights of Users and Survivors of Psychiatry et al, Joint Submission to Human Rights Committee for its review of the United States in October 2013 on nonconsensual psychiatric medication, https://crpdcourse.org/wp-content/uploads/2024/03/CHRUSPUSICCPRshadowreportFINAL.docx; Andrew Byrnes, 'Torture and other Offenses Involving the Violation of the Physical or Mental Integrity of the Human Person,' in Gabrielle Kirk Mcdonald et al, eds., Substantive and Procedural Aspects of International Criminal Law (2000) (discusses Inter-American Convention to Prevent and Punish Torture, which includes alternative criterion of practices that are 'intended to obliterate the personality or diminish the physical or mental capacities of the victim, even if they do not cause physical anguish' understood as referring to the use of mind-altering drugs); Eric Rosenthal and Clarence Sundram, 'The Role of International Human Rights in Domestic Mental Health Legislation: Submitted to the World Health Organization' (cited in WNUSP Contribution to the Working Group, 2003, in author's possession).

[5] E/CN.4/1986/15, para 119 ('The following list, which is not exhaustive, refers to some methods of physical torture: .... Administration of drugs, in detention and psychiatric institutions... neuroleptics, that cause trembling, shivering and contractions, but mainly make the subject apathetic and dull his [or her] intelligence.'); Peter Breggin, Psychiatric Drugs: Hazards to the Brain (1983).

necessity, which attempts to justify acts otherwise qualifying as torture by virtue of a victim's actual or perceived disability, is not a viable justification in light of the CRPD and the principle of non-discrimination. For this reason, the term 'neuroleptic' is preferred rather than 'anti-psychotic,' as it refers neutrally to the action of the drug, which has the same torturous effects on everyone, rather than the sanitized medical term.

- It is also common to use neuroleptic drugs, electroshock and psychosurgery for behavior control in institutions of any kind, qualifying as torture under the punishment or coercion criteria, whether or not a medical or 'best interests' justification is also being claimed.

- Persons with disabilities have a right to be different, to value and appreciate their minds and bodies and to exercise affirmative, free, prior, informed consent about any treatments or interventions.[6] Psychiatric interventions without such consent that rely on a medical justification qualify as torture since these actions inflict severe pain and suffering, and often cause lasting damage to the brain, body and psyche, for reasons based on the discriminatory failure to respect the right to integrity and right to be different of persons with disabilities.

- Persons with disabilities have the right to enjoy and exercise full legal capacity on an equal basis as others (CRPD Article 12). This means that people experiencing extreme states of mind or emotions retain the right to make choices about what kind of assistance to accept or refuse.[7] All mental health services, including hospitalization and treatment, should only be provided following the affirmatively expressed free and informed consent of the person concerned.[8] No one, including children, should ever be subjected to compulsory hospitalization or other compulsory interventions.

- Psychiatric institutions warrant the designation of torturous environments, as described by Special Rapporteur on Torture Nils Melzer in his 2020 report on

---

[6] UNESCO Declaration on Race and Racial Prejudice (1978), Article 1.2 (right to be different); see also sources in footnotes 2 and 3 above.
[7] CRPD General Comment No. 1, paras 18 and 42 (cited in footnote 3); CRPD Guidelines on liberty and security of the person (cited in footnote 3); CRPD Guidelines on Deinstitutionalization, paras 10, 55, and 76 (cited in footnote 3); Special Rapporteur on Torture A/HRC/22/53, para 85(e) (cited in footnote 3); Tina Minkowitz, Reimagining Crisis Support: Matrix, Roadmap and Policy (2021), available at: www.reimaginingcrisissupport.org.
[8] CRPD Guidelines on Deinstitutionalization, para 55.

psychological torture.[9] Involuntary commitment for long or short periods of time is arbitrary detention both because it is discriminatory (based on disability) and because the detention has no fixed term or rules, forcing an engagement with the agendas of institutional personnel in order to secure release.[10] The designation as a mentally ill person said to require institutionalization and forced interventions as a 'treatment' is humiliating and demeaning, and this creates a 'state of exception' in which solitary confinement, restraints, physical assaults and sexual violence are likely to occur in addition to the violent primary purposes of institutionalization, the segregation from society and administration of mind-altering drugs and procedures.[11]

- Even aside from the characterization of psychiatric institutions as a torturous environment, the regime of forced psychiatric interventions that includes both detention for purposes of protective or preventive custody or for treatment and the interventions on the body for purposes of treatment or restraint that are in themselves acts of torture, needs to be understood as a single whole rather than conceptualizing the detention as merely an environment in which torture takes place. Involuntary psychiatric commitment is an illegitimate form of detention inextricably bound up with torturous purposes, and it does a disservice to victims to focus only on the components that clearly amount to torture.

- The concept of forced psychiatric interventions and related actions in the context of this torturous environment should be understood to encompass the following:

  Injection of neuroleptic drugs or forcing the person to take them orally
  Electroshock with or without anesthesia
  Psychosurgery
  Other mind-altering drugs
  Compulsion under threat or intimidation to take neuroleptic drugs, undergo electroshock or psychosurgery, or take any other drug

---

[9] Special Rapporteur on Torture A/HRC/43/49, paras 15(e), 68-70; Tina Minkowitz, 'UN Report: Involuntary Psychiatric Interventions "May Well Amount to Torture"' (March 5, 2020), available at: https://www.madinamerica.com/2020/03/report-psychiatric-interventions-torture/.

[10] Special Rapporteur on Torture A/63/175, paras 64-65 ; Minkowitz slides presented to expert meeting (cited in footnote 2).

[11] Ashe, Leah M. 2019. "Where is the camp? Psychiatry and the State of Exception." Presentation at the International Congress on Law and Mental Health, Panel "Shifting Power: Human Rights Law Confronts State and Psychiatry." Rome, Italy, 21-27 June 2019. Text version available at https://nd.academia.edu/LeahAshe and audio/video version available at http://www.youtube.com/lashend.

Using deceit or manipulation to obtain consent to take neuroleptic drugs, undergo electroshock or psychosurgery, or take any other drug

Failure to provide the opportunity to freely give or refuse informed consent in relation to a neuroleptic drug, electroshock or psychosurgery, or any other drug

Use of any drug, electroshock, or psychosurgery as restraint

Mechanical restraints (straitjacket, four- or five-point leather cuffs, etc.)

