

American Psychiatric Association



World Psychiatric Association



Remigiusz Achilles Henczel, President, United Nations Human Rights Council
Juan E. Mendez, Special Rapporteur on Torture
Office of the High Commissioner for Human Rights
United Nations Office at Geneva
CH-1211 Geneva 10
Switzerland

December 9, 2013

Dear Mr. Henczel and Mr. Mendez,

The **American Psychiatric Association (APA)** and the **World Psychiatric Association (WPA)** are providing a joint statement in response to the report of Special Rapporteur on Torture (A/HRC/22/53), Juan E. Mendez, submitted to the 22nd Session of the United Nations' Human Rights Council (UNHRC). Mr. Mendez's report focused on "certain forms of abuses in health-care settings" that may constitute forms of torture or cruel, inhuman or degrading treatment or punishment. The APA and WPA wish to express great concern regarding the possibility of the definition of "torture" encompassing a range of practices employed by psychiatrists, including (1) the use of involuntary civil commitment, (2) the provision of treatment delivered under the auspices of guardianship and other currently accepted legal processes, and (3) the use of restraint. The APA and WPA are greatly concerned that the adoption of these perspectives and recommendations may be detrimental to the interests of individuals with serious mental disorders, and likely to cause serious harm to the very groups it intends to protect.

Please find attached the following items for consideration: Attachment 1, a paragraph-by-paragraph response to the report of the Special Rapporteur; Attachment 2, a list of recommendations for consideration by the UNHRC; and Attachment 3, a list of official APA position statements relevant to the issue at hand. The APA and WPA greatly welcome the opportunity for further discussion to facilitate a greater understanding of the issue. Please feel free to contact us at internationaloffice@psych.org for any follow-up. Thank you for your consideration.

Respectfully,

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cc
Ambassador Samantha Power, U.S. Representative to the United Nations
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ATTACHMENT 1: Paragraph-by-Paragraph Response to A/HRC/22/53

Below are excerpts from the report of the Special Rapporteur followed by responses for each cited statements. Statements have been provided for paragraphs 32, 35, 63-66, 68, 69, 85(e), and 89(b), (d).

Paragraph 32. The mandate has recognized that medical treatments of an intrusive and irreversible nature, when lacking a therapeutic purpose, may constitute torture or ill-treatment when enforced or administered without the free and informed consent of the person concerned (ibid., paras. 40, 47). This is particularly the case when intrusive and irreversible, non-consensual treatments are performed on patients from marginalized groups, such as persons with disabilities, notwithstanding claims of good intentions or medical necessity. For example, the mandate has held that the discriminatory character of forced psychiatric interventions, when committed against persons with psychosocial disabilities, satisfies both intent and purpose required under the article 1 of the Convention against Torture, notwithstanding claims of “good intentions” by medical professionals (ibid., paras. 47, 48). In other examples, the administration of non-consensual medication or involuntary sterilization is often claimed as being a necessary treatment for the so-called best interest of the person concerned.

There is agreement to the first sentence of paragraph 32 that any treatment without a therapeutic purpose constitutes, at a minimum, ill-treatment. However, the paragraph subsequently asserts that “the *discriminatory character of forced psychiatric interventions* [emphasis added], when committed against persons with psychosocial disabilities, satisfies both intent and purpose required under the article 1 of the Convention against Torture, notwithstanding claims of “good intentions” by medical professionals.” Having begun by condemning treatment with no therapeutic purpose, the Special Rapporteur links such treatment to all involuntary psychiatric intervention when, in fact, involuntary treatment used in appropriate circumstances and when medically indicated, can restore the functional and decisional capacity of persons with severe psychiatric disorders, and can protect them and others from the behavioral consequences of their conditions.

Paragraph 35. The doctrine of medical necessity continues to be an obstacle to protection from arbitrary abuses in health-care settings. It is therefore important to clarify that treatment provided in violation of the terms of the Convention on the Rights of Persons with Disabilities – either through coercion or discrimination – cannot be legitimate or justified under the medical necessity doctrine.

