MENNESKERETTIGHETSSTIFTELSEN REDO

-SENTER FOR RETTIGHETER OG DOKUMENTASJON

Ending psychiatric coercion

- urgent need for effective remedies and reparations

CRPD-based Standards Ending Psychiatric Coercion

Tina Minkowitz

Guidelines on Article 14, paragraph 6

… Impairment in the present guidelines is understood as a physical, psychosocial, intellectual or sensory personal condition that may or may not come with functional limitations of the body, mind or senses. Impairment differs from what is usually considered the norm.

General Comment No. 1, paragraph 42

As has been stated by the Committee in several concluding observations, forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16). This practice denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the Convention. States parties must, instead, respect the legal capacity of persons with disabilities to make decisions at all times, including in crisis situations; must ensure that accurate and accessible information is provided about service options and that non-medical approaches are made available; and must provide access to independent support. .... States parties must abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation found in mental health laws across the globe, despite empirical evidence indicating its lack of effectiveness and the views of people using mental health systems who have experienced deep pain and trauma as a result of forced treatment. The Committee recommends that States parties ensure that decisions relating to a person's physical or mental integrity can only be taken with the free and informed consent of the person concerned.

General Comment No. 1, paragraph 15

In most of the State party reports that the Committee has examined so far, the concepts of mental and legal capacity have been conflated so that where a person is considered to have impaired decision-making skills, often because of a cognitive or psychosocial disability, his or her legal capacity to make a particular decision is consequently removed. This is decided simply on the basis of the diagnosis of an impairment (status approach), or where a person makes a decision that is considered to have negative consequences (outcome approach), or where a person's decision-making skills are considered to be deficient (functional approach).

The functional approach attempts to assess mental capacity and deny legal capacity accordingly. It is often based on whether a person can understand the nature and consequences of a decision and/or whether he or she can use or weigh the relevant information. This approach is flawed for two key reasons: (a) it is discriminatorily applied to people with disabilities; and (b) it presumes to be able to accurately assess the inner-workings of the human mind and, when the person does not pass the assessment, it then denies him or her a core human right — the right to equal recognition before the law. In all of those approaches, a person's disability and/or decision- making skills are taken as legitimate grounds for denying his or her legal capacity and lowering his or her status as a person before the law. Article 12 does not permit such discriminatory denial of legal capacity, but, rather, requires that support be provided in the exercise of legal capacity.

Guidelines on Article 14, paragraph 10

The Committee has repeatedly stated that States parties should repeal provisions that allow for the involuntary commitment of persons with disabilities in mental health institutions based on actual or perceived impairment. Involuntary commitment in mental health facilities carries with it the denial of the person's legal capacity to decide about care, treatment and admission to a hospital or institution, and therefore violates article 12 in conjunction with article 14.

General Comment No. 5, paragraph 48:

[Obligation to respect right to live independently and be included in the community] … entails the obligation to release all individuals who are being confined against their will in mental health services or other disability-specific forms of deprivation of liberty.

Guidelines on Article 14, paragraph 16

The Committee has established that declarations of unfitness to stand trial or incapacity to be found criminally responsible in criminal justice systems and the detention of persons based on those declarations are contrary to article 14 of the Convention, since they deprive the person of his or her right to due process and safeguards that are applicable to every defendant. The Committee has called for States parties to remove those declarations from the criminal justice system. It has recommended that all persons with disabilities who have been accused of crimes and detained in jails and institutions without trial be allowed to defend themselves against criminal charges, and be provided with the support and accommodation required to facilitate their effective participation, as well as procedural accommodations to ensure fair trial and due process.

Special Rapporteur on Torture 1986, para 119

The following list, which is not exhaustive, refers to some methods of physical torture:

…. administration of drugs, in detention or psychiatric institutions … [including] neuroleptics, that cause trembling, shivering and contractions, but mainly make the subject apathetic and dull [the person's] intelligence

….

E/CN.4/1986/15

Special Rapporteur on Torture 2008, paras 40 and 47

Persons with disabilities are exposed to … intrusive and irreversible medical treatments without their consent ([including] interventions aiming to correct or alleviate a disability, such as electroshock treatment and mind-altering drugs including neuroleptics).

… 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.

Special Rapporteur on Torture 2008, paras 48 and 49

The definition of torture in the Convention against Torture expressly proscribes acts of physical and mental suffering committed against persons for reasons of discrimination of any kind. In the case of persons with disabilities, the Special Rapporteur recalls article 2 of CRPD which provides that discrimination on the basis of disability means “any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including lack of reasonable accommodation”.

Furthermore, the requirement of intent in article 1 of the Convention against Torture can be effectively implied where a person has been discriminated against on the basis of disability. This is particularly relevant in the context of medical treatment of persons with disabilities, where serious violations and discrimination against persons with disabilities may be masked as “good intentions” on the part of health professionals. Purely negligent conduct lacks the intent required under article 1, and may constitute ill-treatment if it leads to severe pain and suffering.

Special Rapporteur on Torture 2008, para 65

… the length of institutionalization, the conditions of detention and the treatment inflicted must be taken into account.

Special Rapporteur on Torture 2021, para 37

It must be stressed that purportedly benevolent purposes cannot, *per se*, vindicate coercive or discriminatory measures. For example, practices such as … psychiatric intervention based on "medical necessity" of the "best interests" of the patient … generally involve highly discriminatory and coercive attempts at controlling or "correcting" the victim's personality, behaviour or choices and almost always inflict severe pain or suffering. In the view of the Special Rapporteur, therefore, if all other defining elements are given, such practices may well amount to torture.

Guidelines on Deinstitutionalization, paras 15 and 10

… Mental health settings where a person can be deprived of their liberty for purposes such as observation, care or treatment and/or preventive detention are a form of institutionalization.

Persons with disabilities experiencing individual crises should never be subjected to institutionalization. Individual crisis should not be treated as a medical problem requiring treatment or as a social problem requiring State intervention, forced medication or forced treatment.

Guidelines on Deinstitutionalization, para 76

States parties should ensure that options outside the health-care system, that fully respect the individual's self-knowledge, will and preferences, are made available as primary services without the need for mental health diagnosis or treatment in the individual's own community. Such options should meet requirements for support related to distress or unusual perceptions, including crisis support, decision-making support on a long-term, intermittent or emergent basis, support to heal from trauma, and other support needed to live in the community and to enjoy solidarity and companionship.

Guidelines on Deinstitutionalization, paras 118 and 119

Redress and reparations should be responsive to the violations suffered and the impact on an individual's life during and after institutionalization, including ongoing, consequential and intersectional harm.

Restitution, habilitation and rehabilitation should be tailored to the needs of individuals and to the losses or deprivation that they have experienced, and should respond to their immediate and longer-term desires and aspirations, such as re-establishing relationships with their children or with their family of origin or retrieving any possessions that can be found.

The implementation status quo of the human rights standards including CRPD to end psychiatric coercion

Muhannad Alazzeh

Transversal principles and provisions reiterate the prohibition of arbitrary treatment and hospitalization:

- individual autonomy and independence;
- freedom of choice;
- Equality and nondiscrimination;
- Legal capacity:
- (CRPD: preamble (H) (I) (N), Art. 3 the general principles: (A), (B), (D), Art. 12.

Implementation of Obligation:

Article 4 - General obligations:

- “States Parties undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability. To this end, States Parties undertake---:
- (B) to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities;
- (D) To refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention”.

Are these principles and obligations recognized at the national levels?

Examples on interpretive declarations regarding legal capacity, individual autonomy and body integrity against the CRPD purpose, principles and general obligations.

Egypt:

- “The Arab Republic of Egypt declares that its interpretation of article 12 of the International Convention on the Protection and Promotion of the Rights of Persons with Disabilities, which deals with the recognition of persons with disabilities on an equal basis with others before the law, with regard to the concept of legal capacity dealt with in paragraph 2 of the said article, is that persons with disabilities enjoy the capacity to acquire rights and assume legal responsibility ('ahliyyat al-wujub) but not the capacity to perform ('ahliyyat al-'ada'), under Egyptian law”.

Norway:

- **Article 12**
- “Norway recognizes that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. Norway also recognizes its obligations to take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity. Furthermore, Norway declares its understanding that the Convention allows for the withdrawal of legal capacity or support in exercising legal capacity, and/or compulsory guardianship, in cases where such measures are necessary, as a last resort and subject to safeguards”.

Norway:

- **Articles 14 and 25**
- “Norway recognizes that all persons with disabilities enjoy the right to liberty and security of person, and a right to respect for physical and mental integrity on an equal basis with others. Furthermore, Norway declares its understanding that the Convention allows for compulsory care or treatment of persons, including measures to treat mental illnesses, when circumstances render treatment of this kind necessary as a last resort, and the treatment is subject to legal safeguards”.

Ireland:

- **Declaration and reservation: Article 12**
- "Ireland recognizes that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. Ireland declares its understanding that the Convention permits supported and substitute decision-making arrangements which provide for decisions to be made on behalf of a person, where such arrangements are necessary, in accordance with the law, and subject to appropriate and effective safeguards.
- To the extent article 12 may be interpreted as requiring the elimination of all substitute decision making arrangements, Ireland reserves the right to permit such arrangements in appropriate circumstances and subject to appropriate and effective safeguards.