Solitary confinement

Sterilization

Compulsory abortion

Sexual assault

Forced nakedness

Humiliating treatment

Culture of compliance as psychological torture – pressure to view oneself in psychiatric terms as incapable, defective, dangerous, incomprehensible, and to accept being controlled by drugs as necessary and correct

2. Harm to direct survivors, families, and society from forced psychiatric interventions

It can be hard for survivors to describe the harms. The experience is life-changing and all-encompassing; moreover we often come into this experience of unjust detention and torture in a vulnerable state of psychic openness, feeling badly about ourselves or experiencing expanded awareness. Forced psychiatry is layered on top of this life crisis and overtakes it. We may also struggle to find the words to communicate harm from actions that the world around us promote as beneficial.

Nevertheless, both psychic and physical harms, as well as harms to life opportunities and relationships, are commonly experienced. Physical harm from neuroleptics and other psychiatric drugs, as well as electroshock and psychosurgery, are well documented in medical literature and survivor testimonies.[12] The harm from neuroleptics was summarized in our submission for the ICCPR review of the United States in 2013, included as Appendix A below. Harm from electroshock centers on cognitive impairment and long-term memory loss, which many survivors grieve deeply.[13]

[12] See Peter R. Breggin, Psychiatric Drugs: Hazards to the Brain (1983), and Toxic Psychiatry (1991).
[13] Linda Andre, Doctors of Deception: What They Don't Want You to Know about Shock Treatment (2009).

Responses to survey on harm from forced psychiatric interventions and desired reparations, from survivors throughout the world,[14] include the following descriptions of harm:

1. Exacerbation of emotional suffering.
   'In the psych ward, my feelings of shame, guilt, and pain weren't relieved—they were intensified by the so-called treatments, like the ones I described. I didn't grow. I didn't heal. Instead, I walked away with even deeper wounds. I walked away with even deeper wounds.'

2. Loss of self-esteem and relationships.
   'I lost all confidence in my mothering. I lost the relationship with my 17 year old daughter. I lost all faith and hope.... My family all but disowned me. I forced myself to cut off from most people.'

   'The deepest harm psychiatry did was to strip me from trusting myself; from being in touch with myself and knowing what I want and need; knowing that what I perceive is there/here (!!).'

3. Sense of shame and isolation from others, damaged reputation.
   'The shame of "getting out of an insane asylum";
   The uneasiness and the great feeling of injustice, of being "a damned", when one sees the "normal people" in the street, who walk around and live quietly, who could not understand this experience, and who anyway will never live it, simply because they are "normal" therefore "apprehensible" by psychiatrists and therefore not "potentially dangerous". ....
   The bad reputation, the whispered phrases ("he's a big sicko"), just because one "comes from a mental asylum", which is therefore "proof", for "people", who obviously don't try to understand (fear of everything, fear of the unknown, cowardice...).'

4. Loss of relationship with children, or possibility of having children.
   'I lost my second pregnancy due to those heavy medications.... I got separated from my baby of three months, there was no provision for mothers with their babies.'

---

[14] This survey was conducted by me over a period from 2022 to the present, distributed through survivor networks. Questions can be found at: https://www.reimaginingcrisissupport.org/reparations. Analysis is still in progress and not all responses are accounted for here.
And see also the narratives of harm from neuroleptic drugs in particular the CHRUSP ICCPR submission contained in the Appendix.

5. Sense of abandonment and hopelessness.
   ‘Not only was my life cut into pieces, I was unable to keep my education and job, but I was constantly experiencing the feeling of abandonment in the process. It was as if there was no place to help you, and even the way to obey, such as going back to the clinic, taking medication and being hospitalized, was useless, and then people became more and more friendless and powerless.’

   ‘I was diagnosed with conditions I do not believe I have, when nobody treated my trauma of losing a baby due to hospital negligence, & nearly lost my wife too, both which I witnessed, nobody treated or took into consideration my car accidents where I sustained head injuries, nobody treated my alcohol or drug issues, I had to give up myself, which I did successfully then they killed my baby & tipped me over the edge.’

6. Complex trauma.
   ‘It traumatized me deeply. It caused me permanent physical damage, ongoing moral damage, and mental and psychological damage. It severely stigmatized me. It prevented me from fulfilling my dreams and plans and instilled in me the greatest psychological barbarity, filled with images of rape, blood, and horror, preventing me from enjoying my life and my abilities. It took away the ultimate dignity with which a human being comes into the world. It drugged me uselessly for a long time and caused damage to my physical health. It caused me to go through early menopause, preventing me from starting a family and having a home of my own. It invalidated me family-wise and socially forever. Etc.’

   ‘Tortured by psychiatric drugs through akathisia, neurological disorders that were excruciatingly painful and made it difficult to breath, numerous suicide attempts due to withdrawal effects of the drugs that resulted in life-long, life-altering injuries, the development of PTSD, the prevention of recovery, traumatic withdrawal symptoms, a worsening of the condition the drugs were meant to “treat,” horrific “side effects,” the inability to work because of these “side effects” and injuries caused by forced drugging, violation of dignity and abuse by mental health staff, trauma.’

   ‘Specific acts that I found traumatising:
      Being forced to take medication (including being held down and having intramuscular injections)

Overmedication – losing inability to concentrate, consciousness 'clouded', feeling of a chemical straightjacket
Lack of privacy when showering
Being groomed by psychologist while I was institutionalized, who then later started an unwanted sexual relationship with me (she was later punished and lost her registration/ability to practice as a psychologist)

Perhaps more than the above points, I was always very aware and upset by not being free, of having lost my liberty and being unable to do anything about it. I would ask when I could go home, but not be given clear answers. Knowing that the power of the law and the resources of the State were directed at keeping me locked up was extremely upsetting, dehumanising and disempowering, and the supposedly 'therapeutic' services were very minimal....

The harm has been a negative impact on my emotional (and perhaps unsurprisingly but ironically) on my mental health. The institutionalization and loss of liberty and the stigma around it negatively impacted my sense of self worth and identity. I developed a fear of institutions of all kinds, with unchecked or lightly regulated power structures. I have been reluctant and at times unwilling to access medical care and mental health services (even when I might have wanted them). I have lived in almost constant fear of being forced back into an institution, and the impact on my family and professional life.'

'Psychiatric institutionalization and the attendant forced drugging harmed my body (permanent thyroid disease) and destroyed my self-esteem, ability/desire to trust any kind of professional (this may not be a harm, but just in case it is), gave me a terror sirens and hospitals, traumatized and incapacitated me over and over again, tortured me with poisonous drugs, repeatedly resulted in the torturous use of solitary confinement and shackles, and rendered me unable to get a regular job.'

7. Diminishment of mental and physical capacities, as effects of drugs.
'I can't remember the things that the persons said to me at work, I had many difficulties to talk, I didn't be able to reason. I love sport but with Depakote I couldn't run and also I had many difficulties to walk.'

