

*The following is a presentation by Tina Minkowitz on "Crazy Talks" held on May 5, 2015, transcribed by Irit Shimrat. Crazy Talks is a monthly discussion group meeting in Toronto on psych and mad politics, hosted by Erick Fabris.*

Erick: Tina Minkowitz was instrumental in setting up the psychosocial side of the Convention on the Rights of Persons with Disabilities (CRPD). As an international convention, it has a lot of say as to how we can defend our rights. Canada signed on to CRPD. Of course, when it did that, it was pretending to be compliant with CRPD. It is definitely not compliant. It's not following the rules as it should. And one of the reasons is that it has mental health acts. It has laws that say that psychiatrists can lock you up if you're having any kind of distress – which they call incapacity, or mental illness.

Tina: The CRPD is a human rights treaty of the United Nations; it's part of international law. So, for countries that have ratified it, like Canada, it's actually legally binding, as a matter of international law. But how each country treats it, in terms of its own legal system, domestically, is different. And I think Canada is one of the countries that doesn't make it so easy to actually use the Convention in your own legal system. But, still, there are things we can talk about, in terms of what you can actually do with this treaty.

So, as Erick said, I worked on the Convention, along with other people. And what I was particularly involved with was trying to make sure that this treaty reflected what we wanted. What our movement – you know, I identify as a survivor of psychiatric abuse – what this survivor movement has been wanting for the past thirty, forty years of its existence. And, at the same time, to make sure that we're looking at it holistically.

That's maybe a little bit too abstract. But I see it as having some really key issues, like the right to be free from forced treatment and commitment in a psychiatric institution. The way that I thought to frame that – because if you're going to work on a human rights treaty, you have to relate to the existing human rights framework. You have to look at, what are the human rights that are already recognized in international law, and how can we make sure that those rights are applied to us in the way that we want them to be?

So, that's where the framework of nondiscrimination based on disability comes in. And I know that the concept of whether we identify as people with

disabilities is controversial in the community of users and survivors of psychiatry. For some people, it's very comfortable to identify that way. For others, it isn't.

I have many mixed feelings about it. But the way that I'm most comfortable relating to it is to say that, for me, in my experience, it was a perceived disability. The fact that I was locked up in psychiatry and forced to take drugs – it was an act of violence against me.

And why was it allowed to happen? Why did society think that this was okay to happen to me? Because they think there's something wrong with me, that needs to be fixed. And that, I would consider discrimination based on perceived disability.

And then, at the same time, many people want some kind of support or service or accommodation in order to – one of my friends says, in order to live well. There may be different things that we need, as positive rights. We all, as human beings, need certain things to survive. We all need food, and housing, and health care, and the basic necessities of life. And some of us also need different kinds of supports at different times. So some of us in the user/survivor community also identify that we might need personal assistants, or therapists, or psychiatric help, or peer support, or whatever it is that we use.

So, it's important to understand that the CRPD actually has ways of addressing both those issues: both the fact that we have the right to be free from forced treatment and free from psychiatric detention, or commitment; and the right to have our legal capacity respected. The right to have our decision-making respected, and not have somebody else come in to make decisions for us. And, we also have the right to have positive supports that reflect our own will and preferences.

That's actually part of the structure of human rights law: that you have the right to be free from these intrusions and acts of violence against your autonomy and your physical personhood, and you also have positive rights to the things that human beings need for our well-being, and that the community as a whole has an obligation to provide for each other.

So, that's a kind of basic overview. And I can say, also, that the principles of the CRPD, in Article 3, are a good reference point to show what the values

are, underlying the Convention. So, if people are interested, you could look at the CRPD itself. And I would encourage you to look at the text of the Treaty and see what you find there. The principles are in Article 3. And the first principle, to paraphrase, is respect for individual autonomy, including the freedom to make one's own choices. That's the number-one principle of the Convention.

Also included in the principles are: nondiscrimination; inclusion and participation; respect for diversity – acceptance of people with disabilities as part of human diversity, and part of humanity; accessibility; equality of opportunities. There is language about the evolving capacity of children, and respect for the right of children with disabilities to preserve their identities – so, that's birth registration. And equality between men and women.

