‘SUGGESTED AMMENDMENT’ To:

Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

SUGGESTED AMENDED VERSION: 26 February 2016.

This suggested amendment, (**The Floyd** Amendment), is made by Glenn Floyd after four years deep consultations with psychiatric-survivor Initially NO, and many other survivors deeply harmed by fundamental human rights violating destructive psychiatric practices. These debilitating, harmful practices have developed over time and are led by the destructive false belief in ‘alleged’ miracle drugs and destructive technology (e.g. Electric-Shock) treatments etc. whereby the total focus is on ‘immediate’ interventions (including with highly toxic psychotropic drugs with lifelong debilitating side effects and which are the 3rd leading cause of death after heart disease and cancer)’and not holistic care.

Regrettably, these interventions are also driven by the false notion that isolated treatment of single ‘organs’ for example ‘the brain’ overrides the whole person, where support, society, emotions and the external trauma causing the emotional state, are utterly ignored. It is also formed by detailed research analysis of thousands of personal psychiatric case notes that definitively show criminal removal of enduring power of attorney of citizens, with falsely declared ‘medical-conditions’ made by State agents’ psychiatric-system practitioners.

For a U.N. committee to be formed and titled ‘Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment’, and relating specifically to psychiatric practice; is a profound indictment of the imbedded evil of this horrific system. This system and its practices is demonstrated to be causing global pandemic harm and early and imminent unwarranted suicides and death.

Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment on the rights of persons institutionalized and medically treated without informed consent

I. Introduction

1. The present document is issued in accordance with the Subcommittee’s mandate set forth in article 11 of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

2. The Subcommittee has a mandate to visit places where persons are deprived of their liberty. This includes health-care settings, as defined in paragraph 4 of the Optional Protocol.

3. During its visits, the Subcommittee has documented numerous human rights violations in health-care settings where persons are held and treated without informed consent. Furthermore, it has encountered situations in which the nature of the treatment provided, and the manner in which it is provided, ~~falls short of~~ violates the requirements of international human rights law. This also includes situations where persons are involuntarily