"'Loss of self"... With all this drug crap, you can't think or "function" in the way "you really are" anymore. Everything is altered. You're not yourself anymore. All this is a "rape of the self", at all levels: physically (confinement), mentally (alteration of thoughts and of the self by the drugs, and also obligation to think in a way considered "non-pathological" by the doctors, i.e. you have to have "ordinary"

considerations and reasoning, i.e. "null and void", and then the psychiatrist considers that you "get better"... It's "normalization"!
Sometimes physical pain from medication (especially Tercian). It's very difficult to explain. It's "otherworldly" stuff, it's not human!
Destruction of libido for years (not that big a deal to me, but one should be in complete control of that, it's personal).'

8. Loss of independence
   'I don't feel that I can live independently in this world as an adult anymore, but have to be looked after by my partner. I see more institutionalization right around the corner – I have already been institutionalized over 25 times, so it seems logical that more awaits me. I perceive myself as having no choice about taking psychiatric drugs, and indeed, I've been given none, because I know that any time I have another episode it's right back to an institution. This ongoing drugging has caused a passivity and narrowing of my interest and way of being in the world.'

9. Serious physical health problems as a result of drugs.
   'I have acquired Chronic Kidney Disease, Nephrogenic Diabetes Insipidus, Hypothyroidism from the Lithium treatment over a 17 year time-frame. I took my medication as prescribed and had my regular serum tests however suffered several bouts of Lithium Toxicity which irreparably damaged my renal system.'

   "I was committed to a psych ward at 14 and a half, in 2010, ... I wanted to leave immediately and told them I was leaving. They took me violently and put me in isolation, that was brutal. Then they told me to take some medication otherwise it would be injected. So I did (now I know it is written as "consented to take nozinan & anafranil" on the medical record). This caused problem to pee, and constipation. Because they then refused to believe me for 7 years, it is now a permanent grave neurological disorder. And I have other neurological "oddities" that started during this forced treatment.'

10. Inability to work and consequent impoverishment.
    'My mental health and medical/physical issues have impacted upon my ability to obtain work. As a consequence of these particularly my medical/physical conditions I am not able to work full-time and in fact have not being able to take up an occupation in the last 20 years and finding part-time work is just as hard. It means I rely on a social welfare payment of Disability Allowance as my sole source of weekly income for the last 20 years. I have been studying to try and improve my

circumstances but I am living an existence below the poverty line and struggling to make ends meet. Social welfare is a necessity not a privilege. I am looking for a hand up not a hand out.'

11. Hopelessness and despair.
    'During the hospitalization, mental suffering due to the following:
    The fact that my body is being touched and taken against my will;
    Doubt and loss of self-esteem (i.e. having to submit to the imposed (and repeated) idea that one is "sick") ;
    The horrible idea that my own life was "over", that "I belonged in a hospital" (for example, seeing other "patients" who didn't seem any more "affected" than I was, but who had been there for 25 years!)
    The indescribable psychic suffering of bottomless, dizzying despair, resulting from the impossibility of finding any help, any lifeline, anything, to try to get out of this vile and slimy trap;
    The atrocity of the fact that nobody, nobody knew how long I was going to be there (and nobody seemed to care). ...When there is no fixed "end date", then the idea of an end to detention seems vague, uncertain, and even unlikely, and the duration seems "indefinite" or "for life"...'

    'It took me perhaps 10 years to truly understand and acknowledge the experience as a traumatic one. Strong societal notions, reinforced by the law, that it was 'necessary' informed my earlier thinking. I remember at the time of being deprived of liberty, feeling that it was deeply unfair, and also feeling powerless to challenge it – I was told that judicial review was an option, but I knew that would take many months and was not likely to be effective.'

12. Moral injury from compliance relationship with torturer.
    'Feeling of being in a kind of "sado-masochistic relationship" with the psychiatrist, since he has all the power over me (he decides where, when and how I can get out, what medication I have to take, he has to know my innermost thoughts, my whole family history, he is the only one who can decide to give me back my freedom...), and since I understood that the more I agreed with him (submission), the more the stranglehold loosened.'

    'The first time I was ever restrained was when I tried to cut my hand with a pen cap in the psych ward. At the time, what I really wanted was for someone to notice me, to show some care. I knew it wasn't a healthy way to ask for help, and I couldn't bring

myself to say it out loud—I just wanted to quietly hurt myself. But I was also deeply ashamed and guilty, thinking maybe I was just being "attention seeking." The nurse immediately called security. They dragged me to the isolation room, tied me to the bed. I was in shock. It felt like I was truly being punished—like I was a bad person, someone so pathetic for wanting comfort in such a shameful way. I thought, "Maybe I deserve this." And yet, even as I blamed myself, I still felt hurt and angry inside.'

These harms affect families and societies as well, by distorting relationships and fomenting insensitivity to human suffering, which contributes to intolerance and lack of solidarity.

3. Cessation of violations and guarantees of non-repetition as central demand

The primary obstacle to justice for survivors of forced psychiatric interventions is the ongoing character of violations in every country, authorized and regulated by mental health legislation. For this reason, survivors of forced psychiatric interventions have collectively prioritized guarantees of non-repetition when calling for reparations. Justice starts with being free from both the forced intervention, and the fear of it being reimposed at any time, which is a substantial possibility in many survivors' lives when they seek mental health services, interact with law enforcement or criminal justice systems, interact with social welfare and housing systems, seek support from family and friends, struggle openly with difficult emotions and challenges in their lives.

A. Mental health tribunals and other case-by-case litigation ineffective

Legal proceedings provided for under mental health laws to challenge involuntary hospitalization and treatment are not an effective remedy because they are unreliable to secure release from detention and cessation of torture. On the contrary, they are designed to authorize involuntary measures, contrary to the CRPD, based on standards that uphold a medical model of mental health and negate the right to equal legal capacity to control one's own body and health.[15] These proceedings cannot supply guarantees of non-repetition either to the individual concerned or to anyone else, because the legislative framework authorizing the exercise of coercive power by psychiatric professionals remains in place. Even if the court or tribunal orders release, the same individual can be detained

[15] CRPD Guidelines on liberty and security of the person (cited in footnote 3), para 19 (review of detention should 'under no circumstances… allow for the extension of the arbitrary detention'), and paras 7 and 10-12 (on the linkage of liberty with legal capacity and free and informed consent); CRPD General Comment No. 1 (cited in footnote 3), para 42 and CRPD Guidelines on Deinstitutionalization (cited in footnote 3), para 10 (addressing medical model links with forced psychiatric interventions).

and drugged again and again and will have to seek court intervention to end the arbitrary detention and torture each time (if they have the stamina and wherewithal to do so), with no guarantee that the court will rule in their favor. It is difficult to build up a stable and secure life with this risk always present in survivors' lives, since a past involuntary hospitalization can lead family members, employers, neighbors, health care providers and others to view the person as a liability and burden, and to initiate repeat hospitalizations because they attribute the person's life challenges or emotional ups and downs to a mental illness.