Ireland:

- **Declaration: Articles 12 and 14**
- "Ireland recognizes that all persons with disabilities enjoy the right to liberty and security of person, and a right to respect for physical and mental integrity on an equal basis with others. Furthermore, Ireland declares its understanding that the Convention allows for compulsory care or treatment of persons, including measures to treat mental disorders, when circumstances render treatment of this kind necessary as a last resort, and the treatment is subject to legal safeguards".

Discriminatory and derogatory definition and language in the personal status laws regarding psychosocial disability from Arab and Islamic countries:

- "A lunatic is one whose sense is so disturbed that he has little understanding, his speech is confused, and his reasoning is corrupt;
- "A fool is one who spends his money out of place, is extravagant in his expenditures, and wastes and destroys his money through extravagance, contrary to what is required by Sharia and reason";
- "A foolish person is one who is not guided to beneficial actions and is cheated in transactions due to his stupidity".

Common notes and concluding observations of States parties regarding psychiatric coercion:

- Adoption of the medical model in defining and “classifying” the disability in particular psychosocial disability;
- The absolute authority for doctors and health personnel to involuntary hospitalize and treat persons with psychosocial disability based on discriminatory assumptions, definitions and understanding;
- Discriminatory public health laws;
- Use of physical and chemical restrains;
- The deinstitutionalization strategies do not include psychiatric facilities.

Steps must be taken in full and active involvement of persons with psychosocial disability and their representative organizations:

- Comprehensive legislative and policy reform and taking the CRPD and the human rights standards the only reference;
- The twin-track-approach in reforming the psychiatric practices shall not allow any form of deprivation of liberty or forced treatment and involuntary hospitalization;
- The provided legal authority to doctors, therapists and guardians must be abolished as necessary step to reform the legal system regarding the legal capacity, informed consent and eliminate psychiatric coercion;
- Misleading legal or/and medical definitions for “recovery” as condition to discharge persons from psychiatric facilities must be rejected as “solution” to end hospitalization, and the disability shall not be by any means a reason for detention or deprivation of liberty.

Thank you

MENNESKERETTIGHETSSTIFTELSEN REDO
-SENTER FOR RETTIGHETER OG DOKUMENTASJON

Ending psychiatric coercion

- urgent need for effective remedies and reparations

Panel 1

Human Rights standards (CRPD) relevant for ending psychiatric coercion and for reparations

Tina Minkowitz, Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP)

Mental health and human rights: towards abandonment of coercion in the practice of psychiatry

Dainius Pūras

Vilnius university

Former UN Special rapporteur on the right to health (2014-2020)

Litteraturhuset, Oslo, Norway, September 10, 2024

Developments in the view of the Special rapporteur (2014-2020)

- 2014-2016: exploring the global picture
- 2017-2020: presenting the reports to the UN HRC

  https://www.handover-dialogues.org/
- 2020 - : as a former SR contributing to the process of change in different regions and countries

Insights on the challenges, opportunities and obstacles on the way to ending discrimination and coercion in psychiatry

Reports of the Special rapporteur to the UN Human Rights Council (2017, 2019, 2020)

- **Global burden of obstacles** view highlighted – as a view that questions and opposes the medicalized concept of "global burden of diseases" and the main message of the Movement for global mental health to address and close treatment gap
- **Three main groups of obstacles identified**. They need to be seriously addressed:

  - Dominance of biomedical model and overuse of biomedical interventions

  - Power asymmetries

  - Biased use of knowledge and evidence (amounts to corruption of knowledge)

Other reports and statements by the UN SR– on corruption, on depression and suicide, on COVID-19 and mental health, etc.

Most important is to address determinants of mental health – inequalities, discrimination, violence. Relationships should be targeted rather than brains. Depression could be more about power imbalances, rather than chemical imbalances.

Responses to reports revealed strong level of polarization among stakeholders and experts. Analysis of responses: Jeppe Oute, Susan McPherson. Conflict and antagonism within global psychiatry: A discourse analysis of organisational responses to the UN reports on rights-based approaches in mental health https://onlinelibrary.wiley.com/doi/full/10.1111/1467-9566.13717

Right to mental health – view from the UN

- UN Human Rights Council: resolutions on mental health and human rights (2016, 2017, 2020, 2023)
- CRPD committee: recommendations to Member states, general comments
- UN High Commissioner for Human Rights : report on mental health and human rights (2017)
- UN Special rapporteur on the right to health: reports on mental health (2017, 2019, 2020); country mission reports

  More info: https://www.handover-dialogues.org/

  https://www.ohchr.org/en/special-procedures/sr-health/right-mental-health
- UN Special rapporteur on the right of persons with disabilities: thematic and country mission reports

Evolution of the WHO position

- WHO World health report (2001)
- WHO Mental health action plan (2013-2020-2030)
- **WHO QualityRights initiative**
- **WHO Guidance on community mental health services (2021)**
- **WHO and OHCHR Guidance on mental health, human rights and legislation (2023)**

These documents urge UN Member States to move away from legacy of discrimination, social exclusion, stigmatization, institutionalization, coercion, overmedicalization.

Challenges with the status quo in global mental health. I

- No progress in search of biomarkers. Crisis of biological psychiatry. Promising future for social psychiatry?
- Pathologization of diversity. Medicalization of feelings. Dramatic increase in prescribing psychotropic medications
- Coercion is on the rise within mental health services globally. Examples from different regions
- Case of central and eastern Europe (CEE). The waves of excessive medicalization before and after 1990s. The CEE region continues to rely on institutionalization, reductionist neurobiological approach, over-medicalization and paternalistic attitudes
- Lessons from painful past of psychiatry seem to be forgotten
- Mental health systems and channels of funding are based on “conventional wisdoms” that lack scientific evidence: concepts of “dangerousness” and “medical necessity”
- No progress since the World Health report (2021). Any progress since WHO Guidance (2021)? The need to monitor.
- How are messages from developed countries used by policy makers and professionals in other countries? Scenarios for global South and global North. Role of liberal democracies – such as Nordic countries.

A need for meaningful debate on the need to abandon coercion in the practive of psychiatry: any way to overcome IMPASSE?

Prevailing view among psychiatric profession and policy makers:

Psychiatrists as experts decide when they should step in with using non-consensual measures (coercion) for the purposes of medical necessity or prevention of dangerousness. This is their duty, even if against will, in such way to secure right to health. Psychiatry is a specific field in which such exceptions are unavoidable.

Only through providing treatment it can be ensured that persons with psychosocial disabilities continue living in dignity.

Special cases of emergencies are emphasized

Prevailing view among human rights advocates and UN mechanisms:

Substituted decision making, deprivation of liberty and forced treatment are not acceptable and should be banned. Alternative rights based approaches should be developed and replicated. There should be no exceptions, as exceptions, allowed by the law, use to turn into the rule and pave the way to the global situation when mental healthcare services continue to be a space for systemic human rights violations.

Dignity cannot be compatible with practices of forced placement and treatment which may amount to inhuman and degrading treatment and torture.

Statement of the UN SR on the occasion of the The World Health Day - 7 April 2017

„...Regrettably, recent decades have been marked with excessive medicalization of mental health and the overuse of biomedical interventions, including in the treatment of depression and suicide prevention. The biased and selective use of research outcomes has negatively influenced mental health policies and services. Important stakeholders, including the general public, rights holders using mental health services, policymakers, medical students, and medical doctors have been misinformed. The use of psychotropic medications as the first line treatment for depression and other conditions is, quite simply, unsupported by the evidence. The excessive use of medications and other biomedical interventions, based on a reductive neurobiological paradigm causes more harm than good, undermines the right to health, and must be abandoned...“.

Recovery-based human rights compliant services

- Peer support
- Open Dialogue
- Soteria House
- Mental health crisis units
- Empowerment psychiatry
- Medication-free psychiatric units
- BET
- Personal ombudsman
- Family support conferencing, **and many other innovative good practices (**see list and description of Good practices in the WHO Guidance, 2021).

Lived experiences of users of services. Alternatives to coercion and excessive medicalization, hospitalization and institutionalization. All stakeholders, including governments and leadership of global psychiatry should support these promising innovations

The role of psychiatric profession and its leadership

- The changes towards ending of coercion in mental healthcare needed first of all to end discrimination of persons with psychosocial disabilities and to empower them.
- However, these changes also are needed to liberate the entire field of global mental health from outdated laws, attitudes and practices. These changes are needed also to address image and reputation of psychiatry which is affected by crisis of values and evidence. These changes are not against psychiatry or psychiatrists and they are not „antipsychiatry“
- There are some promising steps with World Psychiatric Association with regard to addressing and substantially reducing coercion (WPA position paper, working group, training).
- However, on the national level in many countries the leadership of psychiatric profession remains on the side of opposing main principles of the CRPD and thus resisting the needed change.
- Challenges for the “coalition of willing” for moving ahead – a) with psychiatry on board; b) without psychiatry on board.

