BEFORE THE UNITED NATIONS HUMAN RIGHTS COMMITTEE

Secretariat of the Committee Against Torture

UNOG- Office of the High Commission for Human Rights

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Switzerland

IN THE MATTER OF NEW ZEALAND'S 6th PERIODIC REPORT BEFORE THE COMMITTEE AGAINST TOTURE

Submission by the Citizens Commission on Human Rights (CCHR) for the United Nations Committee Against Torture, as an NGO shadow report. This report is in addition to previous reports submitted as part of New Zealand's 5th Periodic Report and subsequent comments and lists of issues prepared by the Committee

February 2015

Introduction

The Citizens Commission on Human Rights has previously submitted two reports relating to New Zealand's 5th Periodic Report to the Committee Against Torture. We acknowledge the Committee for their duplication and attention to detail of CCHR's earlier submissions and that of other submitters, with your follow-up list of issues. We felt this helped to focus the State's attention on relevant matters of concern. The knowledge and understanding the Committee and Rapporteur had of the various situations on the ground in New Zealand has given a huge boost to civil society, who for decades have been pushing up against solid brick walls. There is still a long way to go, but with the continued pressure from international committees there is hope to really get human rights properly established throughout society, especially in support and protection of the vulnerable such as those in mental health facilities, who we are mostly concerned with.

The situation in New Zealand is largely unchanged since these reports and the Committee's subsequent comments and lists of issues prepared by the Committee and therefore we wish this submission to be in addition to those. So as to save time and repetition we will attempt to not go over issues that have already been brought to the Committee's attention.

The latest submission of the New Zealand government (4 March 2014) was prepared towards the end of 2013. CCHR submitted a report to the NZ government at this time to provide more context to the government's final report to UNCAT. CCHR's brief submission is attached as Appendix A which addresses the various issues in response to the CAT list of issues of 12 July 2012.

Some Mechanisms are in Place

Mechanisms are mostly in place to <u>prevent</u> ill-treatment and torture with the changes to the Crimes of Torture Act in 2007. This saw the introduction of the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which has seen the establishment of the national preventative mechanism—although this is under resourced making the processes not as effective as they need to be (which is submitted by various other parties).

Independent inspectors exist through OPCAT, though once issues are found there is no body or process (including resources) to impartially and fairly investigate the victim's claims, then to forward this on to prosecution. When an issue is located the matter is brought to the authority's attention and often addressed so that the ill-treatment does not continue, however there is no mechanism to support the victim through this and provide any remedies per the Convention, including the prosecution of a perpetrator.

CCHR is also aware of the importance of employing the right people, proper leadership and experience for those who are put into these roles; maintaining their independence in a small country and whether they have the ability to actually carry out their responsibilities. Meaning, will government officials allow them to do their job, to take allegations seriously, be independent, establish processes that will allow instances of ill-treatment to be investigated promptly and impartially, perpetrators duly prosecuted, and the victims accorded redress, including adequate compensation and rehabilitation (in short apply the Convention as indicated by the Committee)?

The government has also established a means to "listen" (with the Confidential Forum for ex-Psychiatric Patients and the current Listening Service) to victims of ill-treatment, however it seems designed to be "in-house" and "contained" and "protected", not to fulfil obligations under the convention. This was even written about in the NZ Law Journal where it was suggested a low level forum where people could be listened to and acknowledged; therefore purposefully removing the majority of the threat of litigation, bad press, etc. as the victims are effectively silenced. This may be a harsh view, but it is self-evident.

Further, the government also established a means to provide an apology and "compensation"; however this is far from adequate and in fact legally restricted to "ex-gratia payments" in order to nullify any chance of liability or prosecution in the future, for the ill-treatment and abuse that occurred primarily in state-run institutions.

Obstacles to implementing the Convention

We wish to provide some dialogue from our knowledge and experience on the ground in New Zealand, relevant to the 6th periodic review, that we hope will give the Committee further insight into the situation so as to facilitate faster uptake and implementation of more targeted recommendations for the State and others to follow.

The three wise monkeys. "See no evil, hear no evil, speak no evil".

Does torture or ill-treatment exist in New Zealand?

The three wise or mystic monkeys are often used in the western world when there is a denial or turning a blind eye towards corruption, though in this case we are looking at torture and other cruel, inhuman or degrading treatment or punishment.

As discussed at length in our previous submissions, the State seemed to have a lack of will to investigate and prosecute as indicated in the Convention. Their inability to fully see that torture and other cruel, inhuman or degrading treatment or punishment – globally as ill-treatment – actually had and/or does occur in New Zealand, is possibly at the root of their inaction towards full implementation of the Convention. A lack of confront on issues will lead to inaction, which we believe is why there is little chance of properly determining perpetrators and duly prosecuting them.

We do not believe that all the officials in government are evil or bad or criminal. In actuality it is most likely due to the fact that they are honest and good that they are unable to see that someone could or would commit such acts of ill-treatment and torture, especially to the more vulnerable people in our country.

Due to this, we believe the State has a somewhat blinkered view of torture and their obligations to prevent torture and other cruel, inhuman or degrading treatment or punishment. There is a natural abhorrence to the word and when you read the State report in response to the Committee's list of issues, it reads as though they don't see it occurs in their country, especially in relation to the historic cases of psychiatric and welfare abuse within State institutions.

Obviously with international relations, politics, the economy and trade; talk of torture runs against all efforts to promote New Zealand's clean, green image and the need to purely focus the official's attention on looking the best.

Unfortunately this attitude provides an environment whereby perpetrators could hide under the radar easier and where ill-treatment could go undetected; or where it is found, brushed aside, not believed, including the utilisation of legal teams and public relations experts to squash, hide, minimise, suppress and sometimes outright deny.

The General Comments No. 2 and No. 3 of the Committee against Torture and the Implementation of articles 2 and 14 by States parties touch on this. General Comment No. 3 says:

Obstacles to the Right to Redress

37. A crucial component of the right to redress is the clear acknowledgement by the responsible State party that the reparative measures provided or awarded to a victim are for violations of the Convention, by action or omission.

There is no acknowledgement at all that the hundreds of cases of ill-treatment in State institutions have anything to do with the Convention. This is fundamental to being able to apply the Convention.

17. A State's failure to investigate, criminally prosecute, or to allow civil proceedings related to allegations of acts of torture in a prompt manner, may constitute a de facto denial of redress and thus constitute a violation of the State's obligations under article 14.

This is also covered in General Comment No. 2 of the Committee against Torture.

3. The obligation to prevent torture in article 2 is wide-ranging. The obligations to prevent torture and other cruel, inhuman or degrading treatment or punishment (hereinafter "ill-treatment") under article 16, paragraph 1, are indivisible, interdependent and interrelated. The obligation to prevent ill-treatment in practice overlaps with and is largely congruent with the obligation to prevent torture. Article 16, identifying the means of prevention of ill-treatment, emphasizes "in particular" the measures outlined in articles 10 to 13, but does not limit effective prevention to these articles, as the Committee has explained, for example, with

respect to compensation in article 14. In practice, the definitional threshold between ill-treatment and torture is often not clear. Experience demonstrates that the conditions that give rise to ill-treatment frequently facilitate torture and therefore the measures required to prevent torture must be applied to prevent ill-treatment.
Accordingly, the Committee has considered the prohibition of ill-treatment to be likewise non-derogable under the Convention and its prevention to be an effective and non-derogable measure.

And

The Committee considers that amnesties or other impediments which preclude or indicate unwillingness to provide prompt and fair prosecution and punishment of perpetrators of torture or ill-treatment violate the principle of non-derogability.
6. The Committee reminds all States parties to the Convention of the non-derogable nature of the obligations undertaken by them in ratifying the Convention.

There are many issues old and new that fall under the State's obligations, that which are primarily ignored. An example of the extent of the issue surrounds hundreds of deaths in State run psychiatric hospitals that have never been properly investigated, and probably never questioned. We provide a photo we took of an empty field beside Tokanui Hospital and we know similar fields exist at other hospitals around the country. While some of the deaths could be legitimate, the fact that the inexact number of people buried there is troubling.

To highlight a recent example of ill-treatment, other than those mentioned in the OPCAT reports--which referred to patients being restrained in seclusion for very long periods of time, the longest was for six (6) years.

Two weeks ago a young woman decided to speak out how she was abused within a psychiatric facility and was afraid to make a complaint directly with the hospital for fear of reprisals. [Reference, Sunday Star-Times, January 25 2015. http://www.stuff.co.nz/national/health/65394326/Electric-shock-therapy-in-the-modern-day]

> *Emma lives with her dad, is interested in politics and plays piano. Her favourite composer is Chopin. She studies maths and psychology at Wellington's Victoria University.*
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> *Two years ago, aged 18, she tried to kill herself and was placed under the Mental Health Act in Wakari psychiatric ward near Dunedin. During her stay she says she was diagnosed with depression, forced to have seven rounds of electroconvulsive therapy (ECT) and injected with sedatives.*
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> *Nothing was working; she was tired of being away from home and tried to kill herself again.*
>
> *Emma (not her real name) says she was then pinned down by nurses, stripped naked and locked in a small room - part of a practice called seclusion - inside the forensic ward; the general psychiatric seclusion rooms were full. They had also run out of gowns.*
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> *On the hard floor there was no mattress or pillow, she says, despite these being mandatory items for patients in seclusion. Emma used a blanket to cover her body from nurses routinely peeping through the observation window.*
>
> *She rested her head on the cardboard bedpan she'd been given to use as a toilet and relieved herself on the floor, she says.*

We could quote the whole of the Committee Against Torture General Comments No's 2 and 3 as being completely relevant to New Zealand and feel that they are not being applied, which in fact has been pointed out by the Committee and other submitters. Perhaps it could be recommended by the Committee that the State familiarise itself with these and specifically apply them to the State abuses as pointed out by the Committee as part of the 5th Periodic Review.

In all the historic state abuse cases, victims were forced into a regime of having to prove themselves to authorities, as victims, take out a prosecution against the government and most had to appeal for legal aide. Many didn't meet the threshold for various reasons, such as: denial of legal assistance; too traumatic to relive; have to face perpetrators; have to prove themselves to authorities that didn't believe them before, often fobbing them off and saying they are delusional, etc.

The State seemed to go out of its way to distance itself, nullify, deny and prove wrong, any complainant that came forward. The viewpoint seemed that if they could prove in court or defend the allegations of ill-treatment and torture, so it could not go to court, then they would not have any legal or other obligations (e.g. no need to pay, rehabilitate, fully investigate, etc.).

26. Notwithstanding the evidentiary benefits to victims afforded by a criminal investigation, a civil proceeding and the victim's claim for reparation should not be dependent on the conclusion of a criminal proceeding. The Committee considers that compensation should not be unduly delayed until criminal liability has been established. Civil liability should be available independently of the criminal proceeding and necessary legislation and institutions for such purpose should be in place. If criminal proceedings are required by domestic

legislation to take place before civil compensation can be sought, then the absence or undue delay of those criminal proceedings constitute a failure on behalf of the State party to fulfil its obligations under the Convention. Disciplinary action alone shall not be regarded as an effective remedy within the meaning of article 14.

The police criminal investigation into the head psychiatrist, Dr Leeks lasted eight (8) years, which disillusioned the victims. Some gave up or didn't even bother putting a claim in to the Police, disillusioned with the whole process. They could not understand why priests and teaching staff would be extradited and face court action and be convicted (sometimes for crimes older than those of Lake Alice), though nothing seemed to happen when it came to a psychiatrist or mental health staff.

During their time at the Child and Adolescent Unit, a few child victims managed to escape, however they were always found, usually by the Police, and even though they would complain about what was happening to them, this fell on deaf ears and they were delivered back into the hands of the perpetrators of the ill-treatment and punishment. Invariably what ensued was more punishment, standardly more severe than before as they dared to defy their "torturers" who had to teach them a lesson. It is not hard to see how this was re-traumatising these victims and stopping them from pursuing redress or a form of justice, when similar authorities today would not act in support of them when they were children and not believed.

In a Commission of Inquiry into a Niuean boy who had complained about being given ECT against his will (1977), the judge took the psychiatrist's view that it was okay to give children shocks without anaesthetics because their bones were not brittle and would not break from the severe muscle contractions that would occur from the high level of voltage going through their bodies (there have been many reports of adults having their back and other bones broken when being given electroshock treatment). This approach to children and youth was appalling of the day, let alone now. How does one deal with an insurmountable force of medical legitimacy justifying ill-treatment?

