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Submission for Joint CEDAW-CRC General Recommendation/ General Comment on Harmful Practices

Recognizing Forced and Coerced Psychiatric Interventions Against Women, Men and Children as a Harmful Cultural Practice

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I. Introduction

It is time to recognize the practices of involuntary diagnosis, involuntary institutionalization and involuntary treatment in psychiatry as harmful cultural practices emanating from a worldview that separates human beings into scientists and scientific objects, and that, by claiming legitimacy for itself as “scientific,” seeks to erase the worldviews of individuals who reject their objectification. The harmful cultural practices of psychiatry affect both individuals in the countries where psychiatry originated (in the west), and individuals and communities throughout the world where psychiatry is extending its sphere of influence. This paper addresses involuntary (forced, compulsory, without free and informed consent of the person concerned) psychiatry, because part of the harm comes from the erasure of personhood that results from the legalization of violence. However, the methods of modern psychiatry are intertwined with the laws that confer social and legal approval to their use against the will of individuals who resist; the last 50-75 years have seen the rise of physically invasive and harmful practices such as electroshock, psychosurgery and drugs known as “chemical cosh” or “chemical straitjacket” to the virtual exclusion of talk therapies and holistic healing, particularly within publicly funded mental health systems.

The similarities of forced psychiatry to rape – objectification, domination of the body and will, and violation of boundaries of the self – have made these practices doubly traumatizing to women. Forced psychiatry retraumatizes those who seek help for reasons related to rape and other abuse, and the similarity to rape reinforces an experience of gendered (feminized) victimization. The cultural hegemony of psychiatry as scientific expertise silences women’s own stories and divides women against each other based on Madness/mental illness/disability labels.

II. Forced and coerced psychiatric interventions as torture and ill-treatment

Forced and coerced psychiatric interventions have been recognized as a form of torture and ill-treatment, not only when administered for purposes of political repression, but also when used with the best of intentions to treat a diagnosed mental condition.

In 2008 the UN Special Rapporteur on Torture, adopting a concept pioneered by the World Network of Users and Survivors of Psychiatry,¹ articulated a standard for distinguishing between legitimate medical treatments that cause pain and suffering, and those that may constitute torture or ill-treatment:

Whereas a fully justified medical treatment may lead to severe pain or suffering, medical treatments of an intrusive and irreversible nature, when they lack a therapeutic purpose, or aim at correcting or alleviating a disability, may constitute torture and ill-treatment if enforced or administered without the free and informed consent of the person concerned.²

The report contains numerous references to forced psychiatric interventions including electroshock, mind-altering drugs such as neuroleptics, and psychosurgery, as well as indefinite detention and institutionalization, restraint and seclusion as practices that may constitute torture or ill-treatment.³ It also recognizes that older human rights standards contained in non-binding declarations, such as the Principles for the Protection of Persons with Mental Illness (known as the MI Principles), had accepted the legitimacy of involuntary treatment and involuntary confinement, and that such standards run counter to the provisions of the Convention on the Rights of Persons with Disabilities, which now takes precedence as international law throughout the UN system.⁴

II. Globalization of western psychiatry

Western psychiatry is spreading throughout the world and replacing indigenous psychospiritual practices such as mantra, prayer, song, use of percussion instruments, song making, story telling, meditations, yoga, trancing, mediumship and accessing

¹ Summary of WNUSP's desired changes to Bangkok draft convention (submitted to ESCAP regional meeting 14-17 October 2003); International Disability Caucus Advocacy Note: Forced Interventions Meet International Definition of Torture (submitted to Ad Hoc Committee 6th session, August 2006); Tina Minkowitz, *The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions*, *Syracuse Journal of International Law and Commerce* 2007 34:405.

² U.N. Doc. A/63/175, paragraph 47.

³ *Id.*, paragraphs 38, 40, 41, 55-59, 61-65. See also paragraphs 49-50 for elaboration of discrimination as unlawful intent, and deprivation of legal capacity as imposed powerlessness. See paragraphs 71-76 for recommendations.