The need for the shift of paradigm

- Human rights imperative (analogy with addressing HIV/AIDS epidemics). Revitalize the CRPD and its role for protecting human rights in mental healthcare
- Address adversities in childhood and adolescence and promote new evidence of importance of ACEs
- Prevent excessive medicalization of mental distress
- Mainstream mental health and discontinue investments in segregated psychiatric institutions (also in international cooperation)
- Prioritize culturally appropriate community based psychosocial interventions
- Replicate good practices that provide non-coercive community based mental health services
- Address imbalances and biased knowledge in medical education and research. Address the issue of terminology in mental healthcare (mental ilnesses?)
- Use for advocacy the WHO Guidance on community mental health services (2021) and WHO&OHCHR Guidance and practice on mental health, human rights and legislation (2023)
- Address the issue of overuse of psychotropic medications and the role of this phenomenon in doing more harm than good. Address the fact that psychotropic medications are in the WHO Model list of Essential medicines. Such example of biased evidence misinforms stakeholders and contributes to high rates of coercive measures.

European Network of (ex-)Users and Survivors
of Psychiatry (ENUSP)

E-mail: enusp.info@gmail.com Website: www.enusp.org

Ending psychiatric coercion

– urgent need for effective remedies and reparations

Oslo, 10 September 2024

Organized by the Human Rights Foundation ReDo

Panel 2: "Severity of human rights violations and harm done"

Olga Kalina

Introduction: ENUSP members

- 36 member organisations
- in 28 European countries

Northern Region: Denmark, Finland, Iceland, Norway, Sweden

North East Region: Latvia, Lithuania, Russia, Ukraine

North West Region: Germany, Ireland, the Netherlands, United Kingdom

Central Region: Czech Republic, Moldova, Poland, Romania, Slovakia

South West Region: Belgium, France, Italy, Portugal, Spain

South East Region: Bosnia & Herzegovina, Georgia, Greece, Serbia, Slovenia

ENUSP Empowerment Seminar 2015, Brussels

ENUSP and UN CRPD

- ENUSP experts directly participated in the process of creation of the UN CRPD
- a valuable tool for promotion and protection of rights of persons who experience mental health problems and/or mental health services
- not everyone agrees with the terminology, but protection of our rights is there
- ENUSP Shadow report 2015, Submission on CRPD implementation in the European Union, CRPD-Committee, 14th session, led by Jolijn Santegoeds, who passed away in April 2023.
- Jolijn: “Coercion is not care”

Consultation with members

- The second review of the EU's implementation of the UN CRPD by the UN Committee on the rights of persons with disabilities is underway and will take place in March 2025.

- The European Network of (Ex-)Users and Survivors of Psychiatry has held thematic consultations via dissemination of questionnaires and online discussions with its members in EU states

Information:

- Opinion of our members on improvements

- Barriers based on the opinion and lived experience of ENUSP's members with regard to their rights in the mental health care system throughout the EU

- and to discuss our recommendations

Personal experiences related to Articles 14, 15 and 16

France:

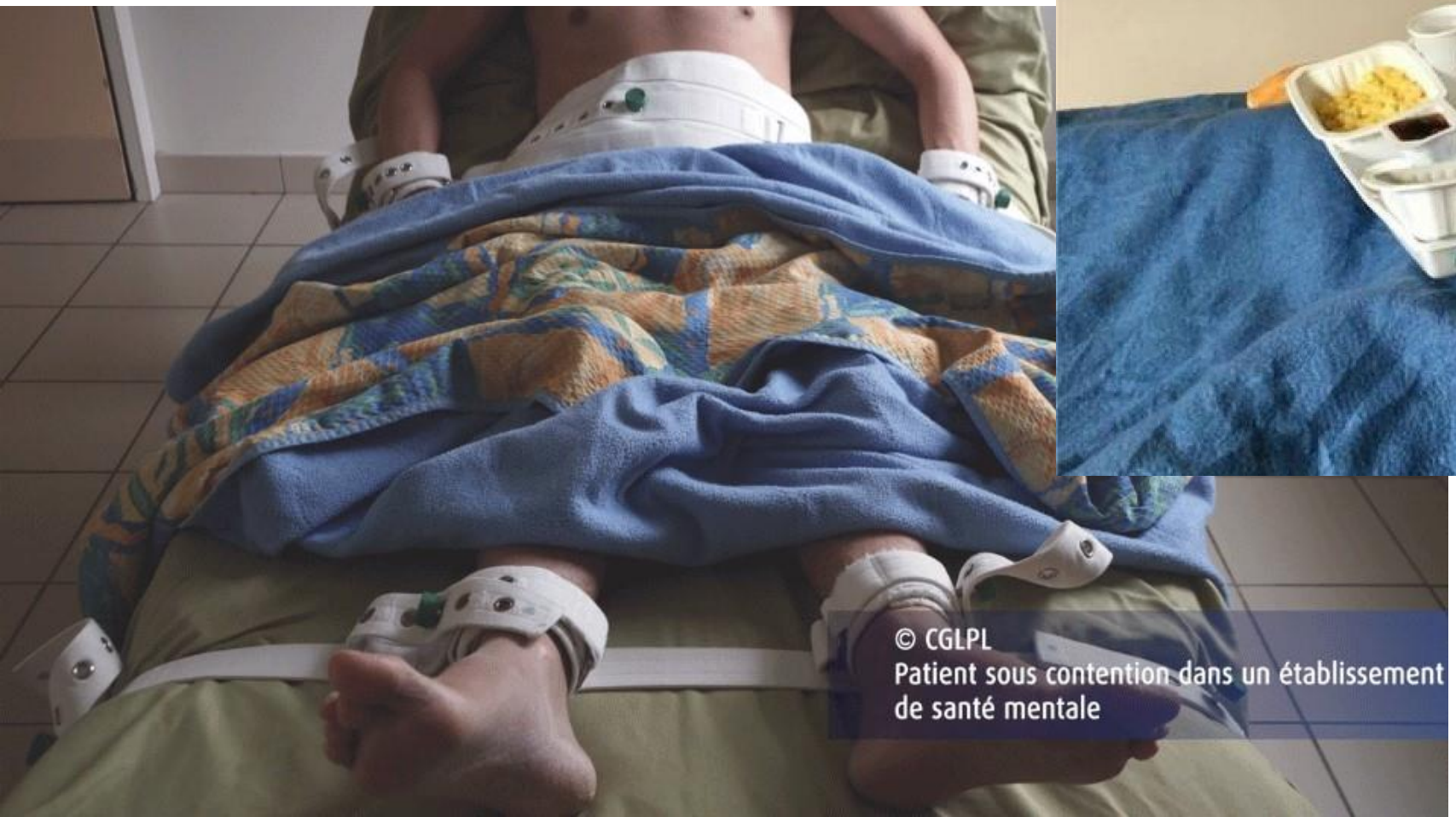
“We consider forced hospitalization as violence and abuse, and a cause of severe traumatization… People may come back with sleep problems, nightmares, fear and dissociation (PTSD). Some people may never understand what happened to them and even build false interpretations, because the medical violence they endured is unbelievable.”

Note: 95,473 persons were hospitalized without their consent and 39,244 were under Community Treatment Orders (CTO) in 2021

Germany:

“During my worst psychotic episodes, I was treated like a villain, like an outsider and with force. Examples [of coercive measures] are restraint, giving me medication without my understanding of what I was taking… “

Monitoring: CGLPL controller general for places of deprivation of liberty, France, photos taken in 2016, 2018



Rehabilitation Center for People with Disability, Romania, 2019

Romania: monitoring of care home in 2023

The image released on July 27, 2023 by the Center of Legal Resources, Romania.

Care home in the village of Bardesti in the Central Romanian Mures county. The Center of Legal Resources, or CLR conducted an unannounced inspection of the home and found “alarming level of neglect and abuse”, six residents were found in the basement beneath the home with 23 residents, four of the residents, with severe disabilities were “lying on mattresses soiled with feces, urine and blood.” (CLR)

https://apnews.com/article/romania-care-homes-scandal-abuse-788423586ca8a8c413f1af0d0b0c2819

Ukraine, residential facility, October 2019, monitoring by NGO member of ENUSP - “USER”

https://www.facebook.com/watch/?ref=saved&v=937404826659713

Article 6: Women with disabilities

- “I was once forcefully kissed by a man [in a psychiatric institution]. After that a nurse came up to me and asked me to stay away from this man because he has a wife and children. Although I was in a very vulnerable state because of my acute psychosocial disability, I was blamed for the act of sexual harassment.”

- Forced sterilization of persons with disabilities is still explicitly allowed in Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, Hungary, Latvia, Lithuania, Portugal and Slovakia according to the analysis of the European Disability Forum.

- The UK protocol on isolation in mental health departments requires women be placed there without underwear and with no access to toilet paper or menstrual supplies. According to women, sometimes they are undressed and put in isolation rooms by male staff.

Romania, Psychiatry Section in Târgu Jiu, January 2019

https://adevarul.ro/locale/targu-jiu/video-scandal-sectia-psihiatrie-targu-jiu-bolnavi-aproape-dezbracati-filmati-timp-saruta-ating-lasciv-printre-grilaj-1_5c5c319adf52022f757ca0ec/index.html?fbclid=IwAR0HHofNJXTao6iHpE8cnlMkTHCsw5C2-Y0NVsxaPU4kvgjEZt9ePhu_Uas

Wider consequences of coercion

Lack of trust,
more self-stigma,
normalization of violence,
trauma, self-harm,
dissociation, suicide, more
isolation,
fear of healthcare system,
fear of police,
more vulnerability to
violence and threats in
order to avoid contact
with the system, etc.