So, those are the principles. And that gives a good picture of what I would call some of the values. So, there's many ways that we need to look at inclusion, for instance. But I think I would like to just talk a little bit about some of the key issues that we worked on – particularly, legal capacity, liberty and freedom from forced interventions.

For me, I often start with the premise that forced interventions are a form of torture. And I've done some work on this – going through the international law on the definition of torture, and how it actually applies very well to acts of forced psychiatry.

In the Convention, there's an article generally prohibiting torture and ill-treatment – Article 15. But the specifics of prohibiting forced treatment are really a result of a provision that says there has to be free and informed consent in health care. And that's Article 25, on health.

It's generally understood that a corollary of the right to free and informed consent – because consent has to be free – is that there can't be any force against the person's will.

Now, we also need legal capacity there. Because, in many countries – in many jurisdictions – the way they legally justify forced treatment is to say that we lack the capacity to make our own decisions. The CRPD is truly innovative with regard to legal capacity, because it says that people with disabilities have legal capacity on an equal basis with others in all aspects of life; that states have an obligation to provide support that people may need in

the exercise of legal capacity – but that all acts related to the exercise of legal capacity, which would include support, have to respect the person’s wishes and preferences.

So, support is basically anything that can help a person to make their own decision, whether it’s talking things out with a friend, or having somebody sit with you while you fill out a form, or explain things to you in plain language that you find it easier to understand. The one thing support can’t do is anything that’s against your will.

The Committee on the Rights of Persons with Disabilities, which monitors this Convention, issued a General Comment on legal capacity – on Article 12, which is the article that deals with legal capacity – about a year ago. They basically affirmed everything that I just said about what the basic meaning of that article of the Convention is. That there cannot be substitute decision-making; that the person’s legal capacity must *always* be respected – even in crisis situations; and that you don’t have to accept support. You have the right to accept or refuse any kind of support. And that a person’s actual or perceived decision-making skill or mental capacity can never be used as the basis for denying the legal capacity of the person – which is the right to make decisions.

So, I would also really encourage you to read this General Comment – it’s General Comment Number One. It’s actually very well written, and I think it’s a good explanation of many areas of legal capacity. In that General Comment, they also say, in several places, that forced treatment is a violation of legal capacity and must be abolished. And they also say that it infringes on the right to freedom from torture and ill-treatment. And that was actually an important step. There’s a lot of potential in how we can use the prohibition and prevention of torture, and the question of the obligation to make reparations for acts of torture and ill-treatment.

The last one that I wanted to mention was liberty. That’s where we say that psychiatric detention is discrimination based on disability, because it’s explicitly only being done to you because you’ve been labeled with a psychiatric diagnosis, which is a perceived disability. So, the fact that there’s this special form of detention that is only applied to people who are labeled with psychiatric diagnoses – it’s a discriminatory form of detention. And it has to be abolished.

If people with disabilities are convicted of having committed crimes, and are subjected to some kind of detention regimen of the state – the CRPD doesn't say that you can't do that. It's not that people with disabilities cannot be subjected to detention. It's only that they can't practise civil psychiatric commitment, because it is a particular form of deprivation of liberty that's based on disability, and is therefore discriminatory.

In regard to procedural obligations, Article 33 of the Convention says that the governments have to create one or more national focal points to work on actually implementing the Convention, and that they have to set up a national monitoring mechanism. And I don't know if Canada has anything like a national human rights institution, but in many countries that have such an entity, the national human rights institution becomes the monitoring mechanism.

Another important thing to know about procedural obligations is that Article 4, Paragraph 3, says that in the development and implementation of legislation that accords with Convention, and in other decision-making processes concerning issues related to people with disabilities, states have to closely consult with and actively involve persons with disabilities through their representative organizations. And it also says, "including children with disabilities." So, that's something I haven't mentioned. But there is an article on children with disabilities. And we know that psychiatry is very damaging to children. So that may be something you want to look at, also.

There are many things in the Convention. I've only talked about the things that I consider the key issues, because these are the areas where the Convention really makes new law – where it breaks new ground in international law, both in its text and in the interpretation which has been made officially, by the Committee, in the monitoring.