⁴ *Id.*, paragraph 44.

alternative states of consciousness.⁵ In addition to extending harmful, coercive practices and their enabling legislation beyond the cultures of origin, the expansion of western psychiatry results in the erasure of indigenous practices of mental healing;⁶ promotion of a western concept of the human being that does not have universal acclaim and is being questioned within the west itself; liberal dumping of drugs to boost an economic boom in neo-colonial states; and promotion of psychosurgery as “modern” brain technology. It is important to emphasize that globally hegemonic practices, including those that claim to be based in scientific method and evidence, are not above or outside of culture and are open to challenge as being harmful.

III. Harms caused

Forced psychiatric interventions cause serious physical and psychic harm, including deaths from the immediate or cumulative effects of treatments. People using neuroleptic drugs have an increased mortality rate that increases further with the number of drugs used simultaneously.⁷ Sudden death is a noted adverse effect of popular neuroleptic drugs as well as of electroshock.⁸ The signature adverse effect of electroshock is permanent memory loss which ranges from mild to severe, along with measurable cognitive impairment.⁹ The signature adverse effect of neuroleptic drugs, a class of powerful central nervous system depressants, is akathisia, an unbearable sense of physical and psychic anguish that can drive some people to take their own lives.¹⁰ Even the sought-after effect of such treatments, psychic numbing or apathy, is far from desirable for many people on whom it is used against their will.¹¹ The traumatic effects of having one's will forced and not being in control of one's own body - not only the immediate electric shock and convulsion, or the ingestion of a drug, but its effects that continue to be experienced as intrusion of something alien to the self - constitute an

⁵ Bhargavi V. Davar and Madhura Lokohare, Recovering from psychosocial traumas: The place of dargahs in Maharashtra, *Economic and Political Weekly* 2009 44:16.

⁶ Bhargavi V. Davar, From Mental Illness to Disability: Choices for Women Users/Survivors of Psychiatry in Self and Identity Constructions, *Indian Journal of Gender Studies* 2008 15:261.

⁷ Matti Joukamaa, Markkku Heliövaara, Paul Knekt, Arpo Aromaa, Raimo Raitasalo and Ville Lehtinen, Schizophrenia, neuroleptic medication and mortality, *British Journal of Psychiatry* 2006 188.

⁸ Wayne A. Ray, Cecilia P. Chung, Katherine T. Murray, Kathi Hall, and C. Michael Stein, Atypical Antipsychotic Drugs and the Risk of Sudden Cardiac Death, *New England Journal of Medicine* 2009 360:225.

⁹ Harold A. Sackeim, Joan Prudic, Rice Fuller, John Keilp, Philip W. Lavori and Mark Olfson, The Cognitive Effects of Electroconvulsive Therapy in Community Settings, *Neuropsychopharmacology* 2007 32:244; Linda Andre, *Doctors of Deception: What They Don't Want You to Know About Shock Treatment* (2009).

¹⁰ Breggin, *Brain Disabling Treatments in Psychiatry*, 2d edition (2008); Cohen, *A Critique of the Use of Neuroleptic Drugs in Psychiatry*, in Fisher and Greenberg eds., *From Placebo to Panacea: Putting Psychiatric Drugs to the Test* (1997). Breggin summarizes up to date research on a wide range of harms caused by neuroleptics and other psychiatric drugs.

¹¹ Id. (both sources).

overlooked social epidemic of suffering at the hands of a profession whose stated aim is to relieve such suffering.¹² This contradiction itself has contributed to the invisibility of the harms, along with persistent societal discrimination against those whose unique humanity manifests in ways labeled as Madness.