Less obvious forms of coercion

Psychiatric hospitals - small group homes

Any real change in culture?

Old building of psychiatric hospital in Georgia: issues with privacy

https://ombudsman.ge/res/docs/20191010141249164 39.pdf

Renovation – but still same issues with privacy

https://ombudsman.ge/res/docs/20191010141249164 39.pdf

Systematic problems → solutions

- There has been no review of EU legislation in order to harmonize it with UN CRPD standards. Initiatives and changes are not compatible with the UN CRPD.
- No tendency to mention reparations
- Council, the European Economic and Social Committee and the Committee of the Regions on a comprehensive approach to mental health" (June 2023): no consultation with us, no reflection on our priorities.
- Existing good practices do not find enough support for their expansion and improvement
- Draft regulation on the protection of vulnerable adults under the Hague Convention
- Still existing possibility of adoption of the Draft Additional Protocol to the Oviedo Convention
- Very much needed: creation of effective monitoring mechanisms of implementation of the Convention, with the meaningful involvement of persons with psychosocial disabilities


THANK YOU
FOR YOUR ATTENTION

Painting by
Elisabeth Andersen

- Our voices are ignored.
We are being maltreated in an attempt to weigh benefits against harms.

MENNESKERETTIGHETSSTIFTELSEN REDO

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The program starts again at 12.00

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The program starts again at 14.00

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Ending psychiatric coercion

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The program starts again at 15.00

한국정신장애연대
KAMI_Korean Alliance for Mobilizing Inclusion

Strategic litigation against psychiatric coercion in Korea

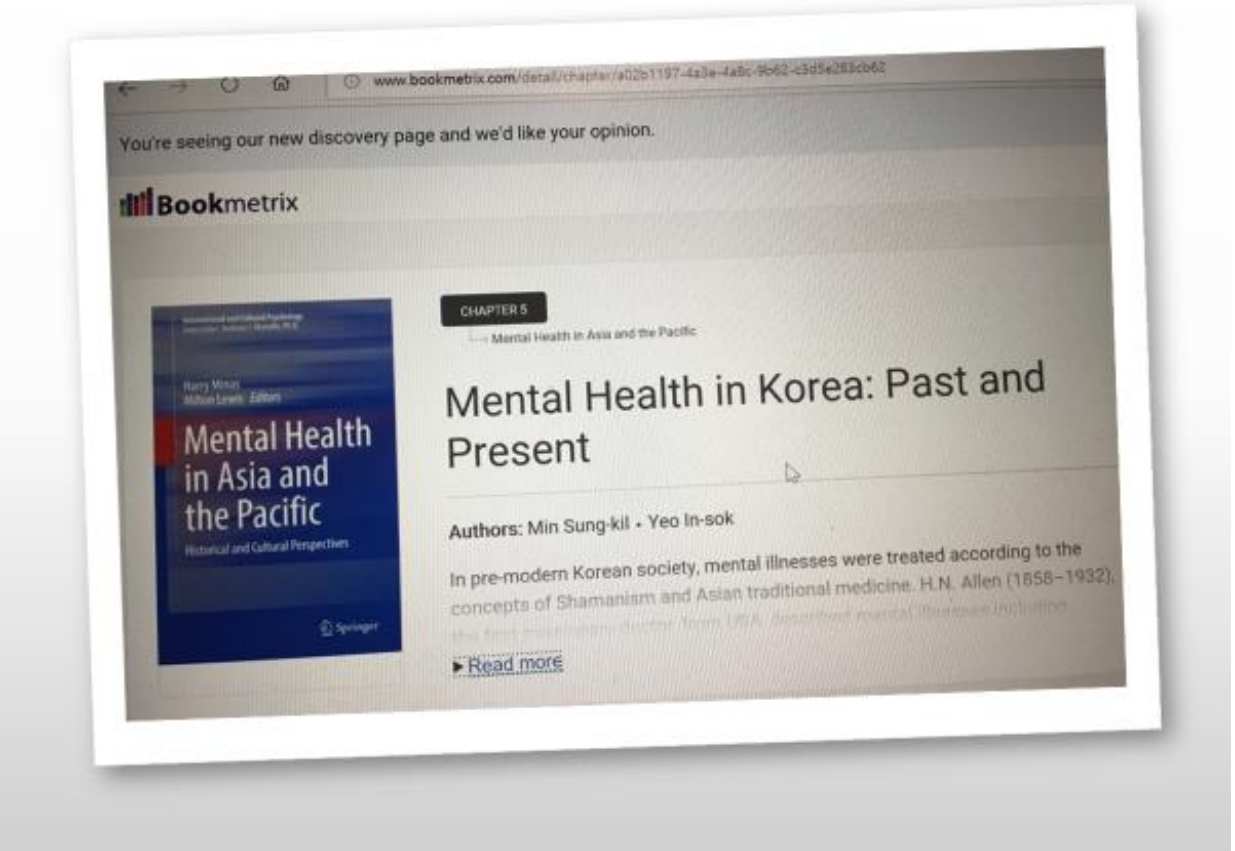
Ohyong Kweon,

esq., Board member of WNUSP

Discrimination and Exclusion of people with psychosocial disabilities in Korea

1. Institutionalization by The Mental Health Act
2. Discrimination by the Legal Guardianship
3. Discriminatory laws and practices

Institutionalization by the Mental Health Act of 1995



Based on a model project of a community mental health center in 1995, 165 community mental health centers (65%) were established in 253 districts by 2012 and nine regional mental health centers were founded in 16 regions. Despite the deinstitutionalization policy, the number of beds in mental hospitals and asylums increased from about 30,000 in 1990 to about 90,000 in 2010 (Lee 2012). This increase was attributed to the uncontrolled governmental subsidy and a hasty, unplanned, not systemic, and bureaucratic policy based on convenience. The government had to revise once again the direction of reform. Since 2012, it has been developing the Comprehensive National Mental Health Promotion Plan.

Why the number of mental hospital beds increased in Korea?

Mental Health Act

- **Enforced from 31 Dec. 1996**
- **The goal of Mental Health Act of 1995 was to prevent mental illness and promote mental health of the people.**
- **But the real purpose of the Act was to prevent crimes from mental illness and to increase mental hospital beds.**

News Report, Nov.1991

연합뉴스

정부 정신보건법 제정추진 - 1

입력 1991.11.28 10:50 수정 1991.11.28 10:50

정신질환자 범죄예방 대책일환 (서울=연합(聯合)) 정부는 날로 심각해지고 있는 정신질환자들의 범죄행위에 적극 대처와 예방조치를 위해 <정신보건법>(가칭)의 제정을 추진할 방침이다.

金基春법무부장관은 28일 오전 鄭元植총리주재로 열린 국무회의에서 "현재 전인구의 2%인 90만명 정도가 정신질환을 앓고 있고 이들 가운데 10만명은 지금 당장 입원이 필요하다"면서 정신보건법을 제정해야 한다고 보고했다.

金장관은 또 "현재는 범죄를 저지른 사람들 가운데 정신질환자들을 공주치료감호소등에 입원시키고 있으나 범죄를 저지를 가능성이 높은 정신질환자들이 적지않은상태여서 이에 대한 대책이 필요하다"면서 정신보건법안을 내년중에 국회에 제출해야 할것이라고 밝혔다.

이에대해 鄭총리는 "범죄예방의 측면에서 적절한 지적"이라면서 정신보건법을 추진토록 지시했다고 회의에 참석했던 정부의 고위당국자가 전했다.(계속)