Habeas corpus proceedings or other mainstream avenues available to challenge arbitrary detentions can in principle be effective for cessation and non-repetition on the individual and systemic levels if courts are willing to apply international human rights norms based on the CRPD along with a reparations framework.[16] However, case-by-case litigation is an onerous and wasteful approach when the human rights norm calls for elimination of a regime of arbitrary detention and torture.

The norm under CRPD is absolute prohibition;[17] failure by states to act systemically to abolish these practices is itself an ongoing violation.

B. CRPD Guidelines on Deinstitutionalization – cessation, non-repetition and reparation measures

The CRPD Guidelines on Deinstitutionalization, Including in Emergencies (CRPD/C/5) provides a detailed framework for ending involuntary psychiatric hospitalization as well as other forms of institutionalization. These Guidelines can be useful for designing measures to stop the violations and guarantee non-repetition by ceasing any further involuntary admissions, releasing all individuals who are involuntarily retained in psychiatric settings and providing them the economic and social assistance they made to live independently in the community, and reforming legislation to eliminate any authorization for such involuntary measures, as well as assessing and re-designing support services to be provided in the community, encouraging and providing training for support networks, and ensuring that all parts of the community and mainstream services are accessible to people leaving institutions without any direct or indirect discrimination.[18]

---

[16] Supporting opinion, amicus curiae, in a trial regarding the involuntary hospitalization of persons with disabilities in psychiatric hospitals in Mexico, Queja 7/2023, submitted by Tina Minkowitz on behalf of the Center for the Human Rights of Users and Survivors of Psychiatry (2023), available at: https://www.academia.edu/110901519/CHRUSP_Amicus_Mexico_SJCN.

[17] CRPD Guidelines on liberty and security of the person (cited in footnote 3), para 6.

[18] Paras 10, 13, 20, 31, 58, 65, 70-73, 76, 86, 90-92.

The Guidelines also set out the obligation to create reparations mechanisms and processes including truth commissions, mechanisms that can recommend further reforms and collective or systemic measures, and individualized pathways for access to justice, which can include redress, reparations and restorative justice.[19] Sanctions against perpetrators must also be a possibility.[20] In all planning and implementation of measures to end institutionalization, design new services, and provide reparations, survivors are to play a leading role, and perpetrators of institutionalization are welcome to accept accountability but not to oversee these processes.[21]

The Guidelines have a transformative dimension that is important for changing public attitudes and social practices, as well as policy and programs of the state. Not only the coercive aspect of involuntary hospitalization and treatment, but also the medicalization of human suffering and the human personality have contributed to the practices now understood as arbitrary detention and torture. Medicalization in this sense is closely related to the denial of legal capacity, in that it refuses to engage with the subjectivity of individuals who are suffering and struggling, but instead labels their entire being with an illness and purports to 'treat' the illness with means that block and assault subjectivity. The Guidelines counter medicalization in several ways: 1) declaring that individual crisis is not a medical problem requiring treatment or a social problem requiring forced intervention;[22] 2) urging states to provide the option of services outside the health system and not requiring a mental health diagnosis, for persons struggling with distress or unusual perceptions, including crisis support, support to heal from trauma, decision-making support, and support to enjoy solidarity and participate in community;[23] 3) emphasizing that housing needs of people leaving institutions should not be met by mental health services and should not require the person to receive any unwanted services;[24] and 4) diminishing the role of service providers in policymaking related to deinstitutionalization, while elevating the role of survivors.[25] In this way, the Guidelines offer guidance for measures of satisfaction, to transform societal perceptions of people with psychosocial disabilities and survivors of psychiatric institutionalization, as well as systemic changes to guarantee non-repetition.

C. Survivor responses to questionnaire

---

[19] Paras 117, 119, 121, and see entire Section IX guidance on reparations obligation and scope and nature of reparations.
[20] Para 123.
[21] Paras 122 and 117.
[22] Para 10.
[23] Para 76.
[24] Para 32.
[25] Para 34.

Survivors were asked what they need from others including the state. A range of selected responses is included below.[26]

- I need a job that guarantees a livable wage under all circumstances. It should provide adequate paid leave, allow for flexible time off and make-up hours, and not withhold pay simply because I take leave frequently.
  I need all environments—whether in the workplace, at school, or elsewhere—to foster open, honest, and trauma-informed communication.
  When I'm facing a crisis involving suicidal thoughts or self-harm, I need to be able to talk about it without being immediately reported or subjected to forced treatment. I need the freedom to explore the complexity of staying alive—and what it means to hurt myself—openly and without fear, especially with people who understand me, like peers.
  When dealing with legal matters, I need a lawyer who is empathetic and understands my trauma and psychosocial disabilities. If necessary, I would also like more emotional support throughout the legal process.

- I have never thought of it in this way, as what I need. I have seen myself as having wronged those around me. At the time, 1966, I had just been assaulted on campus and was blaming myself for being in that position and I see now I was traumatized but my main feelings were shame and horror that anyone would find out what had happened to me. So I attempted suicide by cutting my wrists and my housemother, who was a grad student in Psychiatry, had me committed for only 2 weeks to a psych ward. What I need now is to get back some of my self-esteem, I wish I could tell the others I knew then what actually happened and in fact I did write a letter to one of my classmates about it, this time last year, and I'm sure she shared it with others. Just being able to articulate what happened 60 years ago, and what I was feeling was a relief as I think they must have imagined other things, not sure what.
  I got no reply and didn't expect any but several people from that time have started following me on Facebook so I think that is my reply.

- I do not need anything from state, society or anyone else. I'm doing OK and I've always been very self-sufficient.
  There are however many things that I think need to change, so that the generation after me will not have to suffer like I did.

[26] I have lightly edited for visual clarity but otherwise left responses intact. Some of them may be challenging to hear. Victims of torture carry a great deal of legitimate anger not only against the direct perpetrators but also those who enable them.

- I need some financial renumeration from my family, who forced me in and then brainwashed my children into believing that I am "sick." I never received a phone call. I haven't really talked to them. I would like an apology. Though I don't expect it. I need from the state, an apology and renumeration for the costs I've incurred for legal fees pertaining to the custody issue it caused. I need the state to stop forced commitment. I need from society, more understanding and realization that this is still occurring and that there is no informed consent in the process.