There is disagreement with the conclusion in paragraph 35 that it is “important to clarify the treatment provided in violation of terms of the Convention on the Rights of Persons with Disabilities – either through coercion or discrimination – cannot be legitimate or justified under the medical necessity doctrine.” Although not sufficient by itself to justify involuntary treatment of capable persons, “medical necessity” is a cornerstone of insuring that involuntary treatment is used only when appropriate and when other interventions are not likely to be successful.

Paragraph 63. The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint may constitute torture and ill-treatment (A/63/175, paras. 55-56). The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment (A/66/268, paras. 67-68, 78). Moreover, any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment.⁷⁸ It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions. The environment of patient

powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-consensual treatment, such as forced medication and electroshock procedures.

There is agreement that solitary confinement and prolonged restraint are problematic practices and can constitute abuse. However, there is disagreement that "restraint on people with mental disabilities...constitute torture and ill-treatment." For psychotic patients attempting to severely injure themselves or others, restraint may be the only way to prevent severe injury to the patient and essential to the protection of other patients and staff. It should be noted that patients in restraint must be monitored carefully and such restraints must only be used for the shortest amount of time possible. Short-term restraint, when applied humanely, can be life-saving.

Paragraph 64. The mandate continues to receive reports of the systematic use of forced interventions worldwide. Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment.⁷⁹ Forced interventions, often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged "best interest" of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment (A/63/175, paras. 38, 40, 41). Concern for the autonomy and dignity of persons with disabilities leads the Special Rapporteur to urge revision of domestic legislation allowing for forced interventions.

There is agreement that when "involuntary treatment" is used to inflict severe pain and suffering, rather than for the patient's benefit, it may constitute cruel inhuman and degrading treatment. However, there is disagreement with the statement that "involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment." It should be recognized that involuntary treatment, when used appropriately, is not a form of torture or ill-treatment.

Paragraph 65. Millions of people with disabilities are stripped of their legal capacity worldwide, due to stigma and discrimination, through judicial declaration of incompetency or merely by a doctor's decision that the person "lacks capacity" to make a decision. Deprived of legal capacity, people are assigned a guardian or other substitute decision maker, whose consent will be deemed sufficient to justify forced treatment (E/CN.4/2005/51, para. 79).

There is disagreement with the statement that circumstances, in which illegitimate motives that may underlie interventions, ostensibly intended to protect persons with psychiatric disorders, are present in all such interventions. An appropriate decision that a person lacks the ability to make decisions for himself or herself (e.g. an elderly person with severe dementia), and reached by means protecting the rights of such a person, should be commended and not condemned.

Paragraph 66. As earlier stated by the mandate, criteria that determine the grounds upon which treatment can be administered in the absence of free and informed consent should be clarified in the law, and no distinction between persons with or without disabilities should be made.⁸⁰ Only in a life-threatening emergency in which there is no disagreement regarding absence of legal capacity may a health-care provider proceed without informed consent to perform a life-saving procedure.⁸¹ From this perspective, several of the 1991 Principles may require reconsideration as running counter to the provisions of the Convention on the Rights of Persons with Disabilities (A/63/175, para. 44).

There is disagreement with the second sentence of paragraph 66 as it suggests that the disagreement of a single individual, regarding a person in need of an emergency procedure not capable of consent, is sufficient to block

the procedure. In an emergency, reasonable professional judgment should be relied upon to determine whether a person is competent to make a treatment decision. The mere presence of a dissenting opinion that goes against the consensus of medical professionals involved in the case should not be permitted to halt life-saving procedures.