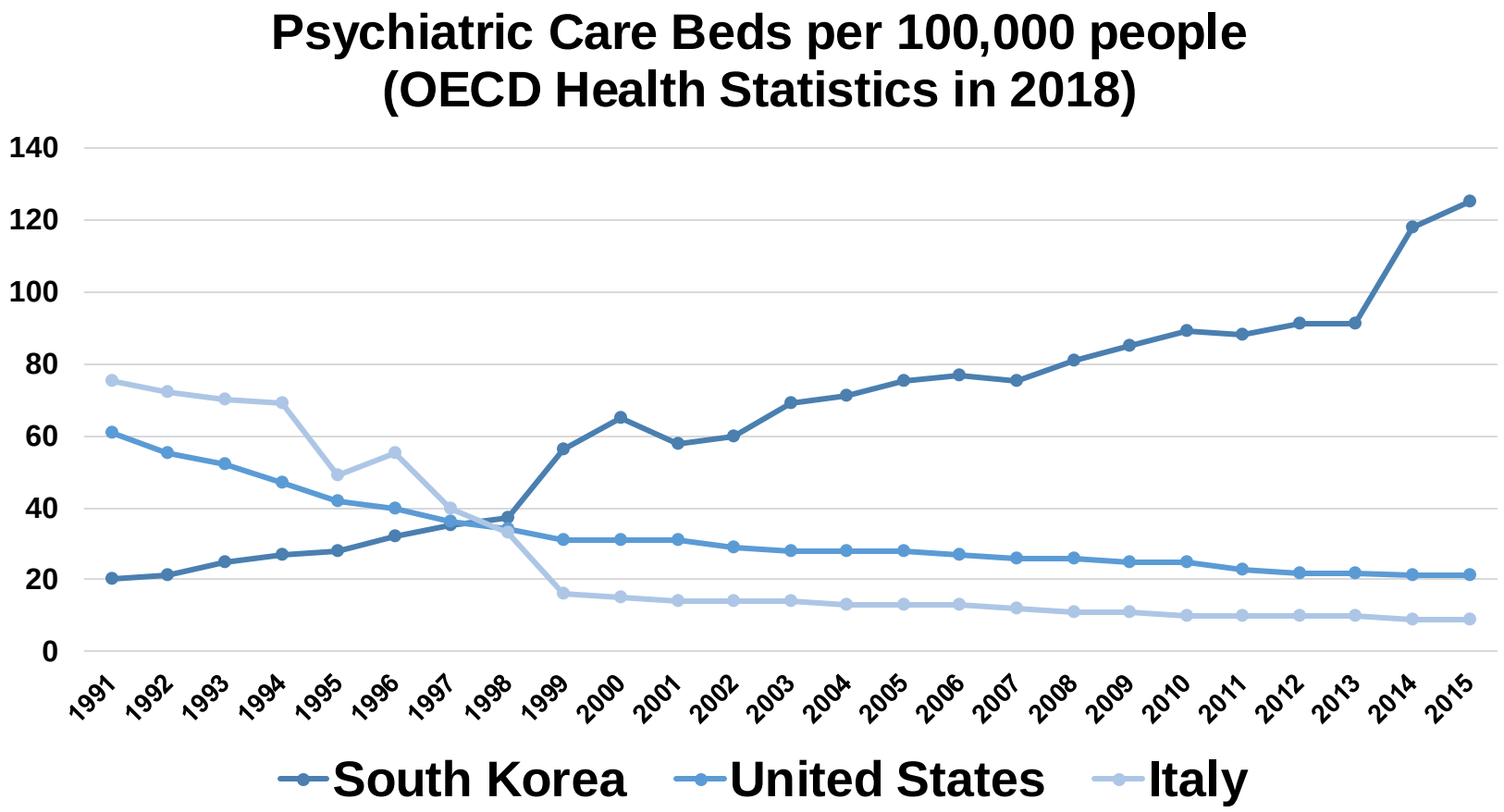
渼鳴?말했다.

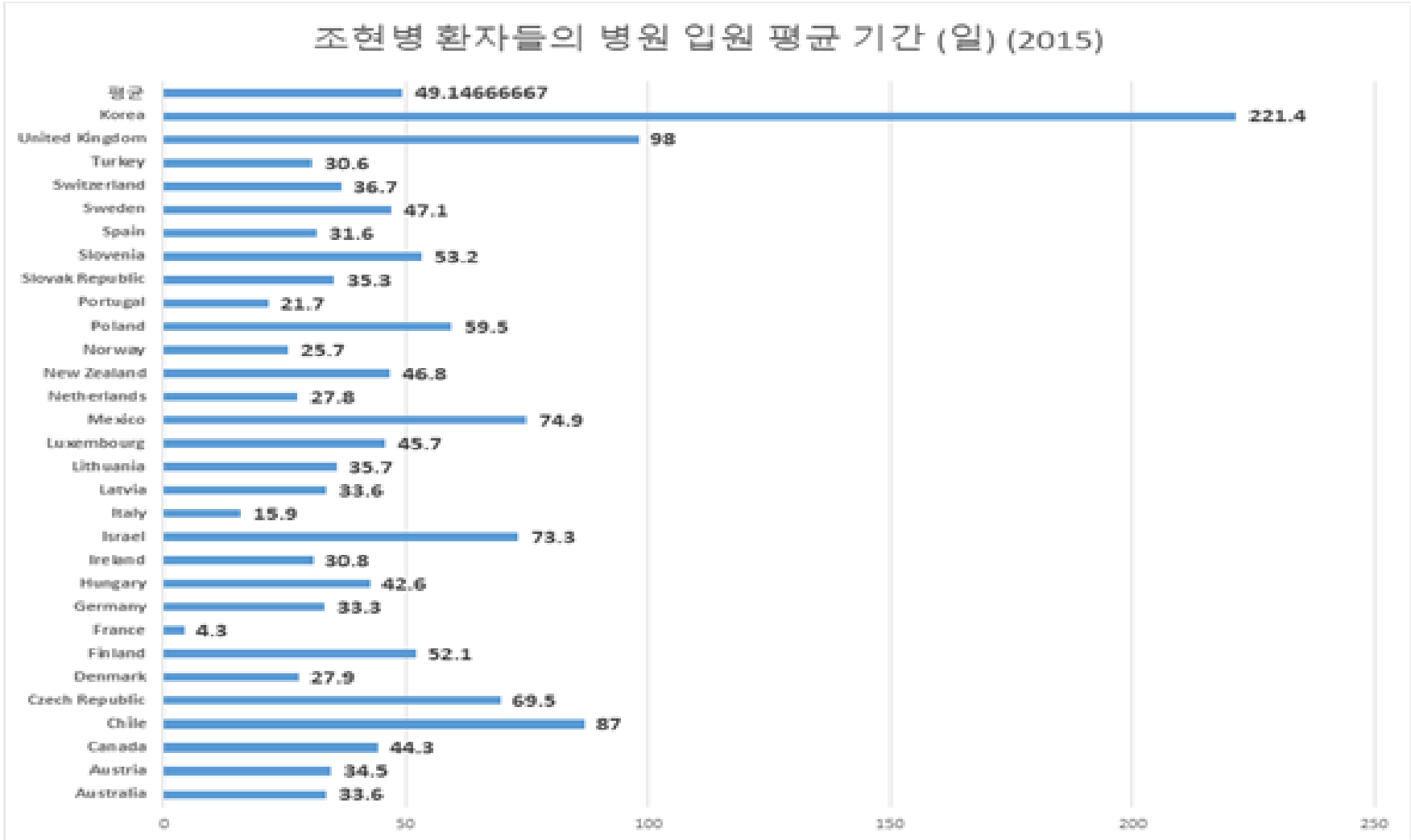
OECD reviewed Korean Mental Health System and published the report in 2014. KAMI consulted the OECD delegation about human right violations of psychiatric hospitalization.

“Making Mental Health Count”, OECD(2014)

- **“Hospitals dominate Korea’s mental health care”**
- **The Korean model of mental health care is based on institutionalization with long lengths of stay.**

Increase of mental hospital beds in Korea




조현병 환자들의 병원 입원 평균 기간 (일) (2015)
평균 49.14666667
Korea 221.4
United Kingdom 98
Turkey 30.6
Switzerland 36.7
Sweden 47.1
Spain 31.6
Slovenia 53.2
Slovak Republic 35.3
Portugal 21.7
Poland 59.5
Norway 25.7
New Zealand 46.8
Netherlands 27.8
Mexico 74.9
Luxembourg 45.7
Lithuania 35.7
Latvia 33.6
Italy 15.9
Israel 73.3
Ireland 30.8
Hungary 42.6
Germany 33.3
France 4.3
Finland 52.1
Denmark 27.9
Czech Republic 69.5
Chile 87
Canada 44.3
Austria 34.5
Australia 33.6
0
50
100
150
200
250

This woman, Applicant of Constitutional Lawsuit expressing the agony and trauma of involuntary hospitalization and coercion in the psychiatric hospital

The psychiatric hospital and the ambulance which took the woman and hospitalized.


강제입원 106일
난 미치지 않았어요
충격실화스릴러
날, 보러와요
2016.04




Preparation meetings was in Dec. 2013 and Jan. 2014 with lawyers and law professors with advocacy organization who gave important advices and help for the lawsuit.

20 Dec. 2013 with lawyers and persons with victims of involuntary hospitalization

14 Jan. 2014. We filed a lawsuit to the Constitutional Court of Korea.

The Hearing of the Constitutional Court for more than 4hours.