Not only forced drugging and other violent treatments, and incarceration in hospitals and institutions, but also psychiatric diagnosis can be considered a harmful cultural practice. Diagnosis is given a social and legal power to define an individual contrary to her/his own experience and identity, and promotes self-hatred and feelings of inferiority particularly among women.¹³

VI. Women

Women's greater social vulnerability to the judgments of others regarding their behavior or questioning the woman's own judgment, can result in greater exposure to coercive psychiatry and legal incapacitation.¹⁴ Women, particularly older women, are consistently treated with electroshock at higher rates than men,¹⁵ and its consequences may be more severe for women.¹⁶ Some women report that electroshock made them more "ductile" or easily led, and unable to defend themselves against rape.¹⁷

IV. Children and youth

Neuroleptics and other mind-altering drugs, as well as electroshock, are increasingly being used on children, even infants from 0-2 years of age.¹⁸ Both the labeling that

¹² Breggin (2009) (see p. 49 for statistics on akathisia as high as 90%); [Statistics from Breggin; Whitaker; Grace Jackson]

¹³ Clare Shaw and Debra Shulkes, The Most Savage Insult: Exposing the Damage Caused by the Borderline Personality Disorder Label, Open Mind, Issue 163, November-December 2010, pp. 10-13; Challenging the label: Suzi's story, full story available at:

http://spn.org.uk/fileadmin/SPN_uploads/Documents/Papers/SPN_Papers/SPN_paper_7.pdf;

Marius Romme and Paul Hammersley, "Abolish Schizophrenia", 24 October 2006,

<http://www.psychminded.co.uk/news/news2006/oct06/Abolish.htm>.

¹⁴ Tina Minkowitz, Women with Disabilities, in aaina, a mental health advocacy newsletter, July 2006.

¹⁵ Bonnie Burstow, Electroshock as a Form of Violence Against Women, Violence Against Women Vol 12 No. 4 (2006).

¹⁶ Sakeim et al (footnote 9).

¹⁷ Personal communications on file with author.

¹⁸ United States Food and Drug Administration Center for Drug Evaluation and Research, Office of Surveillance and Epidemiology, Abilify® (aripiprazole), Geodon® (ziprasidone), Seroquel® (quetiapine), Zyprexa® (olanzapine), Risperdal® (risperidone), Invega® (paliperidone) Drug Use Review, September 3, 2009,

<http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/PediatricAdvisoryCommittee/UCM191615.pdf>;

Duff Wilson, Child's Ordeal Shows Risks of Psychosis Drugs for Young, New York Times, September 1, 2010.

stereotypes a child as being inferior to others, and the effects of the treatments on developing brains, minds and bodies, are scandalous crimes against society's youth. Young people who are put into institutions are deprived of an education and spend their formative years under conditions of repression, unsafety and an ongoing struggle for physical and spiritual survival.¹⁹

V. Older persons

Older persons are also at risk of being heavily drugged with neuroleptics despite the increased potential for harm to their health. Dementia diagnoses have become the equivalent of psychiatric labels for older persons, being used to justify institutionalization, deprivation of freedom, and chemical straitjacketing.²⁰

VII. Alternatives to traumatizing practices

A high percentage of children and adults come into the mental health system for reasons related to traumatic experiences such as rape, sexual abuse and other forms of violence and abuse. A substantial body of work done by survivors has demonstrated the unacceptable retraumatizing effects of common practices in the mental health system such as physical and chemical restraints, isolation rooms, strip-searches, forced and coerced treatments with mind-altering drugs and electroshock, and the deprivation of control over one's body and environment while being under the custody of a state or private institution.²¹ This pioneering work, together with practices developed for peer support in the community of users and survivors of psychiatry, has contributed to creation of alternative ways of responding to people in psychic distress or experiencing altered states of consciousness.²²

¹⁹ Human Rights of Persons with Disabilities, a joint stakeholder report for Universal periodic Review of the United States of America, 9th session 1-12 November 2010, http://lib.ohchr.org/HRBodies/UPR/Documents/session9/US/USHRN_UPR_USA_S09_2010_Annex6_Disability%20Joint%20Report%20USA.pdf.

²⁰ See, e.g. Rebecca Smith, 'Scandalous abuse' of the elderly prescribed antipsychotics in hospital exposed, The Telegraph, 07 Oct 2009, <http://www.telegraph.co.uk/health/healthnews/6264962/Scandalous-abuse-of-the-elderly-prescribed-antipsychotics-in-hospital-exposed.html>. The article errs in one respect; it suggests that "immediate risk of harm to the person or to others" would justify the use of neuroleptic drugs on older persons. Such use of mind-altering drugs for behavior control would amount to torture and ill-treatment, see Minkowitz (footnote 1).