- The Truth,
  An apology
  40 Million US Dollars. 10 Million for each life ruined by Psychiatry. Myself, 2 Daughters and a Grandson = 40 Million. This money may not be taxed or counted as income.
  Complete prohibition of forced treatment and Coercion. Of any type
  End the Troubled Teen Industry
  Force the Pharmaceutical Industry to run advertisements spending twice their current advertising budget to properly Educate everyone about the terrible Harm being caused by Manufacturing, Marketing and Distributing Neurotoxins,
  Abolish Psychiatry and sentence Psychiatrists to work at a Marijuana Dispensary or Farm.
  Recycle all copies of the DSM
  Dismantle SAMHSA
  Expungement of my Criminal Charges. All of them.
  Re-Educate Judges (Mandatory)
  All sitting Judges, Magistrates etc. Administrative, Civil, Family Court, Traffic (I don't care what bench) will receive 1 involuntary shot of HALDOL. Absolutely NO COGENTIN. There will be no religious or medical exemptions. No Shot, No Bench.
  Prohibit parasites like NAMI and Mental Health America from spreading Medical Misinformation by excluding them from ever receiving a donation over $20 US. All profit must be donated to the Psychiatric Survivor Trust Fund.
  Abolish Child Protective Services it is in reality Child Prostitution Services.

In this small sampling, the claims for reparation vary widely, from not needing any personalized measures and only seeking change (guarantees of non-repetition), to measures related to accommodating one's needs as a person with psychosocial disability, establishing the truth within one's own personal circle, seeking amends from family members who instigated the violations, and sanctions against entities and officeholders

that comprise parts of the abusive system. Sanctions against individual persons that are not based on individual responsibility or that constitute torture cannot be countenanced, but the demand should be noted as an expression of legitimate anger against all those who are complicit in legitimizing the same practice when discriminatorily based on disability.

4. How to strengthen implementation of survivor rights and participation

What should be done by States (government, parliament, judiciary, other), national human rights and other independent institutions, non-state actors, and regional and international human rights mechanisms to strengthen the implementation of torture survivors' rights and their active participation in the development of laws, policies and processes that concern them?

States should immediately release persons under arbitrary detention, meaning all those who are hospitalized involuntarily or being kept without their affirmative free and informed consent in any mental health setting, and to immediately stop the compulsory administration of psychiatric drugs, electroshock and psychosurgery.[27] They should in addition support all those who wish to withdraw from using psychiatric drugs to do so, and research, develop and scale-up support services and practices for people struggling with intense emotions and mental states that are based in respect for the person's self-knowledge, and for their will and preferences, including peer support communities and access to spiritual practices.[28]

Legislatures should repeal the mental health legislation that authorizes involuntary measures of any kind, and reform legal capacity to provide for full legal capacity for all adults without any possibility of it being removed or limited.[29] The judiciary should explore and act on any powers it may have to nullify legislation that violates fundamental human rights sua sponte or in response to litigation, and to issue orders for nationwide injunctive relief that would end the involuntary measures, inform individuals they are free to leave,

---

[27] The obligation of immediate release is indicated in CRPD General Comment No. 5, CRPD/C/GC/5 (2017), para 48, as well as CRPD Guidelines on Deinstitutionalization (cited in footnote 3), para 13. The obligation to immediately cease compulsory interventions is indicated in the United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court, A/HRC/30/37 (2015), paras 107 (d) and (e).

[28] Withdrawal from psychiatric drugs is addressed in Guidelines on Deinstitutionalization, para 106, and in United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court, para 107 (e). The remaining obligations are discussed above in 3B. I am proposing to include spiritual practices since several survivors mention spirituality as supportive in healing from forced psychiatric interventions.

[29] CRPD General Comment No. 1 (cited in footnote 3), paras 42 and 50 (c); Guidelines on liberty and security of the person (cited in footnote 3), para 10; Guidelines on Deinstitutionalization (cited in footnote 3), paras 55, 56, 58.

and provide economic and social assistance in the short, medium, and long term as needed, which should not be administered by mental health services or require the individual to accept mental health services or supervision.[30]

Beyond these basic reforms, processes should be established to explore the full nature and scope of harm and develop collective reparations measures and frameworks for individualized reparations.[31] Reparative processes should provide forums for survivors to tell their stories and be heard and responded to, by other community members and by rapporteurs assigned to compile an overview of survivor accounts, designed with feedback so that survivors can ensure they are accurately represented. In addition, meticulous review of laws and policies, and development of reform proposals, should be conducted by expert committees composed of survivors, lawyers and other relevant subject matter experts (for example, related to employment practices or housing), excluding any perpetrators or defenders of forced psychiatric interventions, and ensuring that survivor needs and concerns are effectively addressed. Based on these, further collective measures may be suggested. All reparations processes should be based in the state agencies responsible for justice and human rights, not in those responsible for health or mental health services.

In addition to state-led reparations processes,[32] civil society, led by or in close collaboration with survivors and their organizations, should conduct awareness-raising activities such as Mad Pride marches and festivals, workshops, and open forums, to discuss the harms caused by forced psychiatric interventions and their ongoing impact in survivors' life trajectories, as well as the creative strategies that allow us to survive, the healing we have found or need, and what we may need from our communities, families and each other.

With respect to participation, it is of the utmost importance to make processes for developing, implementing and assessing policies and laws relevant to ending forced psychiatric interventions accessible for all survivors. Many of us are experts in law, policy, support practices, or social sciences (with formal training or by our work in practice), as well as being survivors still experiencing deep pain, grief, anger and trauma reactions. Both our suffering and our expertise need to be acknowledged. Many of us require concerted

---

[30] United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court, paras 107 (d) and (e), Guidelines on Deinstitutionalization, paras 13, 31, 93, 126.

[31] Guidelines on Deinstitutionalization, Section IX.

[32] See COSP15 Side Event on Remedy and Reparation for Institutionalization, Center for the Human Rights of Users and Survivors of Psychiatry and others, available at: https://youtu.be/UOSp7I9z0Nk?si=CKANCHCyCKDgwpqy.

outreach efforts, assistance, and accommodations to participate in these processes and to contribute to formulating outcomes beyond telling our stories. This work will require patience and consistent effort along with breaks for everyone's self-care; as there is a relationship among personal healing from trauma, individualized reparations, telling one's story, and creating the conditions for the stories to be heard and accepted, as well as the societal dimensions of generalized attitudinal and structural change, the concept of reparations should not be limited to formal mechanisms but should be understood as multiple simultaneous processes some of which are ephemeral and known only to those involved, others civil society-driven, and others state-led or led by independent human rights mechanisms, all linked in some way to the aim of repairing the harms of forced psychiatry at all levels. Reparations understood as a movement in this sense brings together what survivors already do individually and collectively, with a responsive environment based in human rights, that needs high-profile endorsement as well as grass-roots work and that can snowball.

