

Tina Minkowitz, JD, LLM

**Comments on draft General Comment 6 on Article 5, equality and non-discrimination**

Introduction

The Center for the Human Rights of Users and Survivors of Psychiatry is a user/survivor-run human rights organization that has special consultative status with UN ECOSOC. CHRUSP President Tina Minkowitz contributed to the drafting of CRPD as representative of the World Network of Users and Survivors of Psychiatry, and has previously served international DPOs as WNUSP co-chair and IDA chair. CHRUSP conducts advocacy and capacity-building activities at the global, national and international (cooperative) levels to promote legal capacity for all, an end to forced psychiatric interventions and psychiatric deprivation of liberty, and availability of support that respects the person’s will and integrity, see <http://www.chrusp.org>, contact information [info@chrusp.org](mailto:info@chrusp.org). CHRUSP activities include a CRPD course from survivor of psychiatry perspective taught by Ms Minkowitz, see <http://crpdcourse.org>, and a campaign for the absolute prohibition of mental health commitment and forced treatment, see <http://absoluteprohibition.org>.

This submission addresses a wide range of topics covered in the draft General Comment, in the sequence in which they appear paragraph by paragraph.

1. Torture and ill-treatment (paragraph 8)

I find it difficult to read the catalog of practices deemed to be torture or other ill-treatment against persons with disabilities including some that are forced medical interventions, and see that there is no mention of forced drugging and forced electroshock. The Committee has recently seemed to back away from its earlier understanding that forced or coerced administration of psychiatric drugs such as neuroleptics is a profound human rights violation.[[1]](#footnote-1) This basic, routine practice that is both widespread and systematic everywhere in the world that psychiatry has penetrated, is the key human rights violation against the integrity of persons with psychosocial disabilities. This widespread and systematic violation, of which I myself am a survivor, was the origin and genesis of Articles 15 and 17 of the Convention and the standard articulated by Special Rapporteur on Torture Manfred Nowak, which proclaimed that

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]](#footnote-2)

Significantly, Special Rapporteur Nowak rejected the notion that ‘therapeutic necessity’ could justify forced interventions that aim at correcting or alleviating a disability,[[3]](#footnote-3) and he left no doubt that psychiatric drugs such as neuroleptics, as well as electroshock and psychosurgery, were the prime example of disability-based practices that qualify as acts of torture and ill-treatment.

I cannot guess at the cause for the Committee’s failure to mention these practices consistently as disability-based violence and call for their immediate abolition. As I have pointed out to the Committee, and as Manfred Nowak acknowledged in his report, nonconsensual administration of psychotropic drugs including neuroleptics is universally and uncontroversially condemned as torture when it is done to presumptively non-disabled people. Failure to address this widespread and systematic practice of violence against people with psychosocial disabilities, which as I have demonstrated meets the criteria for torture,[[4]](#footnote-4) as an Article 15 violation, is itself an act of discrimination.

1. Concept of transformative equality (paragraphs 10 and 11)

Transformative equality has a dynamic dimension that goes beyond both formal and substantive equality to require active intervention to remove the systemic causes of inequality insofar as they can be identified.[[5]](#footnote-5) The CRPD itself, as a process that allowed people with disabilities to transform international law from a starting point of our lived experience and claims for justice, can be viewed as a transformative equality practice. Its implementation and monitoring at the national as well as international levels similarly need to reflect a dynamic dimension of close consultation (Article 4.3) allowing PWD to lead the transformative work of law and policy reform, and adherence to the transformative values expressed in the text. In addition transformative equality requires continual reflection that allows all justice claims of people with disabilities to be considered and innovations adopted when those claims are coherent with the fundamental principle of equality, understood not only as a human right but as a philosophical premise about both worth and power.

1. Equality under the law and equal benefit of the law (paragraphs 15-18)

There is a gap between the conceptualization of equality under the law as prohibiting disability-specific restrictions (para 16) and equal benefit of the law where the Committee focuses on positive measures. As the Committee may be aware, some academics have proposed measures that are designed to achieve the purpose of limiting the exercise of legal capacity by people with disabilities, by crafting broad general legislation that will either expand state intervention into everyone’s sphere of personal autonomy, or, more likely, will be used discriminatorily against people with disabilities and other vulnerable group such as young women and older persons.[[6]](#footnote-6) Similar measures are commonly proposed to incorporate psychiatric forced hospitalization or institutionalization into capacity legislation, on the premise that it is no longer disability-specific, without taking account of the violation of both Articles 12 and 14 entailed in the use of capacity legislation for such a purpose. These proposals represent a threat to people with psychosocial disabilities, as they are discriminatory in purpose and inevitable effect, and risk opening a loophole for discriminatory measures that represent themselves as ‘disability-neutral’. The Committee should address this dimension of equality relative to the law, which probably fits best under ‘equal benefit’.

