Why Mental Health Laws Contravene the CRPD – An Application of Article 14 with Implications for the Obligations of States Parties

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Introduction

This statement argues that all laws authorizing detention and/or compulsory treatment on grounds linked to the existence of a psychosocial disability contravene the Convention on the Rights of Persons with Disabilities. The argument focuses on Article 14, since the majority of such laws depend on the power of incarceration to impose compulsory treatment (with community treatment orders being a recent innovation that depends on the threat of incarceration to enforce compliance). Other provisions of the CRPD and related international law standards are also invoked as needed. This statement further argues that unequal detention regimes for people with psychosocial disabilities as part of the penal system violate Article 14 and other provisions. Conclusions are provided regarding the obligations of States Parties to the CRPD.

Mental Health Laws

1. Most countries have mental health laws that create a specific regime of detention and/or compulsory treatment on grounds linked to the existence of a psychosocial disability (e.g. a “mental illness or disorder” as diagnosed or otherwise attributed to the person) and according to distinct procedures that typically have limited due process guarantees on the assumption that the deprivation of liberty is for beneficial purposes.

2. Mental health laws exist for the purpose of both legitimizing and regulating these schemes of deliberate detention of people with psychosocial disabilities. The oldest form of mental health laws (sometimes called “lunacy acts”) simply provide the legal authority for the state to confine people in asylums who were deemed unable to care for themselves. They codify a paternalistic asylum-based social response to madness that arose in conjunction with institutional confinement of other marginalized populations, such as people living in poverty and people with other types of disability; in many cases, asylums and institutions still house all of these groups together, with a further disproportionate and differential impact on
women and girls, unattached males, racialized peoples, youth, older persons, LGBT people and others who do not have a secure claim on the resources of family and community. Most modern mental health laws codify the power of incarceration and compulsory treatment, while also imposing procedural safeguards and criteria for detention in an attempt to satisfy due process concerns about the deprivation of liberty. Such laws represent a first attempt to come to grips with the human rights implications of this regime, while demonstrating an unwillingness to challenge the supposed necessity for segregation, confinement and compulsion of those labeled as “mentally ill”.

3. Reformed mental health laws, together with a policy shift towards public community-based mental health services, contribute to a cultural shift from asylums to a regime of control that extends into the community. The power of incarceration for long and short terms is retained while adding community treatment orders, along with a web of bundled services that encourages people with psychosocial disabilities to meet their basic needs (such as housing, recreation and income) through the mental health system and leverages compliance with services that may be unwanted. The acknowledgement in principle that Mad people have human rights, and that psychiatric incarceration and compulsory treatment are infringements of the right to liberty, may help to raise awareness and expectations of rights; some individuals may be able to use the procedural guarantees to obtain release. However, such reforms do not substantially change the rate of psychiatric detention (Perlin, Mental Disability Law: Civil and Criminal, Vol. 1, citing Bagby and Atkinson, The Effect of Legislative Reform on Civil Commitment Rates: A Critical Analysis, 6 Behav. Sci. & L. 45 [1988]). Hospitals, their lawyers and the psychiatrists testifying as expert witnesses learn what they have to say and do to meet the standards, and courts, with rare exceptions, defer to psychiatrists, while lawyers for psychiatrically detained people often provide ineffective representation due to their participation in social prejudice against this population.

CRPD Article 14

4. CRPD Article 14, coming out of historic demands of users and survivors of psychiatry for an end to this regime of detention, requires States Parties to ensure that “the existence of a disability shall in no case justify a deprivation of liberty.” No mental health law, no matter how narrowly framed, can ever meet the requirements of Article 14, so long as it contains any provision whatsoever that allows involuntary confinement of people with psychosocial disabilities for purposes of treatment or preventive detention, or for any other reason linked in legislation to the existence of the disability (as diagnosed or attributed in any other way), or any other provisions for involuntary mental health treatment. (Office of the High Commissioner for Human Rights Thematic Study on Legal Measures for Ratification and
Implementation of CRPD, A/HRC/10/48, paragraphs 48-49). Such laws always amount to a justification of detention based on disability, since their reason for being is to regulate such detention by, among other things, establishing criteria that purport to legitimize it.