5. Summary

The report should include forced psychiatric interventions among the forms of torture and include the experiences of survivors and our demands for reparation in its discussion. While some of our needs and concerns may be common to all survivors of torture, the continued legitimation of forced psychiatric interventions by most states and debate on the this question in certain treaty bodies and the Council of Europe indicates the need to emphasize states' obligation to immediately cease these practices and guarantee non-repetition by enacting and enforcing the removal of any domestic legislation that has authorized them. In addition, survivors' experiences and demands demonstrate the need for both fully accessible social environments that accept psychosocial diversity, and the development and scaling up of crisis support that is free from coercion, respects the individual's self-knowledge and responds to their will and preferences, outside the health system and without requiring a mental health diagnosis. Reparations must be comprehensive and society-wide, encompassing an approach to social transformation that internalizes an understanding of the destructive impact of forced psychiatric interventions and that they are unjustifiable, along with creating the social practices that can respond effectively to the needs of all concerned.

Appendix

Excerpts from Center for the Human Rights of Users and Survivors of Psychiatry et al, Joint Submission to Human Rights Committee for its review of the United States in October 2013 on nonconsensual psychiatric medication

Neuroleptic Medications Are Known and Established to Cause Tangible Medical Harm.

This harm is significant, reinforcing the Special Rapporteur's concerns that forceful use of neuroleptics, or their use over a person's objections, amounts to torture or ill treatment.[33] These harms include: Dysphoria, Tardive Dyskinesia (TD), Akathisia, Drug-Induced Parkinsonism, Dystonia, Adverse Cardiac Effects, Autonomic Side Effects, Metabolic Syndrome, and, rarely, Neuroleptic Malignant Syndrome (NMS). Additionally, there is concern that neuroleptic medication is at least partially implicated in a well-established 13-30 year loss of life for individuals with psychiatric disabilities. Lastly, research suggests that administration of neuroleptic medication causes permanent structural changes in the brain.

Neuroleptic dysphoria (ND) is an all-inclusive descriptive phrase that encompasses a variety of unpleasant subjective changes in arousal, mood, thinking and motivation induced by neuroleptic drugs.[34] Also sometimes referred to as "neuroleptic-induced anhedonia" this reaction has been described with virtually all conventional neuroleptics, regardless of dose or type of medication.[35] It has been estimated to occur in as many as 60% of persons treated with neuroleptics, and is acknowledged as a frequent reason for persons to refuse to take neuroleptics. The scientific literature has been aware of this phenomenon for nearly fifty years. It is believed to be related to the mechanism of action for these medications, and unavoidable given their intended effects on dopamine neurotransmission.

Akathisia is a very common effect of neuroleptic medication, occurring in as many as 49% of those receiving neuroleptic medications.[36] Individuals experience a sense of inner restlessness, mental unease, unrest or dysphonia. Restless movements, such as rocking from foot to foot, walking on the spot, shuffling and swinging one leg on the other while

---

[33] Méndez, Juan. Statement of the Special Rapporteur On Torture, 22nd session of the Human Rights Council. 4 Mar. 2013. Pg 4-7.

[34] Voruganti, L., et. al. "Neuroleptic dysphoria: towards a new synthesis." Psychopharmacology (Berl). 2004 Jan;171(2):121-32. Epub 2003 Nov 27. <http://www.ncbi.nlm.nih.gov/pubmed/14647964>

[35] Awad, A., et. al. "Neuroleptic dysphoria: revisiting the concept 50 years later" Acta Psychiatr Scand 2005: 111 (Suppl. 427): 6-13. http://schizophreniaresearch.files.wordpress.com/2011/01/awadneurolepticdysphoria2005.pdf.

[36] Barnes, T. R. E. (1995). Acute and chronic drug-induced akathisia. Psychiatrists Information Service Monograph Series, 1, 4-6.

sitting, may be associated with the subjective experience. Rapid pacing up and down is characteristic of severe cases; such patients may find it impossible to sit, lie or stand in any one position for more than a few minutes.[37] It is the same experience that many withdrawing from opiates feel,[3839] except that it can become chronic in as many as a third of patients receiving neuroleptic medication. Unfortunately, akathisia is often misdiagnosed as psychotic agitation, with a consequent increase in the dose of antipsychotic, which only leads to further deterioration.

Tardive Dyskinesia (TD) is a movement disorder, occurring after months or years of neuroleptic treatment. It involves random movements in the tongue, lips or jaw as well as facial grimacing, involuntary eye movements, and random movements of the extremities. In addition to causing serious discomfort and impairment of mobility, TD can be extremely embarrassing to a person experiencing it, and frequently carries significant social stigma.[40] The prevalence of tardive dyskinesia is estimated to be 10 to 20 percent of individuals treated with anti-psychotic medications.[41] Once Tardive Dyskinesia develops, complete and persistent reversibility is rare, occurring in as few as 2% of cases.[42] It is frequently lifelong and irreversible, even after discontinuation of medication.

Drug-Induced Parkinsonism has essentially the same symptoms as Parkinson's disease. Parkinsonian symptoms induced by neuroleptics or dopamine depleting drugs cannot be distinguished clinically from those seen in PD.[43] It occurs in 15 to 40 percent of persons taking neuroleptic medication, depending on medication and dose.[44] The symptoms include showing little or no facial expression, soft or slurred speech, shaking hands, stiffness and slowing of movement, and difficulty writing.[45]

---

[37] Beaumont, G. "Antipsychotics - The Future of Schizophrenia Treatment" Curr Med Res Opin. 2000;16(1) <http://www.medscape.com/viewarticle/407762_4>

[38] "Tardive Akathisia & Tardive Dyskinesia" <http://www.tardivedyskinesia.com/common-associations/akathisia.php>

[39] Factor, Stewart, e.d. *Drug Induced Movement Disorders* Malden, MA: Blackwell Publishing, 2005: pp 142

[40] "Tardive Dyskinesia" National Alliance on Mental Illness <http://www.nami.org/Content/ContentGroups/Helpline1/Tardive_Dyskinesia.htm>

[41] "Tardive Dyskinesia" Mental Health America <http://www.nmha.org/go/information/get-info/tardive-dyskinesia>

[42] Glazer, W, et. al. "Predictors of improvement in tardive dyskinesia following discontinuation of neuroleptic medication." The British Journal of Psychiatry (1990) 157: 585-592 doi: 10.1192/bjp.157.4.585