Paragraph 68. Involuntary commitment to psychiatric institutions has been well documented.⁸³ There are well-documented examples of people living their whole lives in such psychiatric or social care institutions.⁸⁴ The Committee on the Rights of Persons with Disabilities has been very explicit in calling for the prohibition of disability-based detention, i.e. civil commitment and compulsory institutionalization or confinement based on disability.⁸⁵ It establishes that community living, with support, is no longer a favourable policy development but an internationally recognized right.⁸⁶ The Convention radically departs from this approach by forbidding deprivation of liberty based on the existence of any disability, including mental or intellectual, as discriminatory. Article 14, paragraph 1 (b), of the Convention unambiguously states that “the existence of a disability shall in no case justify a deprivation of liberty”. Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished. This must include the repeal of provisions authorizing institutionalization of persons with disabilities for their care and treatment without their free and informed consent, as well as provisions authorizing the preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness (A/HRC/10/48, paras. 48, 49).

There is disagreement with the conclusion of the last two sentences of paragraph 68 regarding the abolishment of institutionalization legislation. The hospitalization of persons with psychiatric disorders can be life-saving, and result in restoring a person with the ability to direct his or her own life.

Paragraph 69. Deprivation of liberty on grounds of mental illness is unjustified if its basis is discrimination or prejudice against persons with disabilities. Under the European Convention on Human Rights, mental disorder must be of a certain severity in order to justify detention.⁸⁷ The Special Rapporteur believes that the severity of the mental illness is not by itself sufficient to justify detention; the State must also show that detention is necessary to protect the safety of the person or of others. Except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of “unsound mind”.⁸⁸ As detention in a psychiatric context may lead to non-consensual psychiatric treatment,⁸⁹ the mandate has stated that deprivation of liberty that is based on the grounds of a disability and that inflicts severe pain or suffering could fall under the scope of the Convention against Torture (A/63/175, para. 65). In making such an assessment, factors such as fear and anxiety produced by indefinite detention, the infliction of forced medication or electroshock, the use of restraints and seclusion, the segregation from family and community, etc., should be taken into account.⁹⁰

There is disagreement with the statement that the “severity of...mental illness is not by itself sufficient to justify detention.” It should be noted that the severe impairment and suffering as a result of mental illness can be an appropriate basis for involuntary hospitalization. There also seems to be some inconsistency with the statement in paragraph 68 calling for the “repeal of provisions authorizing institutionalization” and paragraph 69 which states that institutionalization is unacceptable “if its basis is discrimination or prejudice against persons with disabilities.” This may leave the door open to the use of involuntary hospitalization when “necessary to protect the safety of the person or others” after this notion was apparently rejected in the previous paragraph.

Paragraph 85 (e). Safeguard free and informed consent on an equal basis for all individuals without any exception, through legal framework and judicial and administrative mechanisms, including through policies and practices to protect against abuses. Any legal provisions to the contrary, such as provisions allowing confinement or compulsory treatment in mental health settings, including through guardianship and other substituted decision-making, must be revised. Adopt policies and protocols that uphold autonomy, self-determination and human dignity. Ensure that information on health is fully available, acceptable, accessible and of good quality; and that it is imparted and comprehended by means of supportive and protective measures such as a wide range of community-based services and supports (A/64/272, para. 93). Instances of treatment without informed consent should be investigated; redress to victims of such treatment should be provided;

There is disagreement with the recommendation of paragraph 85, section e. Clarification and alternate recommendations are provided in Attachment 2: APA and WPA Recommendations for Consideration by the UNHRC.

Paragraph 89 (b). Impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application. The obligation to end forced psychiatric interventions based solely on grounds of disability is of immediate application and scarce financial resources cannot justify postponement of its implementation; 127

There is disagreement with the recommendation of paragraph 89, section b. Clarification and alternate recommendations are provided in Attachment 2: APA and WPA Recommendations for Consideration by the UNHRC.

Paragraph 89 (d). Revise the legal provisions that allow detention on mental health grounds or in mental health facilities, and any coercive interventions or treatments in the mental health setting without the free and informed consent by the person concerned. Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished.

There is disagreement with the recommendation of paragraph 89, section d. Clarification and alternate recommendations are provided in Attachment 2: APA and WPA Recommendations for Consideration by the UNHRC.