I think these are at the core of the ways in which people with psychosocial disabilities are discriminated against and have our rights violated. If these things were resolved, I think issues like discrimination in work, discrimination in access to health care – anything else that we might think of – can be more easily resolved. But we also can look at the Convention holistically, and all the different ways that people are finding their rights violated.

Erick: Tina – can you give us an idea of what life might be like for psychiatric survivors if everything worked out, let's say, in Canada, and they abolished laws that contradicted the CRPD? Can you give us a quick sketch of what CRPD principles might lead to, in terms of what the Convention is pushing for?

Tina: The first step, I think, would be to abolish the forced treatment, commitment and incapacity laws. I think our movement, in many ways, has come to take these laws for granted. So, prior to the CRPD, we were looking for ways to get better rights within those laws; for instance, to make it harder for them to lock us up or force-treat us.

But the CRPD actually says they have to abolish those laws and let everybody out. So there wouldn't be any external locks on the doors of the psych ward. If you're in a place that you're going to for respite, you might want to lock your own door from the inside, so nobody can get in if you don't want them to. But there wouldn't be anybody locking you in. No restraints. No solitary confinement. No take-down. No injections. No force-drugging.

Not even trying to wheedle you into taking drugs that you don't want. They really should not be doing any of that. If a person wants drugs – if a person is open to trying drugs that could help them – could alleviate some of their distress – then there needs to be a respectful informed-consent discussion based on that. But it could never be forced. And it has to be with free, informed consent.

And it could never be coerced, either overtly or even subtly. It can't be, like, "Okay, we'll give you housing if you take the drugs. And if you don't take the drugs, we might deny you housing." You'll have a right to housing, because that's a human right. And you'll have the right not to take drugs that you don't want, because that's a human right.

One article that I didn't mention, but that's related to all this, is Article 19, on living independently and being included in the community. And that says that people with disabilities have the right to live where and with whom they choose, on an equal basis with others. And to have the disability-related supports and services they need to prevent isolation or segregation and to enable living and inclusion in the community – and that can include personal assistants. And that community services and facilities for the general

population are available on an equal basis to persons with disabilities and responsive to their needs.

One comrade, I think from Ireland, once mentioned that he would like the pubs to be places that he could feel comfortable going to, and that he wouldn't feel were excluding him. So, pubs, or places of religious worship, or yoga classes – anything that the community has, needs to be open and welcoming to us, and responsive to our needs.

And people who want them could have personal assistants, or service animals, or whatever kind of supports they need. This is based on the Independent Living movement [which supports the rights of people with intellectual disabilities]. It's an invitation to think, outside the medical model, of what kinds of services and supports we might actually want. What would actually enhance our lives? What could help us if we are concerned that we might have some kind of a crisis?

I know we have a lot of these things. There are a lot of alternatives. And alternatives that exist only in small places, or that survivors would like to use but that aren't available in the mainstream – those have to be brought into the mainstream.

And it has to be done proactively. I don't think we can count on the idea that, just by our abolishing forced treatment, the alternatives will flourish. I think they're complementary – I think you have to abolish forced treatment. And, once you do that, I think it will make it less likely that people will just go to the medical model. But, still, if the medical model is all that's being offered, people are going to be harmed by not getting things that might do better for them. So, we need to have both those kinds of things happen.

And I think we would also see, generally, on the issue of legal capacity – beyond people with psychosocial disabilities, people with intellectual disabilities being included in the community, and having the support they need to make their decisions.

A lot of us are getting older, and are concerned about what will happen to us if we are diagnosed with dementia, or if somebody thinks, because we've reached a certain stage in life, that we no longer have capacity, or that we should be put in an old age home. And that is also prohibited by the Convention.

This is an application of the Convention that there's been some resistance to. And it's not the most active, in terms of advocacy. But I think that it's actually very important, because older people who are being labeled with dementia also count as people with disabilities. The fact that you've reached a certain age doesn't mean that you're no longer covered. You'd still have your rights covered. So you would have the right not to have somebody coming and threatening you with guardianship, or actually putting you under guardianship.