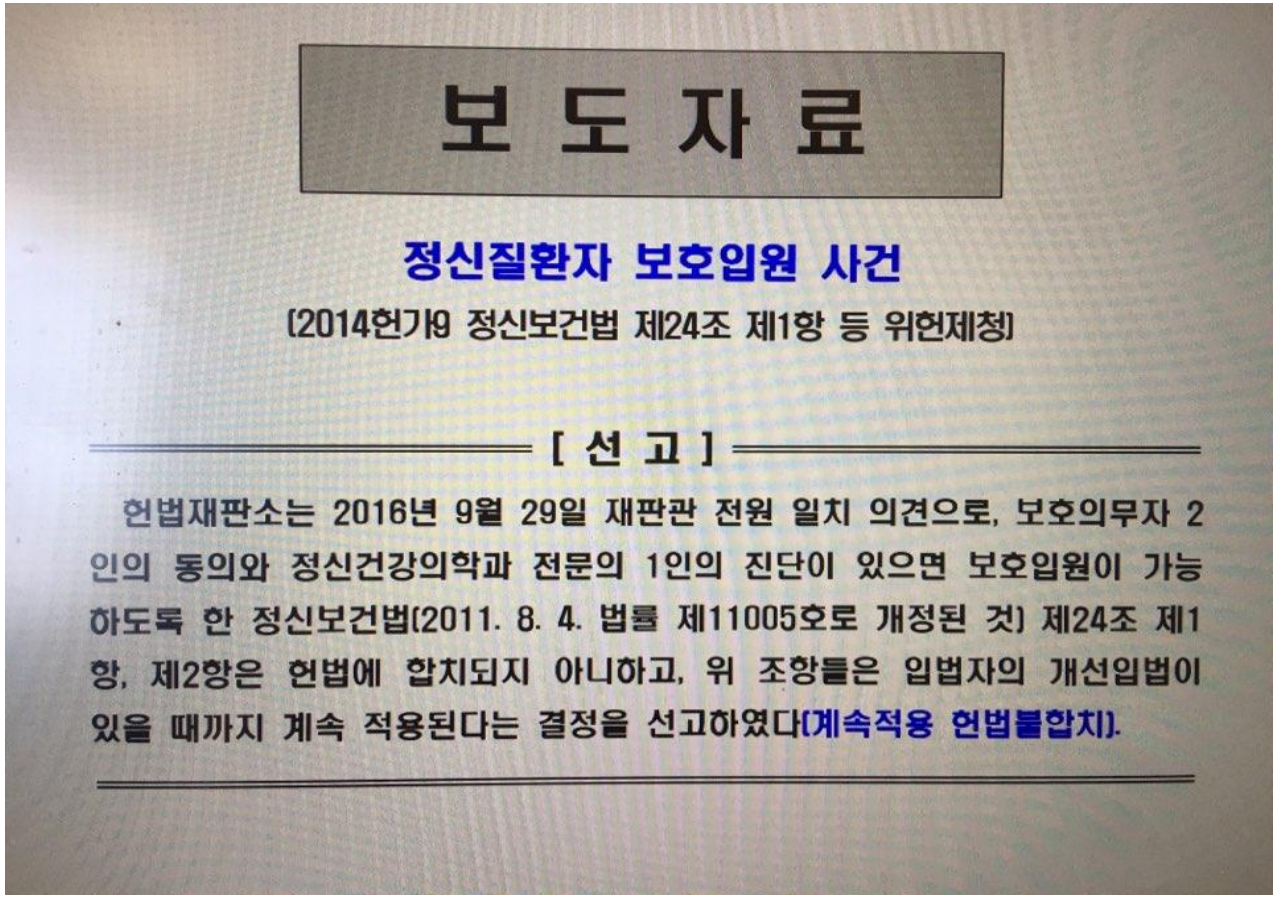
- **The hearing on Mental Health Act Art. 24 was made on 14 April 2016.**
- **Two issues raised.**
  - **Right to equality (Right to Legal Capacity)**
  - **Right to liberty(Due Process)**
- **But the Constitutional Court answered only for the right to liberty not for the right to legal capacity by the decision.**

The constitutional court hearing
14 April 2016

The Constitutional Court Decision

- **The judges of Korean Constitutional Court unanimously for the Art. 24 of Korean Mental Act was actual “inconformity with the constitution.”**
- **The Court worried the confusion from sentencing “Unconstitutional.” Because there were 80000 people was hospitalized and 70% of them were involuntarily hospitalized.**

Press release of the Constitutional Court Decision on MHA 2014Hun-Ka, 29 Sep. 2016



보 도 자 료

정신질환자 보호입원 사건

〔2014헌가9 정신보건법 제24조 제1항 등 위헌제청〕

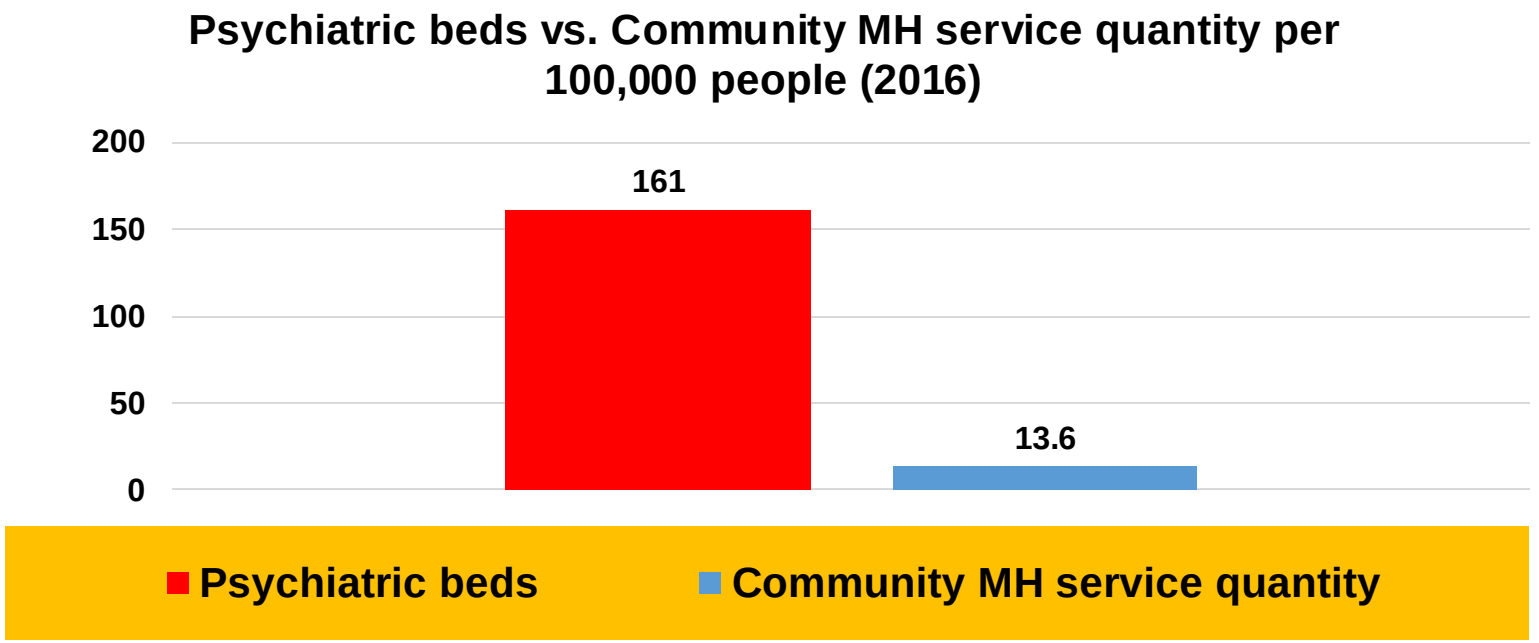
[선 고]

헌법재판소는 2016년 9월 29일 재판관 전원 일치 의견으로, 보호의무자 2인의 동의와 정신건강의학과 전문의 1인의 진단이 있으면 보호입원이 가능하도록 한 정신보건법(2011. 8. 4. 법률 제11005호로 개정된 것) 제24조 제1항, 제2항은 헌법에 합치되지 아니하고, 위 조항들은 입법자의 개선입법이 있을 때까지 계속 적용된다는 결정을 선고하였다(계속적용 헌법불합치).