In the interest of finding out why the State did not pursue a criminal conviction, two CCHR staff met with the Detective Superintendent who conducted the investigation (now Assistant Commissioner) in January of this year, to gain a better insight into the police investigation and procedure regarding the ill-treatment of children at Lake Alice Child and Adolescent Unit by the psychiatrist and nurses. Although it seems that the investigation followed usual procedure, this is perhaps where the issues arise, as the police did not view these cases in the context of the Convention (although perhaps in this case it was due to the fact the events in question occurred prior to the introduction of separate legislation on crimes of torture in NZ). The psychiatrist or psychiatric nurses had not recorded in the medical notes that they shocked and drugged the children and youth for punishment on the hands, shoulders, legs and genitals, etc., nor did any of the staff come forward to confess. Where a staff member refused to be interviewed, including the psychiatrist at the centre of the allegations, the police did not pursue this saying it was their right not to provide a statement, and so decided on the balance of probabilities they did not have enough evidence to be able to mount a successful prosecution. They also sought legal opinion which determined that if they did take the case to court that the psychiatrist's lawyers would heavily defend their client and the possibility of a determination of an abuse of process could result.

Another tactic used by the State to quash complainants is confidentiality and privacy of victims—although, we believe, this may have been taken too far by the legal teams in their attempt to reign in a potential claim against the State.

31. The State party should also take measures to prevent interference with victims' privacy and to protect victims, their families and witnesses and others who have intervened on their behalf against intimidation and retaliation at all times before, during and after judicial, administrative or other proceedings that affect the interests of victims. Failure to provide protection stands in the way of victims filing complaints and thereby violates the right to seek and obtain redress and remedy.

By dealing with the victim or complainant individually tends to make the victim believe they are the only one that this has occurred to, effectively maintaining their silence and minimising their power of choice and determinism to gain recognition, acknowledgement, redress, etc. By keeping victims separated or in the dark that the same perpetrator or systemic abuse has occurred to others, leads away from redress and does not fulfil obligations under the convention. Every now and again over the years we hear of such cases, which makes one wonder what the State actually knows with regards the extent of instances of torture and ill-treatment. If they are kept secret and their legal teams across Ministries have a policy to ensure they remain hidden or are handled in-house, how would civil society or the convention's mechanisms be able to actually monitor their adherence to this and possible violations of many other conventions?

It is also common practice that precedents are not set in regard to claims against a government department. Should the case go to court it is heavily defended and often made too costly for a victim to contend with, and if continued to court, is usually settled out of court, a practice often used by corporates so as to limit the number and extent of damage claims.

Also, many times we have supported victims where we were the first people they had spoken to about their experiences of ill-treatment. This is mainly from fear of intimidation, marginalisation or exclusion from family, friends and colleagues because of stigmatisation and integration into society.

Access to information is not always easy to obtain and the operating basis of the State is to effectively contain allegations against it, isolate these from any other complaints they may also have received, keep it from going public, assert legal privilege and confidentiality to restrict the flow of information, or otherwise defend their position. If an investigation is inevitable, appoint trusted, known people and limit the inquiry's terms of reference, among other things.

An example of this, though not related to one specific incident but to many, was the report that the Human Rights Commission (HRC) prepared concerning the State handling of the numerous complaints of ill-treatment within State institutions. The original draft was handed over to the Ministry for review and has never seen the light of day. It was rewritten due to being seen as too sensitive/damning/negative or having the potential to cause issues for the State. Now, after a few years of changes due to time and actions taken, cases resolved, etc., the report is now seen as irrelevant.

On the contrary, we believe the final draft that was tabled to the Ministry (by the previous Chief Human Rights Commissioner) should still be made public, or at the least, provided in confidence to CAT, as we are sure it would still provide important insights into the processes that were taking place

in dealing with a large amount of complaints of ill-treatment and how their actions relate to complying with the Convention.

None of these actions of the State are new and unknown, though sometimes it is forgotten that this is the operating basis. We are merely pointing this out so that it is in the open, can be confronted head on and actions implemented to ensure that the conventions can be properly realised in our country.

Obstacles to the right to redress

One of the victims CCHR supported from the ill-treatment and punishments of Lake Alice had to go to court to force the government to pay back money he was offered by the State where they withheld a third of the ex-gratia payment due to him (which was illegally removed from all of the second-round claimants). It took four years of battling through the courts and finally winning with the judge calling the actions of the government "Kafkaesque". Then, even after winning the case, the government would not pay what was deemed by the court it owed to the victim of ill-treatment and it took taking this story to the media before they would hand over the money. This case had bearing on all of the other second-round claimants, amounting to almost $3 million that the State took from child victims of ill-treatment and torture in Lake Alice.

Please do not think that we are completely cynical in the State's implementation of the Convention. We are actually amazed at the progress made since 2001, when the government officially recognised that psychiatric ill-treatment and torture exists in New Zealand, made financial pay-outs (as part of an out-of-court settlement) and each of nearly 200 child victims of the Lake Alice Child and Adolescent Unit received a signed apology from the Prime Minister and the Minister of Health.

- The first official recognition that psychiatric abuse actually exists in New Zealand (2001), when the government apologised and gave $13 million to almost 200 child victims from Lake Alice Child and Adolescent Unit. (CCHR NZ uncovered and exposed these abuses).
- The lawyer involved also got $2 million for his part in representing the first 95 former child victims (who received a $6.5million payout deal), making psychiatric violations of human rights a viable cause for lawyers to take on for the very first time.
- This opened the door for more abuse victims of ill-treatment to come forward from other institutions; and upwards of 900 victims including other psychiatric, welfare and even military institutions, came forward with multiple complaints.
- The government commissioned a "Confidential Forum for Former Psychiatric Patients" where 500 victims came forward citing psychiatric abuses over a 50-year period in New Zealand. As a result they produced a very damning report on mental health care. The government then established a Confidential Listening Service enabling abuse victims from institutions to call in and talk about what happened to them. As of 2014 more than 900 more abuse victims have come

forward and told their stories. However these bodies, as mentioned earlier, are not really an effective part of implementation of the Convention.

- The United Nations Committee Against Torture (UNCAT), amongst other things, acknowledging the issues accurately, that psychiatric and other State abuses are torture and ill-treatment and called for the NZ Government to start making the perpetrators accountable; to reopen a police investigation into psychiatrist and staff at the Child Unit, Lake Alice Hospital; and establish a psychiatric oversight mechanism to stop the abuse from happening into the future across the boards.

- The Crimes of Torture Act 1989 was amended significantly in 2007 so as to implement an independent body of inspectors which have powers of access to places, people and information, along with confidentiality and reporting requirements. The NZ government established these governmental-sanctioned independent inspectors, in particularly but not limited to, the Ombudsman's Office as they are independent to the mental health system and have full access to these facilities to look into psychiatric facilities and other places of detention, for crimes of torture. This is connected internationally as part of the UNCAT and has essentially set firm policy, changing legislation and marking the end of unmonitored ill-treatment and torture against the mentally ill in New Zealand. CCHR and other NGOs have been given a direct link to the inspectors on the ground, with the ability to highlight instances of abuse which they can then investigate, independently to the health system.

- This is now linked internationally, not only with UNCAT but also with their Subcommittee on the Prevention of Torture (SPT). Representatives from SPT were in NZ and had a private meeting with CCHR and discussed at length their involvement and CCHR's concerns of victims not receiving the adequate outcome in terms of the convention, and how no perpetrators have been brought to account.

- Example of Ombudsman reports and mechanism in practice (OPCAT). CCHR NZ found an incident where a young psychiatric patient was assaulted by a psychiatric worker, which was not brought before the Police. CCHR alerted the Police and the Ombudsman. The media was interested in the story and the Chief Inspector Ombudsman of Crimes of Torture thanked CCHR for the information as it "gave them a new focus" saying they will look into the issue of patients having access to police and ensuring District Health Boards mental facilities have policies in place to ensure this.

The latest development of the prevention of torture within psychiatry in New Zealand has occurred with the Government of NZ recently signing up to the Convention on the Rights of Persons with Disabilities. This provides for basic rights to be implemented for those with disabilities, which includes people within mental health. The latest report (April 2014) looks at providing rights in general, not just restricted to state care, such as no treatment without consent and freedom from torture. Here is an excerpt relevant to this:

Articles 15, 16 and 17: Respect for personal integrity and freedom from torture, violence, exploitation and abuse

> *38. As has been stated 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. State Parties must, instead, respect the legal capacity of persons with disabilities to make decisions at all times, including in crisis situations, ensure that accurate and accessible information is provided about service options and that non-medical approaches are made available, and provide access to independent support. State parties have an obligation to provide access to support for decisions regarding psychiatric and other medical treatment. Forced treatment is a particular problem for persons with psychosocial, intellectual and other cognitive disabilities. State 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 State 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.*

If the State would actually implement these human rights on the ground, we would see a complete prevention of ill-treatment and torture in these institutions. The key issue being the State's commitment put into action and it not ending up being some form of tokenism.

Additional and relevant information

In addition to the above we wish to bring to the attention of the Committee a report submitted by a UN Rapporteur speaking about similar issues of State parties not acknowledging major abuses within a health setting as clearly coming under the Convention. The report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez presented to the UN General Assembly on 1 February 2013. Most of the report is relevant to New Zealand's reporting under the Convention, so instead of replicating the issues, we attach this to our report for your attention and reference.

Her summary states:

> *The present report focuses on certain forms of abuses in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment. It identifies the policies that promote these practices and existing protection gaps.*
>
> *By illustrating some of these abusive practices in health-care settings, the report sheds light on often undetected forms of abusive practices that occur under the auspices of health-care policies, and emphasizes how certain treatments run afoul of the prohibition on torture and ill-treatment. It identifies the scope of State's obligations to regulate, control and supervise health-care practices with a view to preventing mistreatment under any pretext.*

The Special Rapporteur examines a number of the abusive practices commonly reported in health-care settings and describes how the torture and ill-treatment framework applies in this context. The examples of torture and ill-treatment in health settings discussed likely represent a small fraction of this global problem.

The report is quite relevant and although there may be some things that we would debate, the issues brought forward concerning the acknowledgement of the State to see the abuses as coming under the Convention could be a useful tool in the education of officials in these matters.

Applying the torture and ill-treatment protection framework in health-care settings

13. The Special Rapporteur recognizes that there are unique challenges to stopping torture and ill-treatment in health-care settings due, among other things, to a perception that, while never justified, certain practices in health-care may be defended by the authorities on grounds of administrative efficiency, behaviour modification or medical necessity. The intention of the present report is to analyse all forms of mistreatment premised on or attempted to be justified on the basis of health-care policies, under the common rubric of their purported justification as "health-care treatment", and to find cross-cutting issues that apply to all or most of these practices.

B. Applicability of the torture and ill-treatment framework in health-care settings

1. Overview of key elements of the definition of torture and ill-treatment

17. At least four essential elements are reflected in the definition of torture provided in article 1, paragraph 1, of the Convention against Torture: an act inflicting severe pain or suffering, whether physical or mental; the element of intent; the specific purpose; and the involvement of a State official, at least by acquiescence (A/HRC/13/39/Add.5, para. 30). Acts falling short of this definition may constitute cruel, inhuman or degrading treatment or punishment under article 16 of the Convention (A/63/175, para. 46). The previous Special Rapporteurs have covered in great detail the main components of the definition of torture. Nevertheless, there are a few salient points worth elaborating for the purpose of the present report.

18. The jurisprudence and authoritative interpretations of international human rights bodies provide useful guidance on how the four criteria of the definition of torture apply in the context of health-care settings. ECHR has noted that a violation of article 3 may occur where the purpose or intention of the State's action or inaction was not to degrade, humiliate or punish the victim, but where this nevertheless was the result.3

19. The application of the criteria of severe pain or suffering, intent, and involvement of a public official or other person acting in an official capacity, by consent or acquiescence to abuses in health-care settings, is relatively straightforward. The criterion of the specific purpose warrants some analysis.4

Conclusions and Recommendations

A. CCHR would recommend that the Committee, with their extensive knowledge and combined experience, find the best way to communicate this to our State representatives, so that they will re-evaluate their commitment to the Convention. In this way we wish to see the Convention at the core of their actions to address these issues and the situation of not seeing, hearing or speaking out about ill-treatment and torture is effectively addressed and turned around.

B. The State take appropriate action in dealing with the perpetrators of ill-treatment and torture and that they actually prosecute according to the Convention's process and guidance of international law. This is a fundamental step of New Zealand complying with the Convention.

C. The use of tasers on persons who are seen to have mentally health issues needs to be added to this report to UNCAT. Some reports put this section of society being inflicted with the intense and painful electrification, as high as one-third (1/3) of the total persons applied to. This is a huge portion and extremely significant which will be of interest to the Committee. CCHR would like to see other measures used instead of tasers on this group of already vulnerable individuals.