1. Equal basis with others (paragraph 19)

The Committee should acknowledge that ‘equal basis with others’ also means not restricting the rights of PWD compared with others – no more rights, *and no less rights*, in addition to the positive measures.

1. Direct discrimination (paragraph 20a)

In the examples of disability-based violence, please include forced psychiatric interventions. It would be helpful also to include deprivation of legal capacity and forced hospitalization or institutionalization, as examples of direct discrimination.

It is not clear why you separate out harassment as a category but include disability- based violence under ‘direct discrimination’. Conceptually they appear to be linked, both are direct and both are also an aggression against personal integrity. The CEDAW Committee’s jurisprudence on gender-based violence as a form of discrimination is exemplary and similar reasoning applies to violence targeting PWD that is directly related to their disability, including disability-related forced medical treatment (see below comments on linkage with Articles 14 and 15).

1. Associational discrimination (paragraph 21)

Associational discrimination should be semantically separated from discrimination based on attributed/presumed, past or predisposition to future impairment/disability, in order to maintain the intent of the CRPD to center PWD as the Convention’s rights-holders, who include survivors of forced psychiatric interventions.

Discrimination against a family member or other person associated with a PWD is different from discrimination against a person who is believed to have an impairment or to be predisposed to future impairment, or who may have had a past impairment. As we know, family members are not in the same position as PWD and often deliberately or inadvertently contribute to human rights violations against PWD. Family members and their organizations receive more public sympathy and support than PWD and DPOs, and are often wrongly elevated to speak on behalf of PWD. In contrast, the movement of users, ex-users and survivors of psychiatry and people with psychosocial disabilities in particular does not differentiate between those who experience actual mental health conditions, those who experienced such conditions in the past, and those who are/were presumed to have such conditions but reject the concept or its application to themselves. We all occupy the same de facto inferior status under the law, a form of discrimination that exposes us to additional discrimination in all areas of life.

1. Reasonable accommodation (paragraphs 24-28)

The reference to ‘specific medication modalities’ (para 24) is not clear, and could be mistaken as meaning that people with psychosocial disabilities should be medicated. Please clarify.

In paragraph 27, the verb ‘proving’ in subparagraphs (b) and (c) appears to place a burden of proof on the person requesting accommodation. Determination as to feasibility and relevance should be made based on all available evidence, without requiring the claimant to bear the burden. ‘Assessing whether’ would be more neutral and fair.

Regarding subparagraph (e), ‘objective’ is not necessarily determinative of result. Perhaps change to ‘is suitable to achieve the essential objective’ or otherwise focus on result related to the criteria that are given in that subparagraph.

1. Specific measures (paragraphs 29-31)

In paragraph 29, the reference to ‘respite care’ is problematic as this concept centers needs of carers rather than the PWD as rights holder entitled to independent living model supports. The reference to respite was originally proposed in the negotiations by WNUSP to promote ‘peer respites’ which are a form of crisis hostel or refuge run by and for persons with psychosocial disabilities.

Generally regarding this section, does the Committee consider positive measures required e.g. by Articles 12.3 and 19(b) to be specific measures in the sense of Article 5.4, and would it be desirable to so declare?

Regarding paragraph 31, please state that specific measures must not be adopted if they contravene any rights and principles of the Convention, or if they entail coercion, restriction or limitation of individual autonomy. This is important, as it may not be readily perceived as a form of discrimination unless highlighted. While the state has power to enact laws that restrict the autonomy of all persons (e.g. penal law or general regulatory law), Article 5.4 refers only to disability-specific measures, and unfortunately states regularly do attempt to justify coercive measures against persons with psychosocial disabilities as a means of realizing their human rights.

1. General obligations (paragraphs 32-40)

In paragraph 32, if not too complicated, indicate that the practice as well as the legalization of forced institutionalization and forced treatment in mental health services is discriminatory and must be abolished.

Regarding paragraph 33, anti-discrimination laws can cover the full scope of civil and political rights as well as economic/social/cultural, whether general or disability-specific. Voting, family relations, and legal capacity are all civil and political rights that can be brought under the framework of anti-discrimination obligations, as they are in the CRPD itself.

Regarding paragraph 34, disability-specific equality law must include and be governed by the international human rights standards of the CRPD itself; domestic law is not sufficient.

In paragraph 36, please add as an enforcement measure, taking steps to ensure that guarantees of equality contained in the CRPD are actionable in domestic courts, or that identical guarantees are enacted into domestic legislation and made actionable.

In 37, reiterate the caveat recommended above, stated more generally that specific measures must not have the purpose or result of restricting autonomy or otherwise infringing on enjoyment or exercise of rights by any PWD.

In 38, consultation obligations should not amalgamate lesbians with other groups, as lesbians face multiple discrimination based on sex including within the coalition denominated as LGBTI.