Human Rights and Non-Discrimination Laws for Users and Survivors of Psychiatry

5. If users and survivors of psychiatry in a particular country deem it advisable to enact a law specifically addressing non-discrimination and human rights of people with psychosocial disabilities, rather than integrate their demands into a general law on non-discrimination and human rights of all people with disabilities, such a law should not be conceptualized as a “mental health law.” That terminology reinforces a medical model of psychosocial disability, contrary to the social model espoused in the CRPD. The CRPD takes a comprehensive approach to human rights and non-discrimination in all aspects of life, centers the perspective of people with disabilities as rights-holders, and applies fully to people with psychosocial disabilities without any exceptions, making the CRPD a useful model in content and format for any national law that can be developed to address the rights of users and survivors of psychiatry. The principles in Article 3, and interpretive guidance by the World Network of Users and Survivors of Psychiatry (such as its Implementation Manual on the CRPD, and other materials at www.wnusp.net), can help to inform a correct and meaningful application of all articles in the CRPD to people with psychosocial disabilities.

6. Irrespective of the path chosen to positively implement the CRPD through enactment of human rights and non-discrimination laws, mental health laws – those laws authorizing and regulating involuntary confinement and involuntary treatment of people with psychosocial disabilities – need to be repealed, in accordance with Article 4.1(b). Consultation processes for the development of CRPD-compliant laws and policies need to include a proposal to repeal the mental health law of the country, and to ensure that users and survivors of psychiatry, directly and not through family or provider organizations, are enabled to participate effectively to ensure that the results are relevant to them and reflect their perspectives (taking account of gender, culture, age and other diversity), just as WNUSP did in the development of the CRPD. Domestic user/survivor organizations should be offered the opportunity to obtain technical advice and support from WNUSP, as the global organization representing this constituency (a membership-controlled organization open to all users and survivors of psychiatry and user/survivor organizations), with expertise in the subject matter.

Article 14 and Generally-Applicable Laws

7. Article 14 is a balanced text that does not exempt people with psychosocial disabilities from generally-applicable powers of the state to arrest and detain
people for violations of criminal law or other reasons not linked in legislation to the existence of a disability. However, facially neutral laws that have a purpose or effect of discriminating based on disability will violate Article 14.1(a) as well as Article 5 (see the definition of discrimination based on disability in Article 2). If a state designs a law for preventive detention, or one for detention of people deemed in need of care and treatment, that is aimed at continuing the confinement of people with psychosocial disabilities in institutions against their will, or that has a disproportionate effect of confining people with psychosocial disabilities because of hidden bias in its standards or enforcement, such a law would not be in fact disability-neutral and would need to be repealed.

Incapacity Legislation vs. Stand-Alone Mental Health Laws

8. An approach to the legalization of forced mental health treatment and confinement for the purposes of such treatment based on a theory of legal incapacity to make decisions, or characterizing involuntary measures as a form of support, cannot be considered disability-neutral and violates Article 12 as well as Articles 14.1(a), 17 and 25(d). Article 12 clearly states that persons with disabilities have legal capacity on an equal basis with others and that any measures related to the exercise of legal capacity must respect the rights, will and preferences of the individual. The premise of Article 12 is that persons with disabilities have equal rights as others to enjoy autonomy and self-determination in governing their own lives, including the dignity of risk and the right to make mistakes. Supportive measures can strengthen a sense of mutual responsibility on the part of all members of a community including persons with disabilities, so that no one has to face difficult decisions or their consequences alone. Support cannot be understood to include taking charge of a person’s life or health or finances against his or her will, as such measures violate the individual’s dignity and equality of personhood.