D. Persons lose all rights when in the mental health system, whether compulsorily or voluntarily. They are often seen as less-than-human as a result, which is contrary to international human rights laws, allowing or helping to create an environment conducive to human rights violations. As such, the concluding observations and recommendations from Special Rapporteur are very relevant to this submission that we duplicate them here so as to include as part of recommendations to be applied to New Zealand.

The significance of categorizing abuses in health-care settings as torture and ill-treatment

The preceding examples of torture and ill-treatment in health-care settings likely represent a small fraction of this global problem. Such interventions always amount at least to inhuman and degrading treatment, often they arguably meet the criteria for torture, and they are always prohibited by international law.

The prohibition of torture is one of the few absolute and non-derogable human rights, a matter of jus cogens, a peremptory norm of customary international law. Examining abuses in health-care settings from a torture protection framework provides the opportunity to solidify an understanding of these violations and to highlight the positive obligations that States have to prevent, prosecute and redress such violations.

The right to an adequate standard of health care ("right to health") determines the States' obligations towards persons suffering from illness. In turn, the absolute and non-derogable nature of the right to protection from torture and ill-treatment establishes objective restrictions on certain therapies. In the context of health-related abuses, the focus on the prohibition of torture strengthens the call for accountability and strikes a proper balance between individual freedom and dignity and public health concerns. In that fashion, attention to the torture framework ensures that system inadequacies, lack of resources or services will not justify ill-treatment. Although resource constraints may justify only partial fulfilment of some aspects of the right to health, a State cannot justify its non-compliance with core obligations, such as the absolute prohibition of torture, under any circumstances.

By reframing violence and abuses in health-care settings as prohibited ill-treatment, victims and advocates are afforded stronger legal protection and redress for violations of human rights. In this respect, the recent general comment No. 3 (2012) of the Committee against Torture on the right to a remedy and reparation offers valuable guidance regarding proactive measures required to prevent forced interventions. Notably, the Committee considers that the duty to provide remedy and reparation extends to all acts of ill-treatment, so that it is immaterial for this purpose whether abuses in health-care settings meet the criteria for torture per se. This framework opens new possibilities for holistic social processes that foster appreciation of the lived experiences of persons, including measures of satisfaction and guarantees of non-repetition, and the repeal of inconsistent legal provisions.

Recommendations

(a) Enforce the prohibition of torture in all health-care institutions, both public and private, by, inter alia, declaring that abuses committed in the context of health-care can amount to torture or cruel, inhuman or degrading treatment or punishment; regulating health-care practices with a view to preventing mistreatment under any pretext; and integrating the provisions of prevention of torture and ill-treatment into health-care policies;

(b) Promote accountability for torture and ill-treatment in health-care settings by identifying laws, policies and practices that lead to abuse; and enable national preventive mechanisms to systematically monitor, receive complaints and initiate prosecutions;

(c) Conduct prompt, impartial and thorough investigations into all allegations of torture and ill-treatment in health-care settings; where the evidence warrants it, prosecute and take action against perpetrators; and

provide victims with effective remedy and redress, including measures of reparation, satisfaction and guarantees of non-repetition as well as restitution, compensation and rehabilitation;

(d) Provide appropriate human rights education and information to health-care personnel on the prohibition of torture and ill-treatment and the existence, extent, severity and consequences of various situations amounting to torture and cruel, inhuman or degrading treatment or punishment; and promote a culture of respect for human integrity and dignity, respect for diversity and the elimination of attitudes of pathologizaton and homophobia. Train doctors, judges, prosecutors and police on the standards regarding free and informed consent;

(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;

(f) Ensure special protection of minority and marginalized groups and individuals as a critical component of the obligation to prevent torture and ill-treatment by, inter alia, investing in and offering marginalized individuals a wide range of voluntary supports that enable them to exercise their legal capacity and that fully respect their individual autonomy, will and preferences.

Compulsory detention for medical reasons

(a) Close compulsory drug detention and "rehabilitation" centres without delay and implement voluntary, evidence-based and rights-based health and social services in the community. Undertake investigations to ensure that abuses, including torture or cruel, inhuman and degrading treatment, are not taking place in privately-run centres for the treatment of drug dependence;

(b) Cease support for the operation of existing drug detention centres or the creation of new centres. Any decision to provide funding should be made only following careful risk assessment. If provided, any such funds should be clearly time-limited and provided only on the conditions that the authorities (a) commit to a rapid process for closing drug detention centres and reallocating said resources to scaling up voluntary, community-based, evidence-based services for treatment of drug dependence; and (b) replace punitive approaches and compulsory elements to drug treatment with other, evidence-based efforts to prevent HIV and other drug-related harms. Such centres, while still operating as the authorities move to close them, are subject to fully independent monitoring;

(c) Establish an effective mechanism for monitoring dependence treatment practices and compliance with international norms;

(d) Ensure that all harm-reduction measures and drug-dependence treatment services, particularly opioid substitution therapy, are available to people who use drugs, in particular those among incarcerated populations (A/65/255, para. 76).

Lesbian, gay, bisexual, transgender and intersex persons

The Special Rapporteur calls upon all States to repeal any law allowing intrusive and irreversible treatments, including forced genital-normalizing surgery, involuntary sterilization, unethical experimentation, medical

display, "reparative therapies" or "conversion therapies", when enforced or administered without the free and informed consent of the person concerned. He also calls upon them to outlaw forced or coerced sterilization in all circumstances and provide special protection to individuals belonging to marginalized groups.

Persons with psychosocial disabilities

(a) Review the anti-torture framework in relation to persons with disabilities in line with the Convention on the Rights of Persons with Disabilities as authoritative guidance regarding their rights in the context of health-care;

(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;

(c) Replace forced treatment and commitment by services in the community. Such services must meet needs expressed by persons with disabilities and respect the autonomy, choices, dignity and privacy of the person concerned, with an emphasis on alternatives to the medical model of mental health, including peer support, awareness-raising and training of mental health-care and law enforcement personnel and others;

(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.

[from the report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez presented to the UN General Assembly on 1 February 2013]

We thank you for your time and hope this submission is duplicated to the extent that positive change takes place for victims of ill-treatment and torture in New Zealand. We are a small country which gives a unique position to lead the world in human rights. We are interested to know what more we can do as an NGO working with victims of human rights abuse. CCHR also hopes to meet with the Committee and take part in an oral submission along with at least one of the victims of abuse who will help provide a first-hand account.

Yours truly

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CITIZENS COMMISSION ON HUMAN RIGHTS NEW ZEALAND

Established in 1969 by the Church of Scientology to investigate and expose psychiatric violations of human rights

27 September 2013

MOJ Human Rights Team
Ministry of Justice
Wellington

New Zealand's 6th periodic report on the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Response and support to Government draft report to UNCAT, September 2013.

We would like to thank the Ministers and their officers in drafting their response to the UNCAT reports and their commitment to human rights in New Zealand. CCHR is particularly interested in the protection of rights of victims stemming from Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, etc within mental health settings. This is not limited to health and disability, but includes welfare, corrections, Police as well as specialised facilities and practices for various ethnicities, ages; for example children, elderly, Maori and Pacific, etc.

There is a large part of the Committee's report focussed on these issues and having decades of experience in this field, hope we can add a valuable contribution to the State report later this year. We will, as in previous years, be submitting our own report directly to the Committee.

To provide some context, CCHR has submitted in depth reports to UNCAT over the years, has met with the Human Rights Commission, Chief Inspector of Crimes of Torture with the Office of the Ombudsman, and the United Nations Subcommittee on the Prevention of Torture, as well as a number of government officials and politicians.

We provide here some feedback and comments that we hope are subject of discussions and are of help with New Zealand's submission to the 6th periodic report. For ease of tracking our comments, we submit this in the same sequence as the draft government report.

Article 1. 11. The standards and guidelines on the use of seclusion in mental health facilities, with the overall intent to reduce seclusion, is the correct focus for more human rights in this field. There still needs a much more concerted effort for this and other coercive psychiatric methods used to subdue or quieten individuals in their care. This was the subject of a couple of reports from the Mental Health Commission prior to its disbandment, which would be worth highlighting.

More information about on seclusion and restraint is in Article 16 # 33 (326-335)

. Rights of People in custody

Questions from the Committee and the Rapporteur:

The Committee asked for information on the steps taken by New Zealand to guarantee the rights of persons in police custody. Particular areas of interest were identified by the Committee including the prompt access of a detainee to a lawyer, being informed of the charges against them in a language that they understand, having their detention duly registered, the right to have access to an independent doctor, and the right to notify family members or persons of their own choice about their detention. The Committee indicated an interest in how these practices are implemented in New Zealand and in any restrictions that may be imposed on these rights.

In addition, the Rapporteur asked for more information on the access to justice of mentally ill detainees including any special measures New Zealand takes to ensure that individuals diagnosed with mental illness, or mental or intellectual disabilities are made aware of their rights to contact an attorney and their potential eligibility for public funding for legal services.

Information about charges and access to a lawyer

The government draft report speaks of *access* to a lawyer; however the Committee asked for a response with regards to inmates diagnosed with mentally illness or mental or intellectual disabilities in custody. The key aspect that requires answering is how to ensure that such individuals have proper contact with a lawyer, and also the *effective* right to legal representation. This was emphasised due to the fact that this section of public in practice rarely get access to effective legal representation particularly at the beginning of any court judgements.

District Inspectors have become a part of the health system and could not, from a patient/victim point of view, be seen as being independent, compromising their ability of advocacy.

8. National Preventive Mechanism

Questions from the Committee:

The Committee has asked for information on the functioning of the National Preventive Mechanism and whether it has been provided with the necessary human, material and in particular financial resources to enable it to fully comply with its mandate.

CCHR see the continued and increased support and proper functioning of the National Preventive Mechanism, as a long term solution to eliminating torture and other cruel, inhuman or degrading treatment or punishment within mental health.

There are aspects that are missing around accountability where UNCAT have asked for evidence of prosecutions of any alleged perpetrators of torture or ill-treatment. Additional comments are in the Oversight Mechanism section, 284.

16. Training on the Istanbul Protocol

Questions from the Committee:

The Committee refers to the training on the "Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment" (Istanbul Protocol), and asks for an assessment of that training, as well as of any training on the Istanbul Protocol outside the refugee and immigration context.

CCHR agrees that the implementation of the IP is essential to NZ complying to international human rights and had suggested this in their submission to UNCAT in their report. This is important particularly regarding being able to conduct a prompt, impartial and effective investigation into all claims of abuse of torture and ill-treatment. We note that this came about from an NGO and it would be good to see the government supporting this more directly as well as in collaboration with NGOs.

Articles 12 & 13

22. Investigation of torture and prosecutions

Questions from the Committee:

The Committee has requested statistical data disaggregated by crime committed, ethnicity, age and gender, on complaints relating to torture and ill-treatment allegedly committed by law enforcement officials, and on related investigations, prosecutions, convictions and criminal and disciplinary sanctions applied.

The Committee has requested an indication of whether we have abandoned the system which gives the Attorney-General discretion to prosecute even in cases where there are grounds to believe that an act of torture has been committed.

Also requested is information on whether investigations are conducted if there are reasonable grounds to believe that an act of torture has been committed, even in cases where a commanding officer considers that the allegation is not well-grounded, and whether the New Zealand Police continues to have discretion over whether or not to prosecute alleged perpetrators of offences under the Crimes of Torture Act on the basis of public interest

CCHR feels the government report is a bit light on this section and elude the main issues that the Committee want answers on.

Article 14

Questions from the Committee:

The Committee has asked New Zealand to provide information on redress and compensation measures, including the means of rehabilitation, ordered by the courts and actually provided to victims of torture, or their families, since the examination of the last periodic report in 2009. This information should include: the number of requests made; the number granted; the amounts of compensation ordered, and those actually provided in each case.

25. Compensation to victims of torture

1. The Crimes of Torture Act 1989 expressly prohibits any act of torture against another person in or outside of New Zealand. Claims brought under this Act can be heard before the New Zealand courts. Redress and compensation can be assessed and awarded by the courts on a case by case basis.
2. There have been no prosecutions for an act of torture under the Crimes of Torture Act since our last report.

As in the preceding two sections, it seems that the government submission attempts to mislead the Committee in focussing on the Crimes of Torture Act instead of the various allegations of ill-treatment, both historic and recent.

27. Complaints, claims and compensation

Questions from the Committee and the Rapporteur:

Statistical data is sought by the Committee on the number of historic abuse cases disaggregated by civil claims in court, criminal complaints to the New Zealand Police, complaints to the Office of the Ombudsmen, and claims through the IPCA, the Care Claims and Resolution Team (CCRT) or any other alternative body or

process. Information is requested on the number of prosecutions and convictions of perpetrators and the redress provided to the victim, as well as how compensation is dealt with in cases where limitation restrictions bar claims.