In 39, add ‘sex’ in addition to gender as a ground of discrimination, to fully guarantee the rights of all women and girls. The characterization of ‘sexual orientation’ as an ‘identity’ is inaccurate unless we also treat all other material demographic situations as such (race, sex, etc.). I would suggest the same is true of being intersex. Both are objective realities with definitive meanings.

In 40, the research also should be led by PWD as a matter of preference and states along with academia should cultivate and promote scholarship and critical studies based on the standpoint of persons with all types of disabilities, including Survivor Research and Survivor Knowledge as self-identified to describe the standpoint of survivors of psychiatry.

1. Relationship with other articles (section VII)

* De-link women with disabilities from children with disabilities

In 41 and 42, I don't see the need to link women with disabilities and children with disabilities; too often women are grouped with children suggesting infantilization of women and unworthiness of attention in their own right.

* Children with disabilities

In 43, indicate that it is not only a right to be heard but to have their views be given due weight. Also, though this is a nuanced point, the best interests principle even for children with disabilities can be misused when children, because of their disabilities, are viewed as warranting treatment that if done to others would be acknowledged as torture or other ill-treatment. See Nowak report A/63/175, para 49; the point holds for children as well as adults.

* Awareness-raising

In 44, include the stereotype of PWD as being ‘dangerous to themselves and others’ to be combatted, and the practice of forced disability-specific medical interventions that fails to uphold the equal worth of PWD as whole human beings having a right to respect for their physical and mental integrity.

* Situations of risk

In 53, please indicate that recovery and rehabilitation services must respect individual autonomy and integrity.

* Legal capacity

In 54, the date of GC1 is incorrect.

In 56, subparagraph (b), please specify the criteria for supported decision-making models, in particular: i) universal adult legal capacity without any form of discrimination; ii) support is made available to all PWD who need it, and must respect the autonomy, will and preferences of the person in all dimensions; iii) best interpretation of will and preferences replaces best interests determination in all matters related to adults where it is not practicable to determination the person’s will and preferences. You have addressed this somewhat in (c) but it belongs in (b) as characteristics of supported decision-making system rather than with resources. The reference to GC1 should be applied to the entire paragraph 56.

* Access to justice

Regarding access to justice, 13.1 is not limited to procedural accommodations, and state obligations and actions indicated in para 59 should include removal of legal barriers to PWD acting as parties, witnesses, or jurors in any proceedings, e.g. laws or regulations based on functional capacity or directly excluding PWD or a subgroup of PWD.

Paragraph 62a should be clarified; I suppose you mean that PWD should not be treated as if disability is their sole identity. Also bear in mind that the concept of intersectionality is more precisely related to oppression and discrimination than to identities as such. Sources of group identification are important to us as indicated, cultural, religious and social group identities, as well as political, ideological and even geographical identities, for which we may or may not experience discrimination. Subjective factors such as personal values and self-expression are also part of identity. The Committee should clarify what is intended here, and what is the relevance of complex identities and also intersecting discrimination, in the context of access to justice per se. Complexity of identity relates also to other articles including awareness-raising, training under Article 4, and simply as a general principle related to Article 5 that disability cannot be treated as a ‘master status’ of the individual.

Paragraph 62b seems to make a similar point about diversity of PWD simply as individuals. It is not clear whether diversity is also intended to address impairment groups, as sometimes is the case when we use the term. It is desirable to address this dimension of diversity to ensure that people with psychosocial disabilities and other groups overlooked or not contemplated as PWD under a social model are fully included, and that should be stated explicitly as an affirmative obligation towards under-represented groups.

* Articles 14 and 15

Regarding Articles 14 and 15: Please clarify in paragraph 63 that forced mental health treatment is by definition discriminatory. As I have written, and as Manfred Nowak acknowledged in his 2009 report as Special Rapporteur on Torture,[[7]](#footnote-7) the administration of electroshock or of psychotropic drugs such as neuroleptics against a person’s will is an instance of forced medical treatment to correct or alleviate a disability. This is discrimination in the sense of adverse action directed against a target group without any comparator, when performed as treatment for an actual or attributed mental health condition. If there is doubt as to whether it is performed with the aim of treatment, then it falls under the second prong of Nowak’s formulation, it is forced treatment lacking a therapeutic purpose. The 2009 report was well reasoned, informed by the CRPD, and consistent with the perspectives of the disability community on the topic presented.

It may be that the Committee refers to ‘discriminatory deprivation of liberty’ and ‘discriminatory forced treatment’ in mental health facilities as a characterization and not a limitation. It would be helpful to so indicate, because as written it may be misunderstood as implying that not all forced treatment or deprivation of liberty in mental health facilities, but only a subset that is considered discriminatory, is prohibited. Please clarify as this is a point of contention and misunderstanding among states parties and other actors.