9. Mental health service providers, like peer supporters and members of a family or community seeking to support an individual facing challenging circumstances, need to respond to the person in a way that meets the needs and desires of the individual at that time, and cannot impose their own view of what will be beneficial in an abstract or ideal sense for that person’s life-trajectory. For people with psychosocial disabilities, the principle of respect for diversity (Article 3(d)) means respect for Mad experience and worldviews on an equal basis with others, and accommodating such diversity in interactions related to decision-making. Respect for Mad experience and worldviews changes the premise of mental health services, which can no longer take their own worldviews as unchallenged authority with respect to madness, but instead have to engage in conversations with those they seek to support on a basis of equality and mutuality.
Psychiatric Detention and Other Norms of International Law

10. Psychiatric detention violates other norms of international law in addition to CRPD Article 14. Psychiatric detention is both arbitrary and indefinite as a consequence of the legal standards that give significant weight to the opinions of psychiatrists for the initiation and continuation of such detention (ICCPR Article 9, also incorporated in CRPD Article 14.1(b)). There are no defined behavior standards that would give notice to individuals wishing to avoid psychiatric detention or to obtain their release, only the opinions of psychiatrists abstracting from observation or reports about the person’s behavior, subject to review by tribunals and courts that is almost always highly deferential.

11. Furthermore, psychiatric institutionalization may constitute torture or ill-treatment when it amounts to indefinite detention or continues for long periods of time (UN Special Rapporteur on Torture, Report of July 28, 2008, A/63/175, paragraphs 64-65). In many countries, people are simply abandoned in institutions by their families who then have no further contact with them; without such support they have no hope of release. Even where there are provisions for review by a court or tribunal, there are no outer limits on the duration of detention; a court may renew the term of institutionalization repeatedly. In practice, this means that either individuals have to resign themselves to institutionalization, potentially for life, or seek to discover what will satisfy those in charge of the detention to authorize release. Hospitals use their power of detention to manipulate individuals into accepting unwanted treatment with electroshock or of mind-altering drugs such as neuroleptics – which may in itself constitute torture or ill-treatment – and unwanted supervision, both in the hospital and upon discharge (in the form of compulsory community treatment orders sought and obtained while the individual is still detained in the hospital, which she/he is coerced not to contest with the implication that the order is a condition for her/his release). These conditions cause intense psychic suffering – emotional, mental and moral – and constitute repeated traumatization for the duration of institutionalization, requiring effort to heal spiritually, psychically and socially.

Rights of People with Psychosocial Disabilities and the Penal System

12. People with psychosocial disabilities in jails and prisons have the right to equal benefit of the guarantees of due process and humane conditions of detention under the International Covenant on Civil and Political Rights and other international law, and to be treated in compliance with the objectives and principles of the CRPD (Article 14.2). The CRPD rights apply to prisoners as limited only by the necessary implications of lawful detention. Thus, prisoners with psychosocial disabilities retain the right to not be medicated against their will, and to receive desired supports, services and treatment
provided confidentially and by individuals with no duty to report or account to prison authorities. Prisoners with psychosocial disabilities have the right to create their own peer support and advocacy groups and to have contact with outside peer support and advocacy groups, including access to programs that meet their needs for cultural competence and gender sensitivity.

13. A trauma-informed/harm-reduction approach should be applied to prison policies as a whole, which benefits the vast majority of prisoners who have a prior history of trauma (and are likely to be treated as people with psychosocial disabilities) as well as those who have no such prior history, as a policy that represents both the obligation of humane treatment (ICCPR Article 10) and the obligation to ensure equal access and accommodation to people with psychosocial disabilities in the detention setting (CRPD Articles 5 and 9). The duties to accommodate and to ensure equal access to facilities and services must be applied further to consider the effects of apparently neutral policies on prisoners with psychosocial disabilities, including the effects of intersecting discrimination, and negotiate appropriate accommodations with the prisoners concerned.

14. People with psychosocial disabilities have the right to be considered innocent until proven guilty, and not sanctioned on the mere suspicion of guilt. Jail diversion programs that require a person to plead guilty and comply with a regimen of psychiatric treatment and supervision are contradictory to the objectives and principles of the CRPD and deprive individuals of their right to equal guarantees under Article 14.2.