And, if we want to have support in making decisions – whether we're in a crisis situation, or we're getting older, or we have a progressive illness or disability, and might need increasing support as time goes on – that we have a right to have all that support respect our autonomy and our own choices. That whole issue of what happens when we get older is something that concerns me a lot. It's been an issue in my family.

I think that's important to understand – that this can lead to societal changes beyond the issue of users and survivors of psychiatry, or the mental health system.

I think it means that society in general – members of communities – are going to have to adjust to accepting each other, and learning how to relate to each other with greater diversity, including greater diversity in ways of communicating, greater emotional diversity and mental diversity, and experiences of distress.

What is most interesting to you? What made you interested in coming and participating in this tonight?

A: I have a label. I consider the label a disease, just like cancer. Right now, I'm in remission. I'm taking proactive steps to ensure that I continue to have control over my life. However, realistically speaking, there might be a danger that I'll blow my top. I want to feel secure, that someone in authority – perhaps the police, or the attending psychiatric resident at the hospital – has the knowledge to do for me, until I come back to my senses. If I'm a danger to myself or others, the police are allowed to “form” me, and they take me to a psychiatric ward, and I have to take the treatment that is given. So, I'm just wondering whether or not the Convention would address



anything like that. The first responders. The ambulance people. The police. The resident psych at the emergency department. Is there a place for them?

Tina: That's an important question. The Convention text does not talk about that. But the interpretation being made by the Committee on the Rights of Persons with Disabilities – in the General Comment on Legal Capacity and also in what they say about liberty, in concluding observations on the reports of states' parties, is that people with disabilities have legal capacity, even in crisis situations. And that this notion of danger to self or others is not a legitimate reason for depriving a person of their liberty based on disability.

A: Maybe I'm not making myself clear. I would *like* for them to...

Tina: I understand. I hear you. What I think would be useful to do, is to look at how we can make sure that people can be safe in these situations, without depriving them of their liberty or their legal capacity. The reason I think we have to do it that way is that we need to balance the need that some of us feel for some kind of support that is – that kind of holding you – wanting somebody to take care of things for you until you come back to yourself. To make sure that you're safe. There's that need.

But then there's also the other need that many of us have, not to have other people make assumptions about what we might want or what might be good for us in those kinds of situations. And there are different choices and preferences that people have. So, I think – I'm not someone who works on the alternatives and supports. I think that the people who do, and people who have had a wide variety of different kinds of experiences in this regard, need to figure out some ways of dealing with it.

One way that's provided for in the General Comment is that you could make an Advance Directive. If you know – or even if you don't know, but if you have some idea of, what would work for you – then you make that kind of a plan beforehand. And you can always change it. Nothing's a perfect solution. But it allows you to keep evolving over time, and to keep working out better ways of making something that could work for you, I think.

A: Absolutely. I agree with you totally. And I do have that in place. But, at the point of initial crisis – when it happens – I'm not in the right frame of mind to call my friends and say, "Okay. It's time."

Tina: I think we need – I've actually had an idea that I've wanted somebody to take up, that I could work on the legal aspect, but I don't know the alternatives aspect. I think we need to have some kind of exploratory project, or pilot project, on supported decision-making in crisis situations. What would people want that to look like? How would it work? Who would be the first responders? What would be their duties?

I agree with you that we need to have some kind of first responders, because most of us are probably not going to be able to be proactive for ourselves in a crisis situation. So we need to have some kind of first responders. And they need to be able to operate in a way that is caring and, at the same time, respectful of the person's autonomy.

A: I agree with that suggestion. I also think that they have to be able to speak to the whole continuum, of all degrees of psychosocial illness, right up to a psychotic episode. The first responders have to deal with us, until we get to our caregivers. So that was my question to you. Whether the Convention covers any of that. But I guess that needs to be another project.

Tina: The Convention covers it, in principle. I would really urge you to read the General Comment. It's worth reading the whole thing. It's thirteen pages. But I think, for this issue, I would especially encourage you to read the part that's about Article 12, Paragraph 3. And that includes something about Advance Directives, and different kind of support. But that's just the general parameters of how something could be set up.