²¹ See for example, Jolijn Santegeods, Stichting Mind Rights, Breaking the Cells Down: A First step towards de-institutionalization of Mental Health Care – Report for Global Forum on Community Mental Health 2007; Marc Rufer, Psychiatry: Its Diagnostic Methods, Its Therapies, Its Power, in Peter Lehmann, ed, Alternatives Beyond Psychiatry (2007); contributions of survivors to In Their Own Words, Maine Trauma Advisory Groups Report 1997. See also Burstow (footnote 15).

²² Shery Mead, Peer support as a socio political response to trauma and abuse (2001).

Trauma-informed peer support asks, "What has happened to you?" instead of diagnosing what is "wrong" with you, and engages in mutual conversation and relationship-building rather than providing expert "treatment" in a one-way exchange.²³ The user/survivor movement recognizes that there can be a legitimate role for professional services, particularly those that are trauma-informed, when provided based on the person's free and informed consent, but there is also a need to demystify Mad experience and make it accessible to ordinary people. Peer support begins within the user/survivor community as a "beloved community"²⁴ of strength and resistance, but can also be taught as a practice of non-hierarchical relationships for mutual support that can practice reasonable accommodation and accessibility for Mad people in society as a whole.

The harmful cultural practices of coercive psychiatry are facilitated and enforced by the state through its laws authorizing involuntary institutionalization and compulsory treatment, legal immunities given to medical personnel for acts that would otherwise constitute the crimes of forced imprisonment and assault, and the permissive exercise by such personnel of the state's power to deprive individuals of their liberty.²⁵ While individuals retain their agency and inherent human dignity even under severe oppression, the collusion of the repressive force of the state with the social prestige of medicine in the service of discrimination results in near-powerlessness to effectively defend oneself against harm once denounced to, or caught by, the mental health system.

Trauma-informed, peer-driven and non-hierarchical alternatives exist in projects that can serve as models for system change on larger scales, and this needs to be done both as an inherent social good and in order that society not revert to violence and segregation of Mad people. But ending the harmful practices of coercive psychiatry cannot wait until alternatives are perfected. It is an immediate obligation under Articles

²³ Shery Mead, *Intentional Peer Support Manual* (2008).

²⁴ "Term coined by philosopher Josiah Royce to denote an ideal community, used frequently by Dr. [Martin Luther] King to describe a society of justice, peace and harmony which can be achieved through nonviolence," <http://www.thekingcenter.org/history/glossary-of-nonviolence/>.

²⁵ These laws exist throughout the world, in countries at every level of income and economic development. See for example New York Mental Hygiene Law Article 9; Argentina National Mental Health Law, Public Health Law No. 26,657; Peru Ley No. 29737; Ireland Mental Health Act 2001; South Africa Mental Health Care Act, 2002. The laws in Peru and Argentina were enacted subsequent to those countries' ratification of the Convention on the Rights of Persons with Disabilities, despite their obvious conflict with obligations under that treaty. Uganda and India, also states parties to the CRPD, are considering mental health law amendments that continue to authorize psychiatric incarceration and nonconsensual treatment, in violation of their treaty obligations. However India is simultaneously considering a disability non-discrimination act that, however flawed, would move towards compliance with the CRPD by phasing out involuntary commitment, which would be the first such law in any country. User/survivor organizations in Peru, Uganda, India, Ireland and Norway have recently been active in opposition to mental health legislation and incapacity legislation.

5, 12, 14, 15, 17 and 25 of the CRPD, under the Convention Against Torture, under Articles 2, 7 and 9 of the International Covenant on Civil and Political Rights, and under Articles 2, 3, 5, 6 and 9 of the UDHR, to abolish the practices of psychiatric detention, institutionalization, compulsory treatment, restraints and seclusion in service settings or for mental health reasons; and to repeal or nullify the laws that signify the state's acquiescence in them.²⁶ States must simultaneously undertake awareness-raising activities in cooperation with user/survivor organizations,²⁷ to promote an appreciation of the diverse experiences and perspectives of people with psychosocial disabilities from a social model rather than a medical perspective, and to foster respect for their equal rights and dignity.