15. The plea of not-guilty by reason of insanity also deprives individuals of a clear determination of their responsibility, and relegates insanity acquittees to further segregation and marginalization, as well as to indefinite detention in psychiatric institutions under the harshest conditions and often for extremely long duration. The insanity defense violates the obligation to recognize the legal capacity of persons with disabilities (Article 12.2) as well as Article 14.

Conclusions

16. States Parties to the CRPD must repeal their mental health laws and any other provisions that authorize the deprivation of liberty linked in legislation to “mental illness” or psychosocial disability. They must further ensure that no forms of detention authorized in their laws have either the purpose or effect of confining people with psychosocial disabilities, depriving them of the equal right to liberty and security of the person. They must ensure that persons with psychosocial disabilities are recognized as having the legal capacity to make their own decisions, including decisions about services,
treatment and support, according to the individual’s own worldview at the time such services may be offered.

17. States Parties must ensure that effective legal remedies exist for people with psychosocial disabilities to obtain release from institutions where they may be held against their will, and to be provided with financial and other desired assistance to establish a life in the community. The obligation to release individuals from confinement is not contingent on the availability of assistance, rather the obligation to provide assistance is proactive and positive and should itself be made justiciable. Overall resource limitations in a State Party that make it difficult to comply with the obligation to provide assistance need to be considered in light of the obligation of non-discrimination and the possibility of reallocation of resources, and international cooperation should be sought as needed.

18. Under their obligations to take effective measures to prevent torture and ill-treatment, States Parties must enact and enforce criminal sanctions against perpetrators of psychiatric detention and compulsory treatment, and must provide reparations to victims and survivors. (See Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law, Commission on Human Rights Resolution 2005/35.)

19. States Parties must develop and enforce laws and policies in relation to law enforcement, and conditions of detention in jails and prisons to implement CRPD Article 14.2, including: abolition of jail diversion programs that depend on compliance with mental health treatment; ensuring that prisoners are not medicated against their will and that they are provided with desired supports, services and treatments; ensuring that prisoners with psychosocial disabilities have the opportunity to organize and to be in contact with outside peer support and advocacy groups; instituting a trauma-informed/harm reduction policy in the prison as a whole; and ensuring equal access and accommodation by suitably modifying policies that have a discriminatory effect on prisoners with psychosocial disabilities.

20. In adopting measures to give effect to these obligations, States Parties must consult directly with users and survivors of psychiatry, including women and girls, racialized persons, youth and older persons, LGBT persons, and others of diverse identities, and give priority to their wishes and expertise.

The Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP) provides strategic leadership in human rights advocacy, implementation and
monitoring relevant to people experiencing madness, mental health problems or trauma.

In particular, CHRUSP works for full legal capacity for all, an end to forced drugging, forced electroshock and psychiatric incarceration, and for support that respects individual integrity and free will.

Endorsements as of September 15, 2011
(Note that additional endorsements are expected when the statement is translated into more languages)

Individuals:

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Organizations:

Agate Center for Women with Special Needs, Armenia
Association for Mental Health "The Brotherhood of Hearts", Poland
Aufbruch, Cologne, Germany
Aurora - Support Organization for People with Mental Health Problems, Norway
Australia For All Alliance, Inc.
Bapu Trust for Research on Mind and Discourse, Pune, India
Disabled People Against Cuts (DPAC), United Kingdom
Disability Resources Centre, Melbourne, Australia
Ithaca Mental Patients Action Coalition (IMPAC), United States
IMPERO, Ireland

Intentional Peer Support, United States

International Network of Women With Disabilities (INWWD)

LAP Copenhagen/Frederiksberg, Denmark

MAD images, United Kingdom

Mad Pride Ireland

MindFreedom International

MindFreedom Germany

MindFreedom Kenya

National Alliance for Access to Justice for Persons Living with a Mental Illness (NAAJMI), India

Shanta Memorial Rehabilitation Centre, Bubaneshwar, India

Survivor Research, London, United Kingdom

Voices of the Heart, Glens Falls, United States

We Shall Overcome, Norway

Women With Disabilities Australia (WWDA)

World Network of Users and Survivors of Psychiatry