ATTACHMENT 2: APA/WPA Recommendations for Consideration

Psychiatric disorders, such as schizophrenia, bipolar disorder, and major depressive disorder, along with neurodegenerative disorders such as Alzheimer disease, can impair attention, memory, information processing, emotional regulation, and other brain functions. Persons suffering from psychotic disorders may experience delusional ideation (e.g., believing that other people are controlling their minds) or hallucinatory perceptions (e.g., hearing voices telling them that they are evil and deserve to die). During a major depressive episode, persons may suffer psychic pain so severe that they see no recourse but to end their lives. Although most people with psychiatric disorders retain the capacity to make decisions for themselves—including medical treatment decisions—others lose such capacity, especially during the most acute phases of their illnesses. At such times, they may lack the ability to recognize that they are suffering from an illness or to identify treatments that are likely to be in their interests. Moreover, their illnesses may lead them to behave in ways that are likely to cause serious harm to themselves or other people.

From APA Clinical Practice Guidelines:

The decision to hospitalize a patient involuntarily will depend on multiple factors, including the estimated level of risk to the patient and others, the patient's level of insight and willingness to seek care, and the legal criteria in that jurisdiction. In general others will satisfy the criteria for involuntary admission; however, the specific requirements vary from state to state, and in some states, willingness to enter a hospital voluntarily may preclude involuntary admission. To that end, psychiatrists need to be familiar with their specific state statutes regarding involuntary hospitalization.

Advance directives are attempts to ensure that individuals' wishes about treatment will be honored. Such directives may relate to wishes about treatment at the end of life but may also relate to wishes about psychiatric treatment or assignment of a durable power of attorney or health care proxy to make decisions in the event that the individual lacks capacity to do so. Although the specifics of advance directive regulations vary by jurisdiction, psychiatrists should include in their evaluation whether the patient has executed an advance directive and, if so, the nature of the advance directive should be determined.

In response to the need to protect and treat persons with psychiatric disorders who cannot make capable decisions and/or present a serious risk of harm to themselves or to other people, most countries have developed law and procedures permitting involuntary hospitalization and treatment. The standards and procedures for such interventions differ across jurisdictions. However, when properly implemented, involuntary hospitalization and treatment are reserved for persons who are incapable of making decisions for themselves and/or who as a result of their psychiatric disorders pose a serious risk of harm to themselves or to other people. In addition, except in emergencies, prior to the implementation of involuntary interventions, persons with psychiatric disorders should be afforded appropriate procedural protections intended to protect their rights, encompassed by the term "due process."

Most persons with psychiatric disorders, of course, are not and should not be subject to involuntary interventions. They retain the capacity to make treatment decisions and pose no serious risk to themselves or to other people. However, for the minority of persons who are sufficiently disabled by their disorders to be unable to protect their own interests and/or who endanger themselves or others, the existence of involuntary interventions may be life-saving and may hold the prospect of restoring them to a fully functional, independent life. For this reason, the characterization of involuntary interventions for people with psychiatric disorders in the report is inaccurate and that the related recommendations are harmful and should be reconsidered.

In contrast to the approach recommended by the Special Rapporteur, the APA and the WPA recommend the following:

- 1) that involuntary interventions for psychiatric disorders be recognized as appropriate when persons are incapable of making decisions about their treatment and/or present a serious risk of harm to themselves or other people, and when no less intrusive means are likely to be effective; and
- 2) the rights of people with psychiatric disorders be protected by encouraging every country to develop
 - (a) clear criteria for the use of involuntary interventions, consistent with the criteria in (1),
 - (b) procedures designed to protect the rights of persons with psychiatric disorders, including impartial judicial or administrative review of decisions regarding findings of incapacity, and requests for involuntary hospitalization and involuntary treatment, and
 - (c) mechanisms to investigate improprieties and abuses in the use of involuntary interventions, with appropriate penalties.