[43] Hirose, G. "Drug induced parkinsonism: A review" J Neurol (2006) 253 [Suppl 3]: III/22–III/24 DOI 10.1007/s00415-006-3004-8 <http://www.nlem.in.th/sites/default/files/10_no2_drug_induced_parkinsonism.pdf>

[44] Marsden C., et. al. (1975) "Spontaneous and drug-induced movement disorders in psychiatric patients." In: Benson DF, Blumer D (eds) Psychiatric Aspects of Neurologic Disease. New York, Grune and Stratton, pp 219–226

[45] "Parkinson's disease" Mayo Clinic <http://www.mayoclinic.com/health/parkinsons-disease/DS00295/DSECTION=symptoms>

Dystonia typically involves muscle contractions that result in abnormal postures, such as an inability to move one's head due to neck contractions, difficulty swallowing, or a locking of one or both of one's eyes to one side with an inability to redirect one's gaze.[46] Acute dystonia occurs within 48 hours of beginning neuroleptic treatment in 2.5% of those treated.[47]

Adverse Cardiac Effects and Autonomic Side Effects from neuroleptic medications include cardiac arrhythmia, prolonged QT interval, and significant reductions in blood pressure.[48] In 1990 pimozide was reported to have caused 13 deaths among young patients in the United Kingdom who were using dosages in excess of 20 mg a day. In 1996 sertindole was responsible for 16 deaths from cardiac causes among 2,194 patients who participated in clinical trials.

Metabolic Syndrome typically results in significant weight gain and hyperglycemia, and has been shown to include a neuroleptic-increased risk of type 2 diabetes.[49] A person administered second-generation neuroleptic medication has 3.6 times the risk of developing a metabolic syndrome.[50] When it occurs, the onset of diabetes tends to occur within the first few months of treatment with these drugs.[51] Type 2 diabetes is a lifelong condition, which persons with psychiatric diagnoses may already be at increased risk for, rendering the additional risk of this irreversible condition from neuroleptics all the more concerning in the context of force.

Neuroleptic Malignant Syndrome (NMS) is rare but potentially fatal. Prospective studies have provided disparate estimates of the frequency of NMS, ranging from 0.07% to 2.2% among patients receiving neuroleptics.[52] The syndrome is a form of malignant hyperthermia involving muscle contractions and a life-threatening rapid rise in body temperature.

---

[46] Gardos, G. and Cole, J. O. (1995). The evaluation and treatment of neuroleptic-induced movement disorders. Harvard Rev Psych., 33, 130-139.
[47] Rupniak, N, et. al. “Acute dystonia induced by neuroleptic drugs” Psychopharmacology (Berl). 1986;88(4):403-19. <http://www.ncbi.nlm.nih.gov/pubmed/2871578>
[48] Fayek, M., et. al. “Psychopharmacology: Cardiac Effects of Antipsychotic Medications” Psychiatric Services 2001; doi: 10.1176/appi.ps.52.5.607 <http://ps.psychiatryonline.org/article.aspx?articleID=85863>
[49] De Hert, Marc, et. al. “Metabolic syndrome in people with schizophrenia: a review” World Psychiatry. 2009 February; 8(1): 15–22. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2656262/#B1>
[50] De Hert M, et. al. “Prevalence and incidence rates of metabolic abnormalities and diabetes in a prospective study of patients treated with second-generation antipsychotics.” Schizophr Bull. 2007;33:560–560.
[51] Lieberman, Joseph A. “Metabolic Changes Associated With Antipsychotic Use” Prim Care Companion J Clin Psychiatry 2004;6[suppl 2]:8–13 <http://www.psychiatrist.com/pcc/pccpdf/v06s02/v06s0202.pdf>
[52] Adnet, P., et. al. “Neuroleptic malignant syndrome” Br. J. Anaesth. (2000) 85 (1): 129-135. doi: 10.1093/bja/85.1.129 <http://bja.oxfordjournals.org/content/85/1/129.full>

Persons in the public mental health system in the United States experience a 13-30 year loss of life expectancy.[53] While the exact reasons for this loss of life expectancy are in dispute, it is likely that the harmful effects of neuroleptic medication, especially the cardiac and metabolic effects, are a contributing factor to this discrepancy between the normal lifespan and that seen by persons with psychiatric disabilities.[54] Even if the contribution of the medications is only partial to this loss of life, the forcible administration of them is tantamount to the forcible deprivation of a significant portion of a human being's life.

Lastly, there is strong evidence that neuroleptic medication produces irreversible changes in the human brain, becoming more pronounced the longer one is on them.[55] Very few studies have been done on nonmedicated patients, and, tellingly, studies of neuroleptic changes to the brains of normal controls would be unconscionable. With the documented risk of changing the brains of human beings – indeed their very essences – free and informed consent of the person concerned is essential. Given the number and variety of irreversible negative effects from neuroleptics, along with the evidence of structural changes induced by them in the brain, the administration of neuroleptic medication by force is akin to maiming. Even if the claims of therapeutic purpose and effect are accepted at face value, it is still maiming if done over the objections of the one so modified.

...

Leonid I. Plyushch, a soviet mathematician subjected to neuroleptic treatment in 1973, described his experience:[56]

> I noted with horror the daily progression of my degradation. I lost interest in politics, then in scientific problems, finally in my wife and children. My speech became blurred; my memory worsened. In the beginning, I reacted strongly to the sufferings of other patients. Eventually I became indifferent. My only thoughts were of toilets, tobacco and the bribes to the male nurses to let me go to the toilet one more time.

---

[53] Colton C., et. al. "Congruencies in increased mortality rates, years of potential life lost, and causes of death among public health clients in eight states." Prev Chron Dis 2006;3 (April):1-14. <http://www.cdc.gov/pcd/issues/2006/apr/pdf/05_0180.pdf>

[54] http://www.nasmhpd.org/docs/publications/MDCdocs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf.

[55] Smieskova, R., et. al. "The Effects of Antipsychotics on the Brain: What Have We Learnt from Structural Imaging of Schizophrenia? – A Systematic Review" Current Pharmaceutical Design, Volume 15, Number 22, August 2009, pp. 2535-2549(15)

[56] "SOVIET UNION: The Psukhushka Horror." *Time*. Time, 16 Feb. 1976. Web. 19 Apr. 2013. <http://www.time.com/time/subscriber/printout/0,8816,918016,00.html>

Then I began to experience a new thought: 'I must remember everything I see here, I told myself, so that l can tell about it afterwards.'

Three-and-a-half years on Zyprexa[57]

If you or someone you know is taking this drug; Here is what happened to me while I was on it for 3 and 1/2 years.