The Committee has requested information on the number of cases of patients in psychiatric hospitals processed since 2009; the redress including compensation and rehabilitation provided to the victims; how many claims have been discontinued as a result of the Supreme Court decision of September 2009 on the application of a statutory provision in the Mental Health Act 1969 whereby claims relating to events prior to 1972 can no longer be pursued through the courts; and compensation awarded through individual complaints.

The Rapporteur has asked for data on court claims in connection with the historic abuse cases disaggregated by a range of variables and outcomes. New Zealand is asked by the Rapporteur to elaborate on measures that have been taken to eliminate obstacles to redress affecting victims connected with the historic abuse claims, including statutes of limitations on torture or ill-treatment.

The Rapporteur has requested additional information about the CCRT and its independence, and on claims to the CCRT. The Rapporteur has also asked for information of historic abuse cases against the Crown Health Funding Agency (CHFA), cases received by the New Zealand Police following referral to the CCRT, the number submitted by the CHFA, and the number submitted by private individuals.

New Zealand is asked to specify the number of these complaints that were investigated by the New Zealand Police, the number that resulted in criminal prosecutions and the outcomes of any such prosecutions. *The Rapporteur has also asked for advice on whether any historic abuse cases have resulted in disciplinary action against former CHFA staff.*

The Rapporteur has requested data on the amount of compensation awarded to the victims of torture and ill-treatment perpetrated between 1972 and 1977; the number of victims that received compensation; the amount of compensation awarded to each victim; and the maximum and minimum amount awarded to these victims.

Questions are asked by the Rapporteur about Lake Alice awards, investigations, resulting prosecutions, and the sufficiency of the New Zealand Police investigation into the Lake Alice claims. *A question is asked as to whether Justice Gallen took into account legal fees when making his determinations*

The Rapporteur asks what measures New Zealand has put in place to ensure that torture and ill-treatment are not perpetrated in state facilities in the future.

CCHR was involved with uncovering the abuses of ill-treatment of children at Lake Alice Hospital's Child and Adolescent Unit from the mid-1970s, and have been working to gain acknowledgement, proper investigation and prosecution of perpetrators of the ill-treatment since that time. These abuses brought light to ill-treatment in psychiatric facilities, and with the official apology from the Prime Minister and Health Minister and acknowledgement (finally in 2001). This effectively opened the floodgates to all the other psychiatric facilities around the country now that lawyers were able to viably take on a victim of ill-treatment in mental health. From

here welfare institutions came to light as it was found that the children (often Wards of the State) went through borstals and the like before and after their experiences of psychiatric abuse.

The stories of ill-treatment and torture are well documented, from the nearly 200 children apologised for the serious abuses at Lake Alice; from the Gallen Report (Retired High Court Judge Sir Rodney Gallen); the charges laid by the medical board against the main psychiatrist involved, and the expert psychiatric testimony supplied to the medical board and the NZ Police, etc. Another report that the government may wish to highlight to the Committee is the "*Report of the Confidential Forum for Former In-Patients of Psychiatric Hospitals"* which told the story of 500 people, mainly victims caught up in a coercive system with very few rights.

The United Nations Committee Against Torture (UNCAT) has highlighted these issues quite succinctly; clearly stating the obligations of the State, and there have been huge leaps forward in officials starting to confront these issues. We understand the standard reaction to preserve face and defend its position, however when this relates to torture and ill-treatment, it makes no sense in protecting any alleged perpetrators.

The government draft report includes one conviction of a mental health worker (item 272) under the heading "Prosecutions and convictions of perpetrators" which was from 1989. However it fails to provide context surrounding this event (the woman was a well-known Maori activist). Also why is there no record of other mental health workers before or since, convicted of criminal assault even in well-documented cases such as a recent event when the offender was dismissed for serious misconduct when he forced a young autistic patient to the ground and held him in a headlock? No criminal charges were filed. [NZ Herald 14 August 2013]

CCHR believes that this is the time to draw a line in the sand and fully acknowledge the dark history of abuse within mental health and confront the need to clean it up and stop tolerating the ill-treatment. The protection and defence stance of any perpetrator only serves to drag New Zealand's reputation down with them. The UNCAT and rapporteur reports are guiding NZ to do the right thing; but it will take a strong leader to change the lack of will and reverse the actions up till now.

The ex-gratia payments and apologies go some ways to help acknowledge some of the wrong, and it is good to see funds being created within the various Ministries, however CCHR is not sure that this is adequate redress for what has occurred. Also, it would not be good to be paying off victims of torture and ill-treatment with a "take it or leave it" approach to compensation, with no further recourse and then no effort by the State (after acknowledging the abuse) to seek prosecution of the perpetrators.

Civil society is very willing to work with the government on this and to bring about worthwhile reforms that will see fewer or no victims of ill-treatment, punishment or the like, especially upon our more vulnerable citizens held in mental health facilities.

Oversight mechanism for psychiatric facilities

3. New Zealand has a system of independent oversight of psychiatric institutions. The Ministry of Health funds independent lawyers, known as district inspectors who work to the Director of Mental Health. The district inspectors have right of access to any psychiatric institutions at any time without warning. Further details of their role are outlined in Section 2 under Article 2.

4. The Office of the Ombudsman, in its National Preventive Mechanism role, monitors the conditions of detention in secure health facilities. The Health and Disability Commissioner and the Mental Health Commissioner also provide an important layer of independent oversight.

As mentioned before, the District Inspectors, although a good idea and put in place for a purpose to help the under-represented persons caught up in the mental health system. However, it must be noted that these inspectors were in place when a lot of the historic abuse occurred, that is now the subject of the UNCAT and this government's report. We are not suggesting they do not have a place, but merely pointing out the need from a human rights of victims of torture and ill-treatment is concerned, there needs to be a re-evaluation of their role in this before including them as part of an independent oversight mechanism for psychiatric facilities.

CCHR see the Inspectors of Crimes of Torture coming out of the Office of the Ombudsman, as a definite part of an independent oversight mechanism. The changes to the Crimes of Torture Act with the introduction of OPCAT in the National Preventive Mechanism, including the SPT and other affiliates internationally, has the makings of answering the call of the Committee.

There are resourcing issues that need solving across the board relating to the national mechanism, but we are happy how this has progressed so far, and then elevated more as a priority.

The main area CCHR see as needing support to make the mechanism function properly, is implementing a clear process of dealing with the perpetrators of ill-treatment and torture. This is a fundamental part of New Zealand complying with the steps laid out by the Committee.

The other area and possibly more fundamental which we alluded to earlier, that being that instances of torture or ill-treatment are well documented as occurring in New Zealand psychiatric facilities. This must be confronted and acknowledged so

that a proper, workable mechanism can be put into place, where prompt and impartial investigations take place (by persons trained in the Istanbul Protocol), perpetrators duly prosecuted, and the victims accorded redress, including compensation and rehabilitation.

> "The state party should take appropriate measures to ensure that allegations of cruel, inhuman or degrading treatment in the 'historic cases' are investigated promptly and impartially," UN Committee Against Torture

Article 16

31. Tasers

Questions from the Committee and the Rapporteur:

The Committee has shown an interest in the experience of Taser use in the post-trial period since 2009, including any incidents that may have had serious consequences for the health of the persons against whom Tasers were used; how often Standard Operating Procedures for the use of Tasers are assessed and revised; the periodicity of refresher courses provided to trained and certified staff; and data on the age, sex, and ethnicity of persons against whom Tasers were used since 2009 and the reasons for use.

The Rapporteur has asked if New Zealand has reconsidered its previous position regarding relinquishing Taser use. Information is also requested on the number of police officers certified to use Taser weapons; whether there is any authority other than the supervisor of the officer deploying the Taser who monitors the deployment of the Tasers; how the monitoring function is carried out; whether any police personnel have been subjected to disciplinary or criminal measures for improper Taser use; if there have been any complaints to the IPCA regarding Taser use; and whether any complaints have resulted in criminal prosecution or disciplinary action.

The experience of Taser use, and consequences

The use of tasers on persons who are seen to have mentally health issues needs to be added to this report to UNCAT. Some reports put this section of society being inflicted with the intense and painful electrification, as high as one third (1/3) of the total persons applied to. This is a huge portion and extremely significant which will be of interest to the Committee. CCHR would like to see other measures used instead of tasers on this group of already vulnerable individuals.

33. Steps to protect the mentally ill

Questions from the Rapporteur:

The Rapporteur has requested information about the measures New Zealand is taking to ensure that individuals with mental disabilities are not unreasonably retrained and/or held in seclusion for unreasonable periods of time; has asked that we clarify whether acts by officials responsible for the cases identified were investigated; and has asked whether anyone received administrative or criminal penalties, and what they were.

This is a detailed section surrounding restraint and seclusion that the Committee detailed a number of concerns to the State. Our comments in other sections above surround these issues also and it is heartening to see the government taking positive action to reduce the use of seclusion in mental health facilities.

The two cases of restraint (one horrifically for six years) brought to light by the Ombudsman needs to show what happened to the persons responsible for this, as it seems, even through to today, that nothing has been done to address this. It is pointed out, rightly so that the District Inspectors, right up to the Director of Mental Health for the country, did not know of this occurring. The Director of Mental Health even collected statistics and published a report on seclusion during this time period (without knowing or mentioning it).

There is a report that the Government may wish to highlight for the Committee that was published by the Mental Health Commission, called *"No-Force Advocacy by Users and Survivors of Psychiatry."* This touches on the issues of coercion in the psychiatric setting and would be worth showing as part of the journey toward human rights in this field.

Thank you for taking the time to read our comments and feedback on the draft New Zealand's 6th periodic report on the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

Feel free to make contact directly should you wish further discussions and information surrounding our submission or related issues.

Yours sincerely

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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez

Summary

The present report focuses on certain forms of abuses in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment. It identifies the policies that promote these practices and existing protection gaps.

By illustrating some of these abusive practices in health-care settings, the report sheds light on often undetected forms of abusive practices that occur under the auspices of health-care policies, and emphasizes how certain treatments run afoul of the prohibition on torture and ill-treatment. It identifies the scope of State's obligations to regulate, control and supervise health-care practices with a view to preventing mistreatment under any pretext.

The Special Rapporteur examines a number of the abusive practices commonly reported in health-care settings and describes how the torture and ill-treatment framework applies in this context. The examples of torture and ill-treatment in health settings discussed likely represent a small fraction of this global problem.

Contents

I. Introduction

1. The present report is submitted to the Human Rights Council in accordance with Council resolution 16/23.

2. Reports of country visits to Tajikistan and Morocco are contained in documents A/HRC/22/53/Add.1 and Add.2, respectively. A/HRC/22/53/Add.3 contains an update on follow-up measures and A/HRC/22/53/Add.4 contains observations made by the Special Rapporteur on some of the cases reflected in the communication reports A/HRC/20/30, A/HRC/21/49 and A/HRC/22/67.

II. Activities of the Special Rapporteur

A. Upcoming country visits and pending requests

3. The Special Rapporteur plans to visit Bahrain in May 2013 and Guatemala in the second half of 2013 and is engaged with the respective Governments to find mutually agreeable dates. The Special Rapporteur has accepted an invitation to visit Thailand in February 2014. He also notes with appreciation an outstanding invitation to visit Iraq.

4. The Special Rapporteur has reiterated his interest to conduct country visits to a number of States where there are pending requests for invitations: Cuba; Ethiopia; Ghana; Kenya; United States of America; Uzbekistan; Venezuela (Bolivarian Republic of) and Zimbabwe. The Special Rapporteur has also recently requested to visit Chad, Côte d'Ivoire, Dominican Republic, Georgia, Mexico and Viet Nam.

B. Highlights of key presentations and consultations

5. On 10 September 2012, the Special Rapporteur participated in a Chatham House event in London hosted by REDRESS on "Enforcing the absolute prohibition against torture".

6. On 26 September 2012, the Special Rapporteur met the Director General of the National Human Rights Commission of the Republic of Korea, who was visiting Washington D.C.

7. Between 22 and 24 October 2012, the Special Rapporteur presented his interim report (A/67/279) to the General Assembly and participated in two side events: one, held at the Permanent Mission of Denmark to the United Nations in New York, on "Reprisals against victims of torture and other ill-treatment" and the other organized jointly with the World Organisation Against Torture, Penal Reform International, the Centre for Constitutional Rights and Human Rights Watch on "The death penalty and human rights: the way forward". He also met with representatives of the Permanent Missions of Guatemala and Uruguay.

8. On 17 November 2012, the Special Rapporteur participated in a symposium organized by New York University on the practice of solitary confinement, entitled "Solitary: wry fancies and stark realities".

9. From 2 to 6 December 2012, the Special Rapporteur conducted a follow-up visit to Uruguay (A/HRC/22/53/Add.3), at the invitation of the Government, to assess improvements and identify remaining challenges regarding torture and other cruel, inhuman or degrading treatment or punishment.

10. From 13 to 14 December 2012, the Special Rapporteur convened an expert meeting on "Torture and ill-treatment in healthcare settings" at the Center for Human Rights and Humanitarian Law, American University in Washington, DC.

III. Applying the torture and ill-treatment protection framework in health-care settings

11. Mistreatment in health-care settings[1] has received little specific attention by the mandate of the Special Rapporteur, as the denial of health-care has often been understood as essentially interfering with the "right to health".

12. While different aspects of torture and ill-treatment in health-care settings have been previously explored by the rapporteurship and other United Nations mechanisms, the Special Rapporteur feels that there is a need to highlight the specific dimension and intensity of the problem, which often goes undetected; identify abuses that exceed the scope of violations of the right to health and could amount to torture and ill-treatment; and strengthen accountability and redress mechanisms.

13. The Special Rapporteur recognizes that there are unique challenges to stopping torture and ill-treatment in health-care settings due, among other things, to a perception that, while never justified, certain practices in health-care may be defended by the authorities on grounds of administrative efficiency, behaviour modification or medical necessity. The intention of the present report is to analyse all forms of mistreatment premised on or attempted to be justified on the basis of health-care policies, under the common rubric of their purported justification as "health-care treatment", and to find cross-cutting issues that apply to all or most of these practices.

A. Evolving interpretation of the definition of torture and ill-treatment

14. Both the European Court of Human Rights (ECHR) and the Inter-American Court of Human Rights have stated that the definition of torture is subject to ongoing reassessment in light of present-day conditions and the changing values of democratic societies.[2]

15. The conceptualization of abuses in health-care settings as torture or ill-treatment is a relatively recent phenomenon. In the present section, the Special Rapporteur embraces this ongoing paradigm shift, which increasingly encompasses various forms of abuse in health-care settings within the discourse on torture. He demonstrates that, while the prohibition of torture may have originally applied primarily in the context of interrogation, punishment or intimidation of a detainee, the international community has begun to recognize that torture may also occur in other contexts.

16. The analysis of abuse in health-care settings through the lens of torture and ill-treatment is based on the definition of these violations provided by the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and its authoritative interpretations. In order to demonstrate how abusive practices in health-care

[1] Health-care settings refers to hospitals, public and private clinics, hospices and institutions where health-care is delivered.

[2] World Organization Against Torture (OMCT), *The Prohibition of Torture and Ill-treatment in the Inter-American Human Rights System: A Handbook for Victims and Their Advocates* (2006), p. 107, citing Inter-American Court of Human Rights, *Cantoral-Benavides* v. *Peru*, Series C, No. 69 (2000) para. 99; ECHR, *Selmouni* v. *France*, Application No. 25803/94 (1999), para. 101.

settings meet the definition of torture, the following section provides an overview of the main elements of the definition of torture.

B. Applicability of the torture and ill-treatment framework in health-care settings

1. Overview of key elements of the definition of torture and ill-treatment

17. At least four essential elements are reflected in the definition of torture provided in article 1, paragraph 1, of the Convention against Torture: an act inflicting severe pain or suffering, whether physical or mental; the element of intent; the specific purpose; and the involvement of a State official, at least by acquiescence (A/HRC/13/39/Add.5, para. 30). Acts falling short of this definition may constitute cruel, inhuman or degrading treatment or punishment under article 16 of the Convention (A/63/175, para. 46). The previous Special Rapporteurs have covered in great detail the main components of the definition of torture. Nevertheless, there are a few salient points worth elaborating for the purpose of the present report.

18. The jurisprudence and authoritative interpretations of international human rights bodies provide useful guidance on how the four criteria of the definition of torture apply in the context of health-care settings. ECHR has noted that a violation of article 3 may occur where the purpose or intention of the State's action or inaction was not to degrade, humiliate or punish the victim, but where this nevertheless was the result.[3]

19. The application of the criteria of severe pain or suffering, intent, and involvement of a public official or other person acting in an official capacity, by consent or acquiescence to abuses in health-care settings, is relatively straightforward. The criterion of the specific purpose warrants some analysis.[4]

20. The mandate has stated previously that intent, required in article 1 of the Convention, 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, where serious violations and discrimination against persons with disabilities may be defended as "well intended" on the part of health-care professionals. Purely negligent conduct lacks the intent required under article 1, but may constitute ill-treatment if it leads to severe pain and suffering (A/63/175, para. 49).

21. Furthermore, article 1 explicitly names several purposes for which torture can be inflicted: extraction of a confession; obtaining information from a victim or a third person; punishment, intimidation and coercion; and discrimination. However, there is a general acceptance that these stated purposes are only of an indicative nature and not exhaustive. At the same time, only purposes which have "something in common with the purposes expressly listed" are sufficient (A/HRC/13/39/Add.5, para. 35).

22. Although it may be challenging to satisfy the required purpose of discrimination in some cases, as most likely it will be claimed that the treatment is intended to benefit the "patient", this may be met in a number of ways.[5] Specifically, the description of abuses

[3] See *Peers v. Greece*, Application No. 28524/95 (2001), paras. 68, 74; *Grori v. Albania*, Application No. 25336/04 (2009), para. 125.

[4] Open Society Foundations, *Treatment or Torture? Applying International Human Rights Standards to Drug Detention Centers* (2011), p. 10.

[5] Ibid., p. 12.

outlined below demonstrates that the explicit or implicit aim of inflicting punishment, or the objective of intimidation, often exist alongside ostensibly therapeutic aims.

2. The scope of State core obligations under the prohibition of torture and ill-treatment

23. The Committee against Torture interprets State obligations to prevent torture as indivisible, interrelated, and interdependent with the obligation to prevent cruel, inhuman, or degrading treatment or punishment (ill-treatment) because "conditions that give rise to ill-treatment frequently facilitate torture".[6] It has established that "each State party should prohibit, prevent and redress torture and ill-treatment in all contexts of custody or control, for example, in prisons, hospitals, schools, institutions that engage in the care of children, the aged, the mentally ill or disabled, in military service, and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm".[7]

24. Indeed, the State's obligation to prevent torture applies not only to public officials, such as law enforcement agents, but also to doctors, health-care professionals and social workers, including those working in private hospitals, other institutions and detention centres (A/63/175, para. 51). As underlined by the Committee against Torture, the prohibition of torture must be enforced in all types of institutions and States must exercise due diligence to prevent, investigate, prosecute and punish violations by non-State officials or private actors.[8]

25. In *da Silva Pimentel* v. *Brazil*, the Committee on the Elimination of Discrimination against Women observed that "the State is directly responsible for the action of private institutions when it outsources its medical services" and "always maintains the duty to regulate and monitor private health-care institutions".[9] The Inter-American Court of Human Rights addressed State responsibility for actions of private actors in the context of health-care delivery in *Ximenes Lopes* v. *Brazil*.[10]

26. Ensuring special protection of minority and marginalized groups and individuals is a critical component of the obligation to prevent torture and ill-treatment. Both the Committee against Torture and the Inter-American Court of Human Rights have confirmed that States have a heightened obligation to protect vulnerable and/or marginalized individuals from torture, as such individuals are generally more at risk of experiencing torture and ill-treatment.[11]

C. Interpretative and guiding principles

1. Legal capacity and informed consent

27. In all legal systems, capacity is a condition assigned to agents that exercise free will and choice and whose actions are attributed legal effects. Capacity is a rebuttable

[6] General comment No. 2 (2007), para. 3.

[7] Ibid., para. 15.

[8] General comment No. 2, paras. 15, 17 and 18. See also Committee against Torture, communication No. 161/2000, *Dzemajl et al.* v. *Serbia and Montenegro*, para. 9.2; Human Rights Committee, general comment No. 20 (1992), para. 2.

[9] Communication No. 17/2008, para. 7.5.

[10] Inter-American Court of Human Rights. (Series C) No. 149 (2006), paras. 103, 150; see also Committee on the Elimination of Discrimination against Women, general recommendation No. 19 (1992), para. 9.

[11] Committee against Torture, general comment No. 2, para. 21; *Ximenes Lopes* v. *Brazil*, para. 103.

presumption; therefore, "incapacity" has to be proven before a person can be designated as incapable of making decisions. Once a determination of incapacity is made, the person's expressed choices cease to be treated meaningfully. One of the core principles of the Convention on the Rights of Persons with Disabilities is "respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons" (art. 3 (a)). The Committee on the Rights of Persons with Disabilities has interpreted the core requirement of article 12 to be the replacement of substituted decision-making regimes by supported decision-making, which respects the person's autonomy, will and preferences.[12]

28. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health observed that informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision. Guaranteeing informed consent is a fundamental feature of respecting an individual's autonomy, self-determination and human dignity in an appropriate continuum of voluntary health-care services (A/64/272, para. 18).

29. As the Special Rapporteur on the right to health observed, while informed consent is commonly enshrined in the legal framework at the national level, it is frequently compromised in the health-care setting. Structural inequalities, such as the power imbalance between doctors and patients, exacerbated by stigma and discrimination, result in individuals from certain groups being disproportionately vulnerable to having informed consent compromised (ibid., para. 92).

30. The intimate link between forced medical interventions based on discrimination and the deprivation of legal capacity has been emphasized both by the Committee on the Rights of Persons with Disabilities and the previous Special Rapporteur on the question of torture.[13]

2. Powerlessness and the doctrine of "medical necessity"

31. Patients in health-care settings are reliant on health-care workers who provide them services. As the previous Special Rapporteur stated: "Torture, as the most serious violation of the human right to personal integrity and dignity, presupposes a situation of powerlessness, whereby the victim is under the total control of another person."[14] Deprivation of legal capacity, when a person's exercise of decision-making is taken away and given to others, is one such circumstance, along with deprivation of liberty in prisons or other places (A/63/175, para. 50).

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

[12] See CRPD/C/ESP/CO/1.

[13] Convention on the Rights of Persons with Disabilities, art. 25 (d); see also CRPD/C/CHN/CO/1 and Corr.1, para. 38; A/63/175, paras. 47, 74.

[14] A/63/175, para. 50.

sterilization is often claimed as being a necessary treatment for the so-called best interest of the person concerned.

33. However, in response to reports of sterilizations of women in 2011, the International Federation of Gynecology and Obstetrics emphasized that "sterilization for prevention of future pregnancy cannot be ethically justified on grounds of medical emergency. Even if a future pregnancy may endanger a woman's life or health, she … must be given the time and support she needs to consider her choice. Her informed decision must be respected, even if it is considered liable to be harmful to her health."[15]

34. In those cases, dubious grounds of medical necessity were used to justify intrusive and irreversible procedures performed on patients without full free and informed consent. In this light, it is therefore appropriate to question the doctrine of "medical necessity" established by the ECHR in the case of *Herczegfalvy* v. *Austria* (1992),[16] where the Court held that continuously sedating and administering forcible feeding to a patient who was physically restrained by being tied to a bed for a period of two weeks was nonetheless consistent with article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms because the treatment in question was medically necessary and in line with accepted psychiatric practice at that time.

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.

3. Stigmatized identities

36. In a 2011 report (A/HRC/19/41), the United Nations High Commissioner for Human Rights examined discriminatory laws and practices and acts of violence against individuals based on sexual orientation and gender identity in health-care settings. She observed that a pattern of human rights violations emerged that demanded a response. With the adoption in June 2011 of resolution 17/19, the Human Rights Council formally expressed its "grave concern" regarding violence and discrimination based on sexual orientation and gender identity.

37. Many policies and practices that lead to abuse in health-care settings are due to discrimination targeted at persons who are marginalized. Discrimination plays a prominent role in an analysis of reproductive rights violations as forms of torture or ill-treatment because sex and gender bias commonly underlie such violations. The mandate has stated, with regard to a gender-sensitive definition of torture, that the purpose element is always fulfilled when it comes to gender-specific violence against women, in that such violence is inherently discriminatory and one of the possible purposes enumerated in the Convention is discrimination (A/HRC/7/3, para. 68).

38. In the context of prioritizing informed consent as a critical element of a voluntary counselling, testing and treatment continuum, the Special Rapporteur on the right to health has also observed that special attention should be paid to vulnerable groups. Principles 17 and 18 of the Yogyakarta Principles, for instance, highlight the importance of safeguarding informed consent of sexual minorities. Health-care providers must be cognizant of, and adapt to, the specific needs of lesbian, gay, bisexual, transgender and intersex persons (A/64/272, para. 46). The Committee on Economic, Social and Cultural Rights has

[15] *Ethical Issues in Obstetrics and Gynecology* (2012), pp. 123–124.

[16] Application No. 10533/83, paras. 27, 83.

indicated that the International Covenant on Economic, Social and Cultural Rights proscribes any discrimination in access to health-care and the underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of sexual orientation and gender identity.[17]

IV. Emerging recognition of different forms of abuses in health-care settings

39. Numerous reports have documented a wide range of abuses against patients and individuals under medical supervision. Health providers allegedly withhold care or perform treatments that intentionally or negligently inflict severe pain or suffering for no legitimate medical purpose. Medical care that causes severe suffering for no justifiable reason can be considered cruel, inhuman or degrading treatment or punishment, and if there is State involvement and specific intent, it is torture.

A. Compulsory detention for medical conditions

40. Compulsory detention for drug users is common in so-called rehabilitation centres. Sometimes referred to as drug treatment centres or "reeducation through labor" centres or camps, these are institutions commonly run by military or paramilitary, police or security forces, or private companies. Persons who use, or are suspected of using, drugs and who do not voluntarily opt for drug treatment and rehabilitation are confined in such centres and compelled to undergo diverse interventions.[18] In some countries, a wide range of other marginalized groups, including street children, persons with psychosocial disabilities, sex workers, homeless individuals and tuberculosis patients, are reportedly detained in these centres.[19]

41. Numerous reports document that users of illicit drugs who are detained in such centres undergo painful withdrawal from drug dependence without medical assistance, administration of unknown or experimental medications, State-sanctioned beatings, caning or whipping, forced labour, sexual abuse and intentional humiliation.[20] Other reported abuses included "flogging therapy", "bread and water therapy", and electroshock resulting in seizures, all in the guise of rehabilitation. In such settings, medical professionals trained to manage drug dependence disorders as medical illnesses[21] are often unavailable.

42. Compulsory treatment programmes that consist primarily of physical disciplinary exercises, often including military-style drills, disregard medical evidence (A/65/255, paras. 31, 34). According to the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC), "neither detention nor forced labour have been recognized by science as treatment for drug use disorders".[22] Such detention – frequently

[17] General comment No. 14 (2000), para. 18.

[18] See World Health Organization (WHO), *Assessment of Compulsory Treatment of People Who Use Drugs in Cambodia, China, Malaysia and Viet Nam* (2009).

[19] Human Rights Watch (HRW), *Torture in the Name of Treatment: Human Rights Abuses in Vietnam, China, Cambodia, and LAO PDR* (2012), p. 4.

[20] See Daniel Wolfe and Roxanne Saucier, "In rehabilitation's name? Ending institutionalized cruelty and degrading treatment of people who use drugs", *International Journal of Drug Policy*, vol. 21, No. 3 (2010), pp. 145-148.

[21] United Nations Office on Drugs and Crime (UNODC) and WHO, "Principles of drug dependence treatment", discussion paper, 2008.

[22] Ibid., p. 15.

without medical evaluation, judicial review or right of appeal – offers no evidence-based[23] or effective treatment. Detention and forced labour programmes therefore violate international human rights law and are illegitimate substitutes for evidence-based measures, such as substitution therapy, psychological interventions and other forms of treatment given with full, informed consent (A/65/255, para. 31). The evidence shows that this arbitrary and unjustified detention is frequently accompanied by – and is the setting for – egregious physical and mental abuse.

Overview of developments to date

43. The numerous calls by various international and regional organizations to close compulsory drug detention centres,[24] as well as the numerous injunctions and recommendations contained in the recently released guidelines by WHO on pharmacotherapy for opiate dependence,[25] the UNODC policy guidance on the organization's human rights responsibilities in drug detention centres,[26] and resolutions by the Commission on Narcotic Drugs,[27] are routinely ignored.[28] These centres continue to operate often with direct or indirect support and assistance from international donors without any adequate human rights oversight.[29]

44. Notwithstanding the commitment to scale-up methadone treatment and evidence-based treatment as opposed to punitive approaches, those remanded to compulsory treatment in the punitive drug-free centres continue to exceed, exponentially, the number receiving evidence-based treatment for drug dependence.[30]

B. Reproductive rights violations

45. The Special Rapporteur has, on numerous occasions, responded to various initiatives in the area of gender mainstreaming and combating violence against women, by, inter alia, examining gender-specific forms of torture with a view to ensure that the torture protection framework is applied in a gender-inclusive manner.[31] The Special Rapporteur seeks to complement these efforts by identifying the reproductive rights practices in health-care settings that he believes amount to torture or ill-treatment.

46. International and regional human rights bodies have begun to recognize that abuse and mistreatment of women seeking reproductive health services can cause tremendous and lasting physical and emotional suffering, inflicted on the basis of gender.[32] Examples of such violations include abusive treatment and humiliation in institutional settings;[33]

[23] See for example WHO, UNODC, UNAIDS, *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users* (WHO, 2009).

[24] World Medical Association, "Call for compulsory drug Detention centers to be closed", press statement, 17 May 2011; United Nations entities, "Compulsory drug detention and rehabilitation centres", joint statement, March 2012.

[25] See Wolfe and Saucier, "In rehabilitation's name".

[26] "UNODC and the promotion and protection of human rights", position paper, 2012, p. 8.

[27] Such as resolutions 55/12 (2012); 55/2 (2012) and 55/10 (2012).

[28] See Wolfe and Saucier, "In rehabilitation's name".

[29] HRW, submission to the Special Rapporteur on the question of torture, 2012.

[30] See Wolfe and Saucier, "In rehabilitation's name".

[31] See A/54/426, A/55/290.

[32] CAT/C/CR/32/5, para. 7 (m); Human Rights Committee general comment No. 28 (2000), para. 11.

[33] See Center for Reproductive Rights, *Reproductive Rights Violations as Torture and Cruel, Inhuman, or Degrading Treatment or Punishment: A Critical Human Rights Analysis* (2011).

involuntary sterilization; denial of legally available health services[34] such as abortion and post-abortion care; forced abortions and sterilizations;[35] female genital mutilation;[36] violations of medical secrecy and confidentiality in health-care settings, such as denunciations of women by medical personnel when evidence of illegal abortion is found; and the practice of attempting to obtain confessions as a condition of potentially life-saving medical treatment after abortion.[37]

47. In the case of *R.R.* v. *Poland*, for instance, ECHR found a violation of article 3 in the case of a woman who was denied access to prenatal genetic testing when an ultrasound revealed a potential foetal abnormality. The Court recognized "that the applicant was in a situation of great vulnerability"[38] and that R.R.'s access to genetic testing was "marred by procrastination, confusion and lack of proper counselling and information given to the applicant".[39] Access to information about reproductive health is imperative to a woman's ability to exercise reproductive autonomy, and the rights to health and to physical integrity.

48. Some women may experience multiple forms of discrimination on the basis of their sex and other status or identity. Targeting ethnic and racial minorities, women from marginalized communities[40] and women with disabilities[41] for involuntary sterilization[42] because of discriminatory notions that they are "unfit" to bear children[43] is an increasingly global problem. Forced sterilization is an act of violence,[44] a form of social control, and a violation of the right to be free from torture and other cruel, inhuman, or degrading treatment or punishment.[45] The mandate has asserted that "forced abortions or sterilizations carried out by State officials in accordance with coercive family planning laws or policies may amount to torture".[46]

49. For many rape survivors, access to a safe abortion procedure is made virtually impossible by a maze of administrative hurdles, and by official negligence and obstruction. In the landmark decision of *K.N.L.H.* v. *Peru*, the Human Rights Committee deemed the denial of a therapeutic abortion a violation of the individual's right to be free from ill-treatment.[47] In the case of *P. and S.* v. *Poland*, ECHR stated that "the general stigma attached to abortion and to sexual violence …, caus[ed] much distress and suffering, both physically and mentally".[48]

50. The Committee against Torture has repeatedly expressed concerns about restrictions on access to abortion and about absolute bans on abortion as violating the prohibition of torture and ill-treatment.[49] On numerous occasions United Nations bodies have expressed

[34] See CAT/C/PER/CO/4, para. 23.
[35] E/CN.4/2005/51, paras. 9, 12.
[36] A/HRC/7/3, paras. 50, 51, 53; CAT/C/IDN/CO/2, para. 16.
[37] CAT/C/CR/32/5, para. 6 (j).
[38] ECHR, *R.R.* v. *Poland*, Application No. 27617/04 (2011), para. 159.
[39] Ibid., para. 153.
[40] See ECHR, *V.C.* v. *Slovakia*, Application No. 18968/07 (2011).
[41] A/67/227, para. 28; A/HRC/7/3, para. 38.
[42] A/64/272, para. 55.
[43] See Open Society Foundations, *Against Her Will: Forced and Coerced Sterilization of Women Worldwide* (2011).
[44] See Committee on the Elimination of Discrimination against Women, general recommendation No. 19, para. 22; Human Rights Committee, general comment No. 28, paras. 11, 20.
[45] A/HRC/7/3, paras. 38, 39.
[46] Ibid., para. 69.
[47] Communication No. 1153/2003 (2005), para. 6.3.
[48] ECHR, Application No. 57375/08 (2012), para. 76.
[49] See CAT/C/PER/CO/4, para. 23.

concern about the denial of or conditional access to post-abortion care.[50] often for the impermissible purposes of punishment or to elicit confession.[51] The Human Rights Committee explicitly stated that breaches of article 7 of the International Covenant on Civil and Political Rights include forced abortion, as well as denial of access to safe abortions to women who have become pregnant as a result of rape[52] and raised concerns about obstacles to abortion where it is legal.

C. Denial of pain treatment

51. In 2012, WHO estimated that 5.5 billion people live in countries with low or no access to controlled medicines and have no or insufficient access to treatment for moderate to severe pain.[53] Despite the repeated reminders made by the Commission on Narcotic Drugs to States of their obligations,[54] 83 per cent of the world population has either no or inadequate access to treatment for moderate to severe pain. Tens of millions of people, including around 5.5 million terminal cancer patients and 1 million end-stage HIV/AIDS patients, suffer from moderate to severe pain each year without treatment.[55]

52. Many countries fail to make adequate arrangements for the supply of these medications.[56] Low- and middle-income countries account for 6 per cent of morphine use worldwide while having about half of all cancer patients and 95 per cent of all new HIV infections.[57] Thirty-two countries in Africa have almost no morphine available at all.[58] In the United States, over a third of patients are not adequately treated for pain.[59] In France, a study found that doctors underestimated pain in over half of their AIDS patients.[60] In India, more than half of the country's regional cancer centres do not have morphine or doctors trained in using it. This is despite the fact that 70 per cent or more of their patients have advanced cancer and are likely to require pain treatment.[61]

53. Although relatively inexpensive and highly effective medications such as morphine and other narcotic drugs have proven essential "for the relief of pain and suffering"[62], these types of medications are virtually unavailable in more than 150 countries.[63] Obstacles that unnecessarily impede access to morphine and adversely affect its availability include overly restrictive drug control regulations[64] and, more frequently, misinterpretation of otherwise appropriate regulations;[65] deficiency in drug supply management; inadequate infrastructure;[66] lack of prioritization of palliative care[67]; ingrained prejudices about using

[50] See CAT/C/CR/32/5, para. 7 (m); A/66/254, para. 30.
[51] CAT/C/CR/32/5, para. 7 (m).
[52] General comment No. 28, para. 11; see also CCPR/CO.70/ARG, para. 14.
[53] WHO, "Access to Controlled Medicines Programme", briefing note (2012), p. 1.
[54] Resolutions 53/4 (2010) and 54/6 (2011).
[55] WHO, "Access", p. 1.
[56] See HRW, *"Please Do Not Make Us Suffer Any More...": Access to Pain Treatment as a Human Right* (2009).
[57] Open Society Foundations, "Palliative care as a human right", Public Health Fact Sheet, 2012.
[58] Ibid.
[59] Ibid.
[60] Ibid.
[61] HRW, *Unbearable Pain: India's Obligation to Ensure Palliative Care* (2009), p. 3.
[62] Single Convention on Narcotic Drugs, 1961, preamble.
[63] Joseph Amon and Diederik Lohman, "Denial of pain treatment and the prohibition of torture, cruel, inhuman or degrading treatment or punishment", *INTERIGHTS Bulletin*, vol. 16, No. 4 (2011), p. 172.
[64] See HRW, *"Please Do Not Make Us Suffer"*.
[65] E/INCB/1999/1, p. 7.
[66] A/65/255, para. 40.

opioids for medical purposes;[68] and the absence of pain management policies or guidelines for practitioners.[69]

Applicability of torture and ill-treatment framework

54. Generally, denial of pain treatment involves acts of omission rather than commission,[70] and results from neglect and poor Government policies, rather than from an intention to inflict suffering. However, not every case where a person suffers from severe pain but has no access to appropriate treatment will constitute cruel, inhuman, or degrading treatment or punishment. This will only be the case when the suffering is severe and meets the minimum threshold under the prohibition against torture and ill-treatment; when the State is, or should be, aware of the suffering, including when no appropriate treatment was offered; and when the Government failed to take all reasonable steps[71] to protect individuals' physical and mental integrity.[72]

55. Ensuring the availability and accessibility of medications included in the WHO Model List of Essential Medicines is not just a reasonable step but a legal obligation under the Single Convention on Narcotic Drugs, 1961. When the failure of States to take positive steps, or to refrain from interfering with health-care services, condemns patients to unnecessary suffering from pain, States not only fall foul of the right to health but may also violate an affirmative obligation under the prohibition of torture and ill-treatment (A/HRC/10/44 and Corr.1, para. 72).

56. In a statement issued jointly with the Special Rapporteur on the right to health, the Special Rapporteur on the question of torture reaffirmed that the failure to ensure access to controlled medicines for the relief of pain and suffering threatens fundamental rights to health and to protection against cruel, inhuman and degrading treatment. Governments must guarantee essential medicines – which include, among others, opioid analgesics – as part of their minimum core obligations under the right to health, and take measures to protect people under their jurisdiction from inhuman and degrading treatment.[73]

D. Persons with psychosocial disabilities

57. Under article 1 of the Convention on the Rights of Persons with Disabilities, persons with disabilities include those who have long-term intellectual or sensory impairments, which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. These are individuals who have been either neglected or detained in psychiatric and social care institutions, psychiatric wards, prayer

[67] Palliative care is an approach that seeks to improve the quality of life of patients diagnosed with life-threatening illnesses, through prevention and relief of suffering. WHO Definition of Palliative Care (see www.who.int/cancer/palliative/definition/en/).

[68] E/INCB/1999/1, p. 7.

[69] HRW, *"Please Do Not Make Us Suffer"*, p. 2.

[70] Amon and Lohman, "Denial", p. 172.

[71] See for example ECHR, *Osman* v. *United Kingdom*, Application No. 23452/94 (1998), paras. 115-122; Committee on Economic, Social and Cultural Rights, general comment No. 14.

[72] Amon and Lohman, "Denial", p. 172.

[73] Joint letter to the Chairperson of the fifty-second session of the Commission on Narcotic Drugs, 2008, p. 4.

camps, secular and religious-based therapeutic boarding schools, boot camps, private residential treatment centres or traditional healing centres.[74]

58. In 2008 the mandate made significant strides in the development of norms for the abolition of forced psychiatric interventions on the basis of disability alone as a form of torture and ill-treatment (see A/63/175). The Convention on the Rights of Persons with Disabilities also provides authoritative guidance on the rights of persons with disabilities and prohibits involuntary treatment and involuntary confinement on the grounds of disability, superseding earlier standards such as the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991 Principles).

59. Severe abuses, such as neglect, mental and physical abuse and sexual violence, continue to be committed against people with psychosocial disabilities and people with intellectual disabilities in health-care settings.[75]

60. There are several areas in which the Special Rapporteur would like to suggest steps beyond what has already been proposed by the mandate in its efforts to promote the Convention on the Rights of Persons with Disabilities as the new normative paradigm and call for measures to combat impunity.

1. A new normative paradigm

61. Numerous calls by the mandate to review the anti-torture framework in relation to persons with disabilities[76] remain to be addressed. It is therefore necessary to reaffirm that the Convention on the Rights of Persons with Disabilities offers the most comprehensive set of standards on the rights of persons with disabilities, inter alia, in the context of health care, where choices by people with disabilities are often overridden based on their supposed "best interests", and where serious violations and discrimination against persons with disabilities may be masked as "good intentions" of health professionals (A/63/175, para. 49).

62. It is necessary to highlight additional measures needed to prevent torture and ill-treatment against people with disabilities, by synthesizing standards and coordinating actions in line with the Convention on the Rights of Persons with Disabilities.[77]

2. Absolute ban on restraints and seclusion

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

[74] See HRW, "*Like a Death Sentence": Abuses against Persons with Mental Disabilities in Ghana* (2012).

[75] In November 2012, the Inter-American Commission on Human Rights approved precautionary measures to protect 300 individuals in Guatemala City's psychiatric facility, where unspeakable forms of abuses were documented.

[76] See A/58/120; A/63/175, para. 41.

[77] See for example Organization of American States, Committee for the Elimination of all Forms of Discrimination against Persons with Disabilities, resolution CEDDIS/RES.1 (I-E/11) (2011), annex.

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.

3. Domestic legislation allowing forced interventions

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.

4. Fully respecting each person's legal capacity is a first step in the prevention of torture and ill-treatment

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).

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).

5. Involuntary commitment in psychiatric institutions

67. In many countries where mental health policies and laws do exist, they focus on confinement of people with mental disabilities in psychiatric institutions but fail to effectively safeguard their human rights.[82]

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[78] See CAT/C/CAN/CO/6, para. 19 (d); ECHR, *Bures* v. *Czech Republic*, Application No. 37679/08 (2012), para. 132.

[79] A/63/175, paras. 44, 47, 61, 63; Human Rights Committee, communication No. 110/1981, *Viana Acosta* v. *Uruguay*, paras. 2.7, 14, 15.

[80] See also A/64/272, para. 74.

[81] Ibid., para. 12.

[82] WHO, "Mental health legislation and human rights – denied citizens: including the excluded", p. 1.

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).

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]

70. Moreover, the effects of institutionalization of individuals who do not meet appropriate admission criteria, as is the case in most institutions which are off the monitoring radar and lack appropriate admission oversight,[91] raise particular questions under prohibition of torture and ill-treatment. Inappropriate or unnecessary non-consensual

[83] See Thomas Hammarberg, "Inhuman treatment of persons with disabilities in institutions", Human Rights Comment (2010).

[84] See Dorottya Karsay and Oliver Lewis, "Disability, torture and ill-treatment: taking stock and ending abuses", *The International Journal of Human Rights*, vol. 16, No. 6 (2012), pp. 816-830.

[85] See also CRPD/C/HUN/CO/1, paras. 27-28.

[86] See CRPD/C/CHN/CO/1 and Corr.1, paras. 92-93.

[87] See Peter Bartlett, "A mental disorder of a kind or degree warranting confinement: examining justifications for psychiatric detention, *The International Journal of Human Rights*, vol. 16, No. 6 (2012), pp. 831-844.

[88] See ECHR, *Winterwerp* v. *The Netherlands*, Application No. 6301/73 (1979) and ECHR, *E* v. *Norway*, Application No. 11701/85 (1990).

[89] See Bartlett, "A mental disorder".

[90] Stop Torture in Healthcare, "Torture and ill-treatment of people with disabilities in healthcare settings", Campaign Briefing, 2012.

[91] See CAT/C/JPN/CO/1, para. 26.

institutionalization of individuals may amount to torture or ill-treatment as use of force beyond that which is strictly necessary.[92]

E. Marginalized groups

1. Persons living with HIV/AIDS

71. Numerous reports have documented mistreatment of or denial of treatment to people living with HIV/AIDS by health providers.[93] They are reportedly turned away from hospitals, summarily discharged, denied access to medical services unless they consent to sterilization,[94] and provided poor quality care that is both dehumanizing and damaging to their already fragile health status.[95] Forced or compulsory HIV testing is also a common abuse that may constitute degrading treatment if it is "done on a discriminatory basis without respecting consent and necessity requirements" (A/HRC/10/44 and Corr.1, para. 65). Unauthorized disclosure of HIV status to sexual partners, family members, employers and other health workers is a frequent abuse against people living with HIV that may lead to physical violence.

2. Persons who use drugs

72. People who use drugs are a highly stigmatized and criminalized population whose experience of health-care is often one of humiliation, punishment and cruelty. Drug users living with HIV are often denied emergency medical treatment.[96] In some cases the laws specifically single out the status of a drug user as a stand-alone basis for depriving someone of custody or other parental rights. Use of drug registries – where people who use drugs are identified and listed by police and health-care workers, and their civil rights curtailed – are violations of patient confidentiality[97] that lead to further ill-treatment by health providers.

73. A particular form of ill-treatment and possibly torture of drug users is the denial of opiate substitution treatment, including as a way of eliciting criminal confessions through inducing painful withdrawal symptoms (A/HRC/10/44 and Corr.1, para. 57). The denial of methadone treatment in custodial settings has been declared to be a violation of the right to be free from torture and ill-treatment in certain circumstances (ibid., para. 71). Similar reasoning should apply to the non-custodial context, particularly in instances where Governments impose a complete ban on substitution treatment and harm reduction measures.[98] The common practice of withholding anti-retroviral treatment from HIV-positive people who use drugs, on the assumption that they will not be capable of adhering to treatment, amounts to cruel and inhuman treatment, given the physical and psychological suffering as the disease progresses; it also constitutes abusive treatment based on unjustified discrimination solely related to health status.

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[92] ECHR, *Mouisel* v. *France*, Application No. 67263/01 (2002), para. 48; see also Nell Monroe, "Define acceptable: how can we ensure that treatment for mental disorder in detention is consistent with the UN Convention on the Rights of Persons with Disabilities?", *The International Journal of Human Rights*, vol. 16, No. 6 (2012).

[93] Campaign to Stop Torture in Health Care, "Torture and ill-treatment in health settings: a failure of accountability", *Interights Bulletin*, vol. 16, No. 4 (2011), p. 162.

[94] Open Society Foundations, *Against Her Will* (footnote 43 above).

[95] See HRW, *Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight against HIV/AIDS* (2006).

[96] Ibid., p. 44.

[97] A/65/255, para. 20.

[98] See HRW, *Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation* (2004).

74. By denying effective drug treatment, State drug policies intentionally subject a large group of people to severe physical pain, suffering and humiliation, effectively punishing them for using drugs and trying to coerce them into abstinence, in complete disregard of the chronic nature of dependency and of the scientific evidence pointing to the ineffectiveness of punitive measures.

3. Sex workers

75. A report on sex workers documented negative and obstructive attitudes on the part of medical workers, including denial of necessary health-care services.[99] Public health rationales have in some instances led to mandatory HIV testing and exposure of their HIV status, accompanied by punitive measures.[100] Breaches of privacy and confidentiality are a further indignity experienced by sex workers in health settings.[101] Most recently, the Committee against Torture noted "reports of alleged lack of privacy and humiliating circumstances amounting to degrading treatment during medical examinations".[102] The mandate has observed that acts aimed at humiliating the victim, regardless of whether severe pain has been inflicted, may constitute degrading treatment or punishment because of the incumbent mental suffering (E/CN.4/2006/6, para. 35).

4. Lesbian, gay, bisexual, transgender and intersex persons

76. The Pan American Health Organization (PAHO) has concluded that homophobic ill-treatment on the part of health professionals is unacceptable and should be proscribed and denounced.[103] There is an abundance of accounts and testimonies of persons being denied medical treatment, subjected to verbal abuse and public humiliation, psychiatric evaluation, a variety of forced procedures such as sterilization, State-sponsored forcible anal examinations for the prosecution of suspected homosexual activities, and invasive virginity examinations conducted by health-care providers,[104] hormone therapy and genital-normalizing surgeries under the guise of so called "reparative therapies".[105] These procedures are rarely medically necessary,[106] can cause scarring, loss of sexual sensation, pain, incontinence and lifelong depression and have also been criticized as being unscientific, potentially harmful and contributing to stigma (A/HRC/14/20, para. 23). The Committee on the Elimination of Discrimination against Women expressed concern about lesbian, bisexual, transgender and intersex women as "victims of abuses and mistreatment by health service providers" (A/HRC/19/41, para. 56).

77. Children who are born with atypical sex characteristics are often subject to irreversible sex assignment, involuntary sterilization, involuntary genital normalizing surgery, performed without their informed consent, or that of their parents, "in an attempt to

[99] Campaign to Stop Torture in Health Care, "Torture", p. 163; see also A/64/272, para. 85.
[100] WHO and the Global Coalition on Women and AIDS, "Violence against sex workers and HIV prevention" (WHO, 2005), p. 2.
[101] Campaign to Stop Torture in Health Care, "Torture", p. 163.
[102] CAT/C/AUT/CO/4-5, para. 22.
[103] PAHO, " 'Cures' for an illness that does not exist" (2012), p. 3.
[104] See HRW, *In a Time of Torture: The Assault on Justice in Egypt's Crackdown on Homosexual Conduct* (2003).
[105] PAHO/WHO, " 'Therapies' to change sexual orientation lack medical justification and threaten health", news statement, 17 May 2012; and submission by Advocates for Informed Choice to the Special Rapporteur on the question of torture, 2012.
[106] PAHO/WHO, " 'Therapies'".

fix their sex",[107] leaving them with permanent, irreversible infertility and causing severe mental suffering.

78. In many countries transgender persons are required to undergo often unwanted sterilization surgeries as a prerequisite to enjoy legal recognition of their preferred gender. In Europe, 29 States require sterilization procedures to recognize the legal gender of transgender persons. In 11 States where there is no legislation regulating legal recognition of gender,[108] enforced sterilization is still practised. As at 2008, in the United States of America, 20 states required a transgender person to undergo "gender-confirming surgery" or "gender reassignment surgery" before being able to change their legal sex.[109] In Canada, only the province of Ontario does not enforce "transsexual surgery" in order to rectify the recorded sex on birth certificates.[110] Some domestic courts have found that not only does enforced surgery result in permanent sterility and irreversible changes to the body, and interfere in family and reproductive life, it also amounts to a severe and irreversible intrusion into a person's physical integrity. In 2012, the Swedish Administrative Court of Appeals ruled that a forced sterilization requirement to intrude into someone's physical integrity could not be seen as voluntary.[111] In 2011, the Constitutional Court in Germany ruled that the requirement of gender reassignment surgery violated the right to physical integrity and self-determination.[112] In 2009, the Austrian Administrative High Court also held that mandatory gender reassignment, as a condition for legal recognition of gender identity, was unlawful.[113] In 2009, the former Commissioner for Human Rights of the Council of Europe observed that "[the involuntary sterilization] requirements clearly run counter to the respect for the physical integrity of the person".[114]

79. The mandate has noted that "members of sexual minorities are disproportionately subjected to torture and other forms of ill-treatment because they fail to conform to socially constructed gender expectations. Indeed, discrimination on grounds of sexual orientation or gender identity may often contribute to the process of the dehumanization of the victim, which is often a necessary condition for torture and ill-treatment to take place."[115] "Medically worthless" practices of subjecting men suspected of homosexual conduct to non-consensual anal examinations to "prove" their homosexuality[116] have been condemned by the Committee against Torture, the Special Rapporteur on the question of torture and the Working Group on Arbitrary Detention, which have held that the practice contravenes the prohibition of torture and ill-treatment (A/HRC/19/41, para. 37).

5. Persons with disabilities

80. Persons with disabilities are particularly affected by forced medical interventions, and continue to be exposed to non-consensual medical practices (A/63/175, para. 40). In the case of children in health-care settings, an actual or perceived disability may diminish the

[107] A/HRC/19/41, para. 57.

[108] Commissioner for Human Rights of the Council of Europe, *Discrimination on Grounds of Sexual Orientation and Gender Identity in Europe* (2011), pp. 86-87.

[109] D. Spade, "Documenting gender", *Hastings Law Journal*, vol. 59, No. 1 (2008), pp. 830-831.

[110] *XY* v. *Ontario*, 2012 HRTO 726 (CanLII), judgement of 11 April 2012.

[111] Mål nr 1968-12, Kammarrätten i Stockholm, Avdelning 03, http://du2.pentagonvillan.se/images/stories/Kammarrttens_dom_-_121219.pdf, p. 4.

[112] Federal Constitutional Court, *1 BvR 3295/07*. Available from www.bundesverfassungsgericht.de/entscheidungen/rs20110111_1bvr329507.html.

[113] Administrative High Court, No. 2008/17/0054, judgement of 27 February 2009.

[114] "Human rights and gender identity", issue paper (2009), p. 19.

[115] A/56/156, para. 19. See also E/CN.4/2001/66/Add.2, para. 199.

[116] Working Group on Arbitrary Detention, opinion No. 25/2009 (2009), para. 29.

weight given to the child's views[117] in determining their best interests, or may be taken as the basis of substitution of determination and decision-making by parents, guardians, carers or public authorities.[118] Women living with disabilities, with psychiatric labels in particular, are at risk of multiple forms of discrimination and abuse in health-care settings. Forced sterilization of girls and women with disabilities has been widely documented.[119] National law in Spain, among other countries,[120] allows for the sterilization of minors who are found to have severe intellectual disabilities. The Egyptian Parliament failed to include a provision banning the use of sterilization as a "treatment" for mental illness in its patient protection law. In the United States, 15 states have laws that fail to protect women with disabilities from involuntary sterilization.[121]

V. Conclusions and recommendations

A. Significance of categorizing abuses in health-care settings as torture and ill-treatment

81. **The preceding examples of torture and ill-treatment in health-care settings likely represent a small fraction of this global problem. Such interventions always amount at least to inhuman and degrading treatment, often they arguably meet the criteria for torture, and they are always prohibited by international law.**

82. **The prohibition of torture is one of the few absolute and non-derogable human rights,**[122] **a matter of *jus cogens*,**[123] **a peremptory norm of customary international law. Examining abuses in health-care settings from a torture protection framework provides the opportunity to solidify an understanding of these violations and to highlight the positive obligations that States have to prevent, prosecute and redress such violations.**

83. **The right to an adequate standard of health care ("right to health") determines the States' obligations towards persons suffering from illness. In turn, the absolute and non-derogable nature of the right to protection from torture and ill-treatment establishes objective restrictions on certain therapies. In the context of health-related abuses, the focus on the prohibition of torture strengthens the call for accountability and strikes a proper balance between individual freedom and dignity and public health concerns. In that fashion, attention to the torture framework ensures that system inadequacies, lack of resources or services will not justify ill-treatment. Although resource constraints may justify only partial fulfilment of some aspects of the right to health, a State cannot justify its non-compliance with core obligations, such as the absolute prohibition of torture, under any circumstances.**[124]

84. **By reframing violence and abuses in health-care settings as prohibited ill-treatment, victims and advocates are afforded stronger legal protection and redress**

[117] Committee on the Rights of the Child, general comment No. 12 (2009), para. 21.
[118] See A/HRC/20/5, para. 53 (d); A/63/175, para. 59.
[119] See Independent Expert for the Secretary-General's Study on Violence against Children, *World Report on Violence against Children* (2009).
[120] Open Society Foundations, *Against Her Will* (footnote 43 above), p. 6, A/64/272, para. 71.
[121] Open Society Foundations, *Against Her Will*, p. 6.
[122] Convention against Torture, art. 2, para. 2, International Covenant on Civil and Political Rights, art. 7.
[123] See International Criminal Tribunal for the Former Yugoslavia, *Prosecutor* v. *Furundzija*, case No. IT-95- 17/1-T, judgement (1998).
[124] See Committee on Economic, Social and Cultural Rights, general comment No. 14.

for violations of human rights. In this respect, the recent general comment No. 3 (2012) of the Committee against Torture on the right to a remedy and reparation offers valuable guidance regarding proactive measures required to prevent forced interventions. Notably, the Committee considers that the duty to provide remedy and reparation extends to all acts of ill-treatment,[125] so that it is immaterial for this purpose whether abuses in health-care settings meet the criteria for torture per se. This framework opens new possibilities for holistic social processes that foster appreciation of the lived experiences of persons, including measures of satisfaction and guarantees of non-repetition, and the repeal of inconsistent legal provisions.

B. Recommendations

85. **The Special Rapporteur calls upon all States to:**

(a) Enforce the prohibition of torture in all health-care institutions, both public and private, by, inter alia, declaring that abuses committed in the context of health-care can amount to torture or cruel, inhuman or degrading treatment or punishment; regulating health-care practices with a view to preventing mistreatment under any pretext; and integrating the provisions of prevention of torture and ill-treatment into health-care policies;

(b) Promote accountability for torture and ill-treatment in health-care settings by identifying laws, policies and practices that lead to abuse; and enable national preventive mechanisms to systematically monitor, receive complaints and initiate prosecutions;

(c) Conduct prompt, impartial and thorough investigations into all allegations of torture and ill-treatment in health-care settings; where the evidence warrants it, prosecute and take action against perpetrators; and provide victims with effective remedy and redress, including measures of reparation, satisfaction and guarantees of non-repetition as well as restitution, compensation and rehabilitation;

(d) Provide appropriate human rights education and information to health-care personnel on the prohibition of torture and ill-treatment and the existence, extent, severity and consequences of various situations amounting to torture and cruel, inhuman or degrading treatment or punishment; and promote a culture of respect for human integrity and dignity, respect for diversity and the elimination of attitudes of pathologizaton and homophobia. Train doctors, judges, prosecutors and police on the standards regarding free and informed consent;

(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;

[125] General comment No. 3, para. 1.

(f) Ensure special protection of minority and marginalized groups and individuals as a critical component of the obligation to prevent torture and ill-treatment[126] by, inter alia, investing in and offering marginalized individuals a wide range of voluntary supports that enable them to exercise their legal capacity and that fully respect their individual autonomy, will and preferences.

1. Denial of pain relief

86. **The Special Rapporteur calls upon all States to:**

(a) Adopt a human rights-based approach to drug control as a matter of priority to prevent the continuing violations of rights stemming from the current approaches to curtailing supply and demand (A/65/255, para. 48). Ensure that national drug control laws recognize the indispensible nature of narcotic and psychotropic drugs for the relief of pain and suffering; review national legislation and administrative procedures to guarantee adequate availability of those medicines for legitimate medical uses;

(b) Ensure full access to palliative care and overcome current regulatory, educational and attitudinal obstacles that restrict availability to essential palliative care medications, especially oral morphine. States should devise and implement policies that promote widespread understanding about the therapeutic usefulness of controlled substances and their rational use;

(c) Develop and integrate palliative care into the public health system by including it in all national health plans and policies, curricula and training programmes and developing the necessary standards, guidelines and clinical protocols.

2. Compulsory detention for medical reasons

87. **The Special Rapporteur calls upon all States to:**

(a) Close compulsory drug detention and "rehabilitation" centres without delay and implement voluntary, evidence-based and rights-based health and social services in the community. Undertake investigations to ensure that abuses, including torture or cruel, inhuman and degrading treatment, are not taking place in privately-run centres for the treatment of drug dependence;

(b) Cease support for the operation of existing drug detention centres or the creation of new centres. Any decision to provide funding should be made only following careful risk assessment. If provided, any such funds should be clearly time-limited and provided only on the conditions that the authorities (a) commit to a rapid process for closing drug detention centres and reallocating said resources to scaling up voluntary, community-based, evidence-based services for treatment of drug dependence; and (b) replace punitive approaches and compulsory elements to drug treatment with other, evidence-based efforts to prevent HIV and other drug-related harms. Such centres, while still operating as the authorities move to close them, are subject to fully independent monitoring;

(c) Establish an effective mechanism for monitoring dependence treatment practices and compliance with international norms;

[126] See Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 43 (a)-(f).

(d) Ensure that all harm-reduction measures and drug-dependence treatment services, particularly opioid substitution therapy, are available to people who use drugs, in particular those among incarcerated populations (A/65/255, para. 76).

3. Lesbian, gay, bisexual, transgender and intersex persons

88. **The Special Rapporteur calls upon all States to repeal any law allowing intrusive and irreversible treatments, including forced genital-normalizing surgery, involuntary sterilization, unethical experimentation, medical display, "reparative therapies" or "conversion therapies", when enforced or administered without the free and informed consent of the person concerned. He also calls upon them to outlaw forced or coerced sterilization in all circumstances and provide special protection to individuals belonging to marginalized groups.**

4. Persons with psychosocial disabilities

89. **The Special Rapporteur calls upon all States to:**

(a) Review the anti-torture framework in relation to persons with disabilities in line with the Convention on the Rights of Persons with Disabilities as authoritative guidance regarding their rights in the context of health-care;

(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]

(c) Replace forced treatment and commitment by services in the community. Such services must meet needs expressed by persons with disabilities and respect the autonomy, choices, dignity and privacy of the person concerned, with an emphasis on alternatives to the medical model of mental health, including peer support, awareness-raising and training of mental health-care and law enforcement personnel and others;

(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.

5. Reproductive rights

90. **The Special Rapporteur calls upon all States to ensure that women have access to emergency medical care, including post-abortion care, without fear of criminal penalties or reprisals. States whose domestic law authorizes abortions under various circumstances should ensure that services are effectively available without adverse consequences to the woman or the health professional.**

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[127] Convention on the Rights of Persons with Disabilities, art. 4, para. 2.