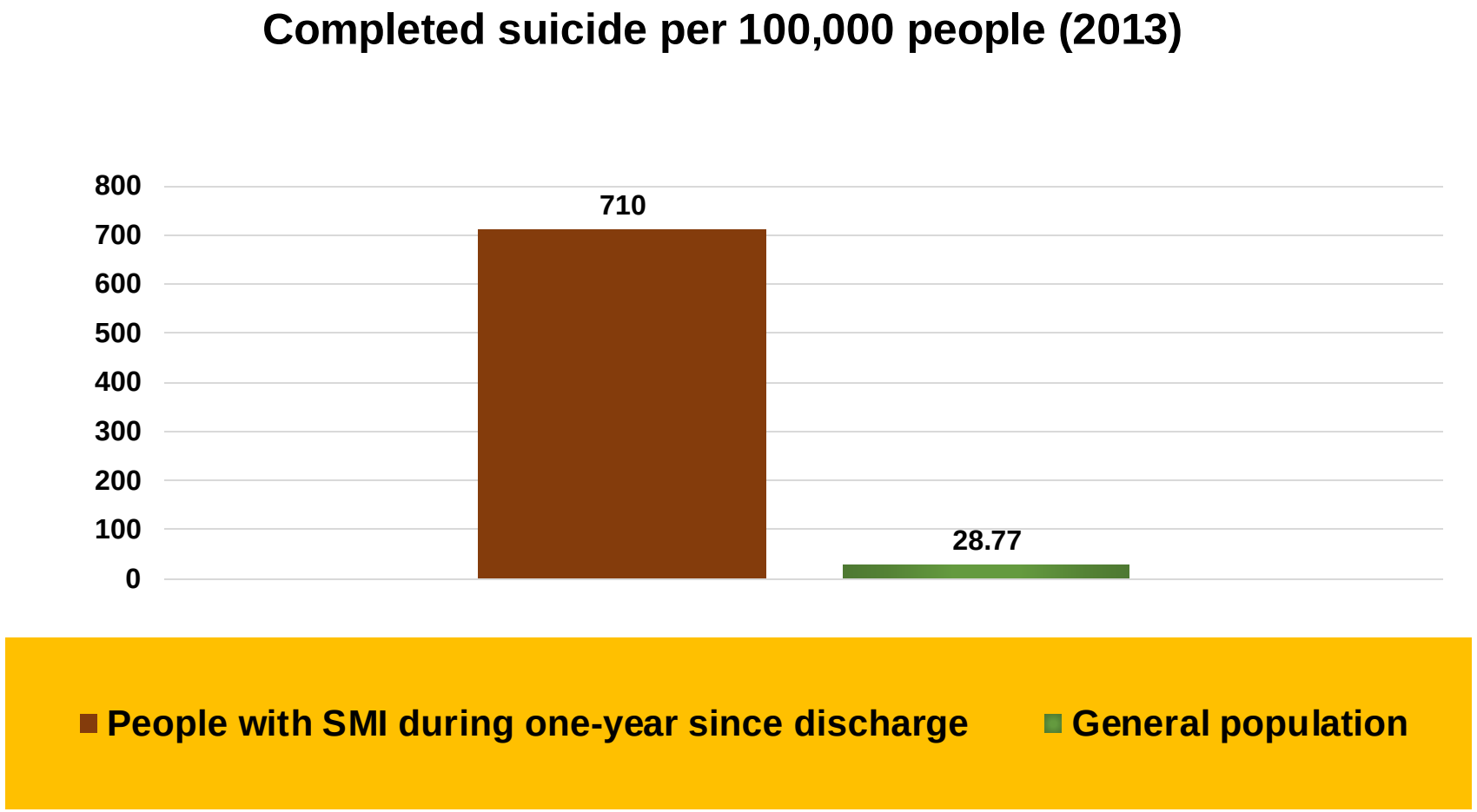
Korean National Assembly amended MHA in May. 2016 after the Constitutional Court Hearing before the Court Decision Made

- Korean government and the National Assembly amended the MHA to strengthen procedural safeguards.
- The rate of involuntary hospitalization dropped from 70% before the revision to 37.1% after one year of enforcement (Government news release, April 2018)
- But only 3,000 of 69,162 mental hospital inpatients.(may be below 4%)

No help in the community



Suicide rate of the people with SMI during one year since discharge.



Conclusion

- **Deinstitutionalization and living independently in the community is the constitutional and conventional rights of the persons with psychosocial disabilities.**
- **The MHA of Korea was made to establish mental hospitals to keep people with psychosocial disabilities aside from the community.**
- **The reforming of the MHA should be the first thing for community inclusion of the people with psychosocial disabilities.**
- **Strategic litigation helped the government and the national assembly to move forward.**

References

- **Monthian Buntan, State obligations under UNCRPD and Concluding Observations, New opportunities for Korean persons with psychosocial disabilities**
- **OECD, Making Mental Health Count, 2014**
- **CRPD Committee, Concluding Observations for Korea, 2014**
- **Min Sung-Kil & Yeo In-Seok, Mental Health in Korea: Past and Present**
- **Bae Jin-Young, Institutionalization of the People with Psychosocial Disabilities in Korea, 2023.**

Strategic Litigation in Africa

Jennifer Wairimu
Litigation Officer

Oslo 10 September 2024

Introduction & Strategic Litigation Overview

- Validity Foundation is currently handling almost 60 active cases across Central and Eastern Europe, and Eastern and Southern Africa.
- Our focus: Addressing major systemic issues identified in various countries and creating systemic change.
- Set clear strategic objectives: (e.g. Challenging a practice, advocating for a specific service, accountability for rights violations) – Not just obtaining a judgment, but ensuring its enforcement; urging governments to act and implement change.

Strategic Litigation Approach

- Strategic litigation is about taking individual cases which represent widespread systematic problems and using that case to create legal precedent that can bind the state, precedents that can push for reforms that are more in line with human rights norm.
- These precedents push for reforms aligned with international human rights norms.

Steps before Litigation

1. Identify the violations and why they need addressing.
2. Develop a strategy with national lawyers, persons with psychosocial disabilities and interested stakeholders.

Cont:

3. Ask key questions:

- What is the violation that needs to be addressed and why?
- What should be stopped/started?
- Who is responsible for the violation?

Post Judgment:

- Holding duty bearers accountable to take steps in line with judgments.
- Follow-up litigation
- Engage in advocacy and continuous monitoring.

Case Study: Centre for Health, Human Rights & Benon Kabale v Attorney General

Ending the practice of seclusion in Uganda:

- A constitutional human rights challenge against the practice of long-term use of segragation and isolation in Uganda's psychiatric national facility.
- Court Judgment: The court dismissed Benon's testimony based on his psychosocial disability, questioning his credibility.
- Next Steps: The matter is pending at the Court of Appeal and is being escalated to the African Commission on Human and Peoples' Rights (ACPHR).

Case Study: Validity Foundation between FIDA & Another v Butabika National Refferal Mental Hospital & AG

- *Validity Foundation between FIDA & Another v Butabika National Refferal Mental Hospital & AG.*
- MLM, under the care of Butabika Hospital for medical treatment, was injected with a drug against his will.
- He was forcibly restrained and assaulted three times on the head.
- Actions caused injuries that ultimately led to his death.
- As Amicus, Validity submitted analysis of international law, case law and reports for the High Court of Uganda - Kampala to put into consideration in deciding the case.

Case Study: Perez Mwase

- *Centre for Health, Human Rights and Development (CEHURD) & 3 Others Vs. Buyende District Local Government & Another(Perez Mwase case)*
- The case challenged the failure of the Government to provide early detection, rehabilitation and habilitation services at the primary health care level for persons with autism.
- The High Court found that the failure by the Government to provide said services to PM, amounted to a violation of the right to equality and non discrimantion and ordered the Government and other relevant stakeholders to develop Guidelines that will allow early detection and assistance for children with autism in Uganda.

SGBV Cases in Uganda involving women with psychosocial disabilities

- **ABM Case:** Right to family; right to health; right to access health information; right to access community-based support services.
- **AD & NA Case:** Right to health; right to access health information; right to freedom from cruel, inhuman and degrading treatment; right to access community-based support services.
- **CG Case:** Access to justice, right to redress, psychosocial support and protection, right to access community-based support services.

Validity's strategic aim with the 3 cases:

- Bring out intersectionality between disability and gender.
- Highlight rape as a specific form of torture and ill-treatment
- Seek recognition of the state's positive obligation to develop appropriate community-based services to address the trauma and prevent further human rights violations.

Zambia Case Study

Background: *Gordon Maddox Mwewa and Others v AG* challenging the constitutionality of derogatory terminologies in the 1949 Mental Disorders Act.

Success: Offensive language such as 'idiots' and 'imbeciles' was struck down and court called the Legislature to review the old law , which later culminated to the enactment of the Mental Health Act 2019.

Current Issue: The Mental Health Act 2019 (MHA) still deprives persons with psychosocial disabilities of their legal capacity as argued in *Sylvester Katotonka & Another v AG.*

- National courts decided that Section 4 of MHA does not infringe on the rights of persons with psychosocial disabilities despite MHA allowing subtituted decision making.
- Next steps: take the case to the African Commission.

Kenya Case Study

- Ongoing case touching on stigma, discrimination and barriers experienced by persons with disabilities when excercising legal capacity.
- Background- Petitioner faced discrimination while attempting to open and operate an account in one of the banks in Kenya.
- The bank sought that either the Petitioner donate his power of attorney to a person known to him OR sign a deed of indemnity.

VALIDITY

Thank you!

jennifer@validity.ngo

Strategic litigation and where next?

Steven Allen
Validity Foundation

About Validity

- The **Validity Foundation** – formerly the Mental Disability Advocacy Centre (MDAC) – was established in 2002.
    - Mission: Deploy legal strategies to promote, protect and defend the rights of persons with disabilities, under the instructions of persons with disabilities
    - Where: Headquartered and operating in CEE since establishment. From 2010, began working in east and southern Africa.
    - What: Strategic litigation, documentation and research, advocacy

Roles that strategic litigation can play

- **Strategic litigation** is a form of legal advocacy that can contribute to broader reforms (legal, policy, service reform):
  - Giving effect to international human rights obligations of States within national legal systems (monist and dualist traditions)
  - Establishing that a law, policy or practice violates HR obligations/standards – *and must change*
  - Establishing that certain practices amount to unlawful discrimination – *and must end*
  - Making human rights standards actionable and enforceable for rights holders
  - Enumerating positive and negative obligations of duty bearers flowing from (i) IHRL standards, and (ii) findings of specific violations

Strategic disability rights litigation

- Validity's strategic litigation focused on **addressing widespread and systematic violations** emanating from abusive systems of segregation, separation and control of persons with disabilities.

    - **Legal capacity and guardianship**
    - **Disability-based detention and institutionalisation**
    - **Freedom from torture and ill-treatment**
    - **Access to justice**
        - *and links between these*

- Most commonly **actions for individual victims of violations** that, e.g., exemplify a widespread problem, highlight specific egregious abuses, tackle access to justice barriers, achieve effective remedies

What can litigation achieve? What are the limits?