1) Type 1 diabetes

2) high cholesterol and triglycerides

3) more severe blood pressure problems

4) Severely restricted communicative skills (e.g. I could comprehend everything, but Zyprexa is known to cause disturbances in the area of the brain which controls speech in humans). As a result I went from an extremely outgoing personality brimming with thought and interactions…to an almost invisable lump of, well…who knows what?! Not being able to coordinate speech and thought meant the whole process from listening, reasoning and speaking out with own opinions became a two or three minute process. Of course, by the time I was finally able to speak…the conversation had moved on. The longer I was on the drug; the more effort communication became; until I just sank into a pessimistic fog and I withdrew from my family and friends.

5) Five hospitalizations for pancreatitis in a 2-3 year period.

6) One of those hospitalizations was 23 days with 21 of them in ICU on a ventilator.

7) Deepening dependence on insulin for higher and higher doses being needed.

8) One hospitalization for a week when my digestive tract shut down.

9) My appendix has been removed

10) My gall bladder has been removed

Before I started taking Zyprexa because of a court ordered hospitalization; I took medicine for high blood pressure and a diuretic. Nothing else. Nothing considered psychotropic.

Now I take 14 physical medications and 3 psychotropics.

[57] http://psychrights.org/index.htm.

Will Hall's account (US)[58]

I ended up in the locked unit of public psychiatric ward in San Francisco. I was never asked if I wanted to go to the hospital, or given options or support in figuring out what to do. I was just observed for several hours in a clinic, and then they announced that I couldn't leave. I was told I was a danger to myself and that it was for my own good, but like so many people it was really being in the wrong place at the wrong time.

[...]That began a year-long stay in the public mental health system. I needed help, but instead I was treated like a disobedient child with a broken brain, punished and controlled, including more than two months in a locked unit. I went from being a human being to being a mental patient. I was put in restraints – not because anything I did but they said it was just for transporting me to the hospital. After being restrained I had nightmares that I was being raped, and I still have flashback reactions to anything that reminds me of that experience. During the time I was in the system I was locked in an isolation cell, threatened with being strip-searched, given more than a dozen different drugs, and subjected to patronizing group therapy that never acknowledged what was really going on.

I spent several months taking a very powerful 'anti-psychotic' tranquilizer drug called Navane, used to treat schizophrenia. It completely changed my personality and denied me the most basic sense of who I was; it made me stupider, slower, fatter, and also, because of the side effects, at times more desperate and suicidal. At one residential facility I was at, a man had killed himself right before I arrived. A patient who was his friend told me why: he was having severe side effects from his meds and no one was listening to him. The meds were why he jumped off the roof and killed himself, not mental illness. When I was on medication it was impossible to know how much of my pain was the medication, not the problems I had to begin with.

I have photos of that time, and the look in my eyes is totally different, not me, a different person. I was basically a zombie, but I was being docile so they considered it recovery. Today I worry that I might have some lingering side effects from the Navane and other drugs I took, including twitching in my body, memory disturbances, and worsened panic. There could be other long term damage that I may never be able to sort out and recognize.

---

[58] http://beyondmeds.com/2009/04/29/will-halls-updated-recovery-story/

Joanna Badura's account (Poland)[59]

> I will always remember this conversation: I was talking to a young psychiatrist with a rather impressive list of scholarly publications. I told him that I was having serious doubts as to my diagnosis. I told him that I felt a strong wish to come off neuroleptics. I described in detail the effects my drug had on me. I mentioned what I had read about neuroleptic-caused brain damage. [...]The doctor's reaction was like a blow. According to him, the diagnosis was correct and I should take a neuroleptic for years. And coming off my "medication" was highly likely to lead to "drug-resistant psychosis" and might even make ECT necessary
>
> [...] I will always remember, too, the words "chemical lobotomy". The effect of the drug Largactil (chlorpromazine), which I trustfully swallowed when I knew nothing about neuroleptics. I remember sleeping for hours, feeling like a zombie and having difficulty in getting up from a chair, and the intense pain in my joints. Even before I read the words "chemical lobotomy", I knew that these drugs could not be good for me.
>
> [...] None of the psychiatrists I have come across has made an effort to find out about the exact circumstances of my mental breakdown. They all seemed to believe that I was simply yet another individual who had something wrong with her brain.[...] As to myself, however, I knew since the very beginning that I suffered a highly spectacular breakdown because of intense emotional distress.. [...]After some days, I was committed to a psychiatric hospital. I was told that if I were not compliant, I might be put into restraints and injected with a drug. I chose, of course, to be very compliant, even though the nurse who took me to the ward behaved almost as if I were a young offender. I very soon began to be forcibly given neuroleptics: I knew that if I resisted, I would be injected with the drugs.
>
> This was a mixed ward, which undeniably worsened my mental state. I was offered absolutely no form of psychotherapy and I was not allowed to go outdoors for a month. When the first neuroleptic (Olanzapine) did not seem to have any effect on me, I was given Trilafon (perphenazine). The effects terrified both me and my family. I found it increasingly difficult to make any movements, I developed severe Parkinson-like symptoms and I finally began to have difficulty even in eating and brushing my teeth. I was also unable to read. My psychiatrist needed some convincing before he agreed to change the drug to another one, Abilify.[...]

[59] http://www.madinamerica.com/2013/02/close-encounters-with-biopsychiatry/

> The idea that someone like me must take neuroleptics was becoming increasingly disturbing to me. I suffered from akathisia and had some difficulty in having conversations with other people. I had attacks of drowsiness, often even at work. Symptomatically, doctors seemed to believe that I should just put up with all the unpleasant effects of the drug. And they did not tell me that my difficulties in reading (longer texts began to frighten me!) were caused by the drug: for several months, I believed that it was due to my "illness" and thought with sadness that I might never again enjoy reading as much as in the past. When I told my psychiatrist about a worsening of my eyesight, he claimed that it had nothing to do with the neuroleptic, which later proved to be blatantly untrue. When I mentioned my fear of tardive dyskinesia, he was just as dismissive. When I told other psychiatrists that I woke every night to realize that the fingers of my hand were numb, they simply chose not to comment on it.

Helena King's account (Ireland)

> I got elated after my first baby in 1970. After 6 weeks at home breastfeeding they put me in a mental hospital. There I was made mentally ill by haldol and largactil. I was then deeply depressed and even forgot about my baby. I had the shakes, lockjaw and a terrible thirst and drooling. I couldn't even walk.

…

In each instance, attention is called to a diminishing of the power of human volition, as well as the loss of many of the aspects of human emotional and cognitive experience that make life worth living.