In addition to clarifying in paragraph 63, it would be helpful to include an explanatory paragraph on forced mental health treatment as an important, perhaps primary, subset of forced treatment aimed at correcting or alleviating a disability, explaining it as discrimination with the reasoning supplied.

* Article 27

Paragraph 73d is unclear; does it refer to hiring and firing, or to retirement, or include all these? Please clarify.

Please clarify also paragraph 73g; is it a requirement for universally-designed occupational safety and health regulations that are non-discriminatory and inclusive/ attentive to the requirements of PWD?

Paragraph 73i should address all facets in which PWD are entitled to non-discrimination, e.g. recruitment, hiring, dismissal, pay, conditions of work. Also reasonable accommodation in the workplace needs to be addressed explicitly in 73i, and/or 73f needs to be reworded to address reasonable accommodation not only in training and education but also in the workplace itself.

* Article 28 absent?

Article 28 is highly relevant as the Committee has made significant contributions on the human rights violations caused by austerity measures. Linkage to Article 28 is an opportunity to develop further the obligation of non-discrimination in enjoyment of all economic, social and cultural rights.

* Article 29

Please include in 74 chapeau or 74a a reference to ‘functional capacity’ approach that has been used to limit right to vote of PWD.

1. Implementation at national level

Paragraph 76b is unclear as to the meaning of ‘broad impairment-related’ definition of disability. I think the intention is to ensure that a wide range of impairment groups are included, but it is left open as to which those are. If this is the Committee’s intention, there should be a reference to Article 1 enumerated groups as a minimum, so that no one is left out, and a forthright acknowledgement that the Committee recognizes persons with psychosocial disabilities (and perhaps autistic persons) under the category of ‘mental impairment’ and uses the terminology preferred by those DPOs.

Paragraph 76c should add ‘forced psychiatric interventions’ or ‘forced mental health treatment’ to the items of disability-specific discrimination, and should further indicate that the full range of civil, political, economic, social and cultural rights should be covered by anti-discrimination legislation. E.g. discrimination in voting or in parental rights may or may not be covered as deprivation of legal capacity, depending on the wording of national legislation.

In paragraph 76d, please add ‘disability-based violence’ as a form of discrimination in its own rights, possibly linked to harassment (see comments above on paragraph 20a).

In paragraph 76e the phrasing should be ‘organizations representing the diverse range of persons with disabilities’ to be clear about multiplicity and avoid misunderstandings such as the notion that governments can choose organizations they deem to be representative from among those actually formed by PWD.

Remedies are addressed in both 76g and 76h, and the relationship between them might be clarified. In addition, the Committee should consider referring to the reparations framework as it did in the Guidelines on Article 14, and could link to paragraph 24 of the Guidelines as example of earlier jurisprudence. Note that the CEDAW Committee invoked the reparations framework for obligation of non-discrimination in General Recommendation 28 (paragraphs 32 and 37b).

Regarding 76k, the Washington Group short set of questions cannot achieve the purpose of Article 31 to monitor anti-discrimination policy and laws as they affect persons with psychosocial disabilities. That set of questions is discriminatory and cannot be reconciled with Article 1 which requires that the rights and freedoms of all PWD be guaranteed on an equal basis with others. Please refrain from endorsing any methodology until such time as persons with psychosocial disabilities have had the opportunity to be adequately consulted and participate in developing appropriate questions.

In 76l, indicate that the national mechanisms should conduct their work in close consultation with DPOs.

In 76m, following comments above on paragraph 38, please spell out the different constituencies and do not incorporate lesbians in particular into the formulation LGBTI.

In 76n, indicate that the services provided must reflect the social model of disability and respect the individual’s autonomy, will and preferences.

1. Concluding Observations on Peru (2012). [↑](#footnote-ref-1)
2. A/63/175. See also Annex III to report of the OHCHR expert meeting on torture and people with disabilities, <http://www2.ohchr.org/english/issues/disability/docs/torture/AnnexIII.ppt>, Minkowitz, UN CRPD and the Right to be Free from Nonconsensual Psychiatric Interventions, Syracuse J. Intl. Law & Commerce 34:405 (2007). [↑](#footnote-ref-2)
3. See also para 49 of that report. [↑](#footnote-ref-3)
4. See Minkowitz (2007), full citation above. [↑](#footnote-ref-4)
5. See Minkowitz, CRPD and Transformative Equality, International Journal of Law in Context, 13,1 pp. 77–86 (2017) © Cambridge University Press 2017 doi:10.1017/S1744552316000483. [↑](#footnote-ref-5)
6. See Minkowitz (2017), full citation above. [↑](#footnote-ref-6)
7. Sources in footnote 3 above; please see paragraphs 38-40 and 47 of Nowak report in particular. [↑](#footnote-ref-7)