VIII. Conclusion

The following should be treated as harmful cultural practices:

- Any and all psychiatric diagnosis, psychiatric treatment, and psychiatric hospitalization or institutionalization, without the free and informed consent of the person concerned.
- Psychiatric diagnoses, treatments and services that humiliate, objectify and have a disabling impact (including injury and impairment of the brain as well as social disablement).
- Social and legal power of psychiatric labels to invalidate an individual's own experience and identity.
- Displacement of indigenous and traditional healing practices by western psychiatry.
- Legal provisions that create an inferior system of rights for people selected for adverse treatment via a psychiatric diagnosis: in particular mental health laws giving psychiatrists power of incarceration and compulsory treatment, incapacity laws (another route to institutionalization and compulsory treatment, and to deprivation of autonomy in any aspect of life), and laws discriminating in the right

²⁶ See OHCHR Thematic Study on Legal Measures for Ratification and Implementation of the CRPD, U.N. Doc. A/HRC/10/48, paragraphs 48-49 (see also paragraphs 43-47 on legal capacity); OHCHR Information Note on Detention and Persons with Disabilities issued for Dignity and Justice for Detainees Week, October 6-12, 2008; WNUSP Statement on CRPD and Prohibition of Forced Treatment; WNUSP Submission to Committee on the Rights of Persons with Disabilities on Legal Capacity; Center for the Human Rights of Users and Survivors of Psychiatry, Why Mental Health Laws Contravene the CRPD: An Application of Article 14 with Implications for States Parties (last three items available on www.wnusp.net and www.chrusp.org).

²⁷ See CRPD Article 4.3 (requiring close consultation with organizations of persons with disabilities on all implementation matters) and 8 (awareness-raising obligations).

to vote, right to hold public office, right to be a parent, right to marry, right to own and administer property, etc.

The framework for prohibiting and preventing torture should be invoked to begin a process of reparations beginning with depriving these practices of state approval (repealing, revoking or nullifying the laws and policies that authorize them). Positive practices should be identified to meet the needs of individuals and communities in a spirit of cooperation, equality, respect for diversity, and respect for self-determination at both the individual and collective levels.

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The World Network of Users and Survivors of Psychiatry is a democratic organization of users and survivors of psychiatry that represents this constituency at the global level. In our Statutes, "users and survivors of psychiatry" are self-defined as people who have experienced madness and/or mental health problems, or who have used or survived mental health services.

WNUSP had its beginnings in 1991 and became a full-fledged organization with a democratic global structure on adopting its statutes in 2001. Currently we have members in over 50 countries, spanning every region of the world.

WNUSP is a member of the International Disability Alliance (IDA), and is represented on the Panel of Experts of the UN Special Rapporteur on Disability.

WNUSP was involved in the work on the Convention on the Rights of Persons with Disabilities (CRPD) since the inter-regional expert meeting convened by the Mexican government before the 1st session of the Ad Hoc Committee (the UN forum in which the CRPD was negotiated), and has been active and successful in achieving our aims for the Convention, especially with regard to legal capacity, liberty, integrity and free and informed consent, as well as principles of autonomy, human diversity and equality reflected not only in article 3 but throughout the Convention. WNUSP brought over 20 users and survivors of psychiatry to the UN, from every region of the world, in addition to representatives of other user/survivor organizations that worked closely with us, such as Mind Freedom International and People Who.

WNUSP was among the organizations that created the International Disability Caucus, and served on its steering committee; it is also currently on the steering committee of the IDA CRPD Forum. WNUSP was also one of the organizations represented in the 2004 working group that produced the first official draft text of the CRPD, and was represented as one of two civil society speakers at the adoption of the CRPD by the General Assembly.

Since the adoption of the CRPD, WNUSP has produced an Implementation Manual from a user/survivor perspective (available on our website), and continues to work with

the rest of the international disability community, especially through the Legal Capacity Task Force, a working group of the IDA CRPD Forum.

WNUSP has Special Consultative Status with the Economic and Social Council of the United Nations (ECOSOC).

Please see our website www.wnusp.net for more information.