I'll share with Erick, and he can make available to you, an article that I wrote on legal capacity, where I'm proposing this kind of pilot project on supported decision-making in crisis situations. Maybe somebody in Canada would be interested in working on something like that. Nobody has done it yet, and I think it's one of the things that's most needed.

A: That sounds good.

Tina: Yeah. And thank you for that question.

B: [comment about methadone clinic procedure]

Tina: I'm not sure I understood everything you said. Were you saying that, in the methadone clinic, if people were psychotic, the protocol was to call the

police, and they were supposed to take them to a psych hospital or psych clinic, but then they would take them to jail instead?

B: Yes.

Tina: Wow!

Erick: Was there any reason given? Were there “no services,” and so they had to send them somewhere else? Was there any kind of excuse given? Often policemen have told us activists that if they go to the mental health ward, then they’re stuck there for twelve hours, and ...

B: Exactly.

Erick: But then why should they take someone to jail? I think that’s your point, right?

B: Yes.

C: Prison’s better than – I mean, the difference between psych ward and jail – I mean, both of them are not places you want to be. Some people say you have more rights in the criminal system.

Tina: This is actually raising an interesting question, because in both places – if they take you to a psych ward *or* if they take you to a jail – somebody is taking away your right to make your own decisions. If people were psychotic, I guess the first question is, can they be accommodated in the methadone clinic? Is there some way that the clinic can develop the skills to support people who are going through that state, at the same time that they also have the substance-abuse issues?

Even private clinics are regulated in some way by the state. So, thinking about a private mental health clinic – I don’t want to get into things that I don’t really know about. But private clinics would still have certain obligations – for instance, nondiscrimination. And, under the Convention, governments would need to pass laws to ensure that there be no discrimination based on disability. It may actually constitute discrimination for a private clinic to turn somebody away because of their psychosocial disability – unless there was some way they could say that the person couldn’t be reasonably accommodated in the existing situation.

I think that in such a case, calling the police is an act of discrimination. Because, what are you calling the police about, you know? Because, under the CRPD, you would not be able to call the police – or call *anybody* – to have somebody taken away because they're psychotic. There should be no kind of protocol that a methadone clinic, or a mental health clinic, or your neighbours, or anybody else could just call the police and have you taken away.

So, let's say it's supposed to be to a psych hospital. I guess they could arrest you and take you to jail on some pretext. Now, that brings up the whole question of the criminal context. That does get a little bit more complicated. Because if the criminal laws say, for instance, that there's a crime, that – in New York, they have “disorderly conduct.” If the police don't like what you're doing in the street, they may arrest you for disorderly conduct. And I could imagine that kind of thing being used, if somebody wants to get rid of somebody who's in a psychotic state.

But I think we're going to need to look at whether and how those kinds of laws are being used specifically to get rid of people with psychosocial disabilities. Because that needs to be stopped. There needs to be a way to address those kinds of things, as a matter of policy.

Something that, for many people, is more controversial – we're starting to deal with the question of criminal responsibility. The Committee on the Rights of Persons with Disabilities, which monitors this Convention, is starting to say that you can't just have some kind of blanket exemption from criminal liability based on a disability. You have to have the right to go through your trial and be adjudicated guilty or not guilty.

Many of us, including myself, believe that the system of forensic psychiatry needs to be gotten rid of. Instead of having people go back and forth – “which one is better, the prison or the psych institution?” – we need to get rid of the psychiatric commitment system – psychiatric lock-ups and forced treatment – and deal with, do we want to abolish prison also? Can we have a system of restorative justice that would completely replace the criminal justice system?

Or, if we do still need some kind of criminal justice system and prison system, what would need to be done in order to make sure that people with

psychosocial disabilities are treated with dignity and with whatever care and support and services they might need, if they're sentenced to a prison term?

Erick: Ellen Sachs once wrote that she thinks people should have one shot from psychiatry, and see if it works. And if it doesn't work, then they're off. There's no preemptive strike, as it were. So it takes care of this question of, what if you really don't have the wherewithal to actually admit you want that treatment? Of course, Jim Gottstein [director of the Law Project for Psychiatric Rights] said, "That one strike could be lethal." And he's quite right. So I was wondering what you thought of that?