Precedent-setting cases can and have achieved certain forms of recognition and redress for individuals, and can provide the basis for more systemic reforms.

- **Stanev v. Bulgaria, App. No. 36760/06 ECHR:** institutionalisation on basis of disability authorised by a guardian without appeal amounts to unlawful deprivation of liberty, denial of access to justice, and resulted in ill-treatment in violation of the European Convention
  - Limitations: Implementation oversight (so-called 'executions process' is slow, restrictive and limited
- **Shtukaturov v. Russia, Application No. 44009/05 ECHR:** guardianship violated right to fair trial, respect for private life, and resulted in unlawful deprivation of liberty and denial of access to justice
  - Limitations: Does not call into question psychiatric detention *per se* – the issue of 'safeguards' comes up again and again in European litigation
- **Černaková v. Slovakia, Communication No. 890/2018, UN Committee against Torture:** condemning the use of physical, mechanical and chemical restraints (cage beds, sedatives), and ordered actions to prevent recurrence
  - Limitations: only particularly egregious practices identified as TCIDPT
  - Gaining the engagement of treaty bodies has been challenging, particularly in relation to psychiatric detention
- **More recently:** UN Subcommittee on Prevention of Torture has adopted a general comment that begins to signal a broader understanding of disability-based detention in accordance with the DI Guidelines. **And in Europe?** Compare and contrast with the CPT, which recently explicitly refrained from providing a view on the applicability of CRPD/SPT standards within Europe, and ongoing work on the draft Additional Protocol to the Oviedo Convention and Article 5 ECHR jurisprudence (legal tests: 'last resorts', 'proportionality')

Can and should strategic disability rights litigation go further? 1/2

Recognition and redress are important, but more work needed to link individual remedies to wider social and political processes seeking reparations

- **Recognition** can be a crucial first step: framing 'social issues' and disability discrimination as judicially cognizable claims → increasing awareness, supporting advocacy
- **Redress** is important for individual applicants, but rarely goes further than providing monetary compensation.
- In limited cases, we can achieve orders that engage **positive obligations** (e.g. to provide housing, services, rehabilitation, etc.) – but this remains challenging in many jurisdictions

Can and should strategic disability rights litigation go further? 2/2

- **While other remedies might be pursued, legal and judicial practice makes them highly challenging to achieve through litigation alone.** Outcomes depend on:
  - choice of forum, available remedies and judicial practice
  - what we ask for, what lawyers believe is possible, limits imposed by national laws (*note: there are major differences between different constitutional traditions*)
  - wider strategy/campaigns activities → courts must not operate in bubbles
- The reparations framework **<u>does</u>** provide new impetus, and is influencing what and how we litigate going forward.
- We questions do we ask ourselves in this areas?
  - How do we **enhance knowledge of the reparations framework**? Process of developing DI Guidelines was notable for engaging the global disability community, but not yet States. How to engage lawyers and judges?
  - How can we design litigation strategies that **explicitly seek reparative justice as a key demand** as part of wider campaigns?
  - How might we obtain **orders for cessation**? ECHR (*general measures and follow-up to execution of judgments*); collective complaint mechanisms (*in particular, European Committee for Social Rights*)
  - Can we achieve **public recognition/apologies** for the harm caused by disability-based detention?
  - Can we invite **respondent States and authorities** to publicly acknowledge harms caused?

How reparations and DI Guidelines are informing our legal work 1/2

- **The process of developing the Guidelines was a powerful, collective journey – this inspires our work**
- Cooperation with survivors of institutionalisation first (*working hard to access people in institutions, banging on doors, pushing hard for people to speak in person in court where they wish to do so*) – critical to success
- Case strategies explicitly seek reparations as framed in the DI Guidelines (*legal research and creative lawyering is essential*)
- Submissions directly reference the DI Guidelines (*with early signs of judicial acknowledgement – even in Hungary – e.g. recent Topház first instance judgment*)
- Mitigating client risks, while consciously pushing the boundaries of what is (*legally/procedurally*) possible
- Individual remedies framed so as to invite courts/duty-bearers to acknowledge *collective harms*

How reparations and DI Guidelines are informing our legal work 2/2

- Strategies to achieve reparations and justice should pursue multiple tracks. Legal work may support various tracks.
- Multi-track litigation strategies are often required to pursue reparative justice – criminal, administrative/constitutional, civil and collective claims – and working with lawyers to understand the need to go far beyond monetary damages
- Continuously (re)assessing the full array of available legal forums and avenues

  - **Constitutional litigation** – often provides wider scope of possible remedies
  - **Collective litigation** – uncommon in many domestic jurisdictions, but possibilities exist before certain regional bodies
  - **Individual communications and inquiry procedures** – e.g. OP-CRPD
  - Being very careful with **traditional forums**: especially ECtHR in recent years
  - **Non-traditional judicial and semi-judicial forums**: e.g. European Court of Justice
  - Engaging with **community and traditional justice mechanisms** where these have influence
  - **Execution of judgments**, structural interdicts and exercising ongoing judicial oversight mechanisms (*where they exist*)

Some examples – on the long road 1/2

1. **Hungary: Inquiry under OP-CRPD (2020)**
   - Grave and systematic violations of Articles 5, 12 and 19 of the CRPD, specifically addresses involuntary detention and treatment in psychiatric facilities, notes psychiatry is excluded from national DI plans
   - State primarily responsible, but EU was also named → hugely significant in terms of financing of the country's fake "deinstitutionalisation process".
   - Follow-up review process (2023) strengthened by reference to DI Guidelines:
     *The Committee calls for the State Party to "provide **remedies and reparations** for persons with disabilities seeking redress for their institutionalization that include pecuniary and non-pecuniary reparations and to ensure access to justice for persons with disabilities who are survivors of deinstitutionalization"*

2. **Challenging institutionalisation in Moldova before the ECtHR (2024)**
   - Over the last ten years, we have initiated or acted as *amicus* in a number of cases targeting institutionalisation. Consistent engagement seems to be bearing better judgments from this desk.
   - V.I. v Moldova, App. No. 38963/18, judgment 26 March 2024 – detention of a minor in a psychiatric institution; significant reliance on CRPD; general measures uncharacteristically wide for ECtHR:

     "*The Court considers that the nature of the violations found suggests that for the proper execution of the present judgment the respondent State would have to **take a number of general measures** aimed at **reforming** the system of involuntary placement in a psychiatric hospital and of involuntary psychiatric treatment of persons with intellectual disabilities, and in particular children. Without taking a position on the nature and scope of the reform to be undertaken, the Court considers that these measures should include the **legal safeguards and mechanisms** described in its judgment and **should address the discrimination** of persons with intellectual disabilities, and in particular children.*"
   - **General measures open the door to ongoing assessment of implementation of the judgment (but note this is an inherently political process)**

Some examples – on the long road 2/2

3. Domestic claims

- Hungary (István Cservenka, forthcoming):
- Decision to leave an institution following decades of disability institutionalisation.
- Upon deciding to leave, threatened with guardianship. Claim successfully defended, personal support agreement recognised.
- Client seeks acknowledgement, apology and reparations for himself and others.
- National research indicates 'just satisfaction' as a potential domestic remedy that could provide public acknowledgment and apology, but low likelihood of domestic success.

4. CEE country: Request for a new Inquiry under OP-CRPD

- Article 14, separately and in conjunction with Article 19, targeting the country's national system of psychiatric detention and involuntary treatment.
- Extensive engagement with survivors, OPDs and other civil society on the heels of mainstream news scandals.
- Individual survivors plan to join Inquiry request in their own names, seeking acknowledgment of collective harms.
- Broader advocacy strategy is survivor-led and taking inspiration from DI Guidelines, particularly reparations framework.

An emerging field – some thoughts

- **The reparations framework provides a powerful new impetus in the pursuit of strategic litigation.**
  - It informs both **how** we litigate and **what** we seek.
  - It forces us to work hard to **show the link** between individual violations to collective harms.
- **Strategic litigation can help in achieving some components of reparations:**
  - Traditional legal mechanisms can often provide **recognition**, **apologies**, **individual redress, orders for cessation,** and **some wider remedies (including orders to prevent future repetition)**.
  - While it can be a powerful addition to wider movements, SL will never be a silver bullet
  - Judicial oversight mechanisms and non-traditional forums may help us to achieve broader goals. Constitutional litigation, structural interdicts, public inquiry mechanisms (where they exist) may be able to go much further, but there are few examples of this worldwide.
- **Knowledge is power.**
  - Much more work is needed to build awareness of the CRPD, DI Guidelines and reparations framework.
  - While persons with disabilities worldwide contributed to the Guidelines, uptake and dissemination has not always been prioritised. Potential impact of SL limited unless and until survivors and OPDs are demanding it.
  - Leadership is crucial, and ensuring the leadership of survivors is a pre-requisite to achieving change – and, indeed, in informing SL in the future.

Thank you!

Steven Allen
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the Human Rights Foundation ReDo

Ketil Njaa Solberg memorial fund

Ketil Njaa Solberg's human rights award - for battle against infringements, abuse and coercion in mental health - 2024