Tina: I agree with Jim Gottstein. I was locked up in psychiatry only once, and once was way too much. And I know people who were locked up for even shorter periods than I was, and had it devastate their whole life.

I don't think psychiatry deserves any shots. We're seeing such a total debunking of psychiatry by people like Robert Whitaker, David Cohen, Paula Caplan, Peter Goetsche in Denmark. There are people all over the world debunking this thing. Why should it have any shot at people?

Looking at psychiatry, it's an institution – and I don't want to disrespect anybody who is using psychiatry and finds help there. But I think, as a powerful social institution, psychiatry has gotten away with bad science. It has been given a position of being a kind of proxy for the state, where they have the power to actually lock you up against your will. They have the power to hold you down and inject you, and put you in solitary confinement.

D: But, you know what? Going along with that theory, where would you put the Jeffrey Dahmers of the world? How would you define them? Do they have a disease of the mind?

Tina: I think somebody who commits those kinds of acts of violence – we have to deal with the violence, and not with what is causing it in his mind. I want to get rid of forensic psychiatry. I want to get rid of the psychiatric aspect. I think if people commit acts of violence, and society decides that they should be kept in prison – I think they should be held criminally responsible. So I actually believe in doing away with the insanity defence as we know it. I believe that there needs to be some kind of way to take into consideration what the person's state of mind was, but not ...

D: Exactly! Doesn't forensic psychiatry do that? Investigating the criminally insane?

Tina. No, it actually doesn't. That's not the way I think it should be taken into account. I don't think it's a matter of having psychiatrists give their expert opinions, and then it's decided whether the person should go into a prison or into a psychiatric institution. That's essentially what the forensic system does now. But I think that's not what we need.

I would prefer, first, getting rid of the insanity defence. Then your Jeffrey Dahmers would be held criminally responsible and go to jail. That's what we do because, as a society – if we don't have any other way of handling people who we believe represent a violent threat to others, based on the fact that they've committed these acts of violence – not based on a *prediction*. Because I think psychiatric civil commitment, where it's based on this idea of danger to self or others – that's a prediction, and a speculation. Nobody knows what you're going to do, in the future.

But if somebody has committed these serious acts of violence, I would hold them criminally responsible. And, if that's what we need to do, we put them in prison.

D: Absolutely. But I think we also still have to look at them and see how we can prevent this from happening with the younger people coming up. So that's where the forensics comes in. It's not just one area of studying the human brain. It's also about preventing it from happening again.

Tina: I'm not sure anybody has ever figured out – I don't see that as forensic, so much as just plain psychology. Psychological studies. When I say I want to get rid of the forensic system, I mean forensic psychiatric institutions, primarily. Because, to me, that's a logical corollary. If we're getting rid of psychiatric lock-up because it's illegitimate as a reason for, and as a form of, detention, then the forensic psychiatric system, I think, needs to be gotten rid of, too – in terms of the institutions. In terms of people being sent to this kind of institution instead of a regular prison.

And I would also say that people who are in jail or prison should have the right – I know, in some jails and prisons, there's a mental health unit in the prison. If people actually feel safer there, and they want to be there, I don't have a problem with that.

I do have a problem with people being transferred to that unit because somebody decides they should be there. And I do have a problem, if somebody wants to be in that unit because they feel safer there or because they want treatment or services – I would have a problem with that if they have to be forcibly drugged or put in restraints. I think mental health services, in prison as well as anywhere else, need to be based on the person's free and informed consent.

Erick: If psychiatry as we know it was abolished, that wouldn't necessarily mean that serial killers couldn't get some kind of conversation going, in a social justice or restorative justice context, that could actually work, in much the same way that you're talking about, with regard to how to prevent violence.

Tina: It's been a pleasure to talk with you all, and good luck with the Shadow Report and with any other way that you may want to work on this. If anybody is interested in following up with me, Erick, you can give out my email address, and I'd be happy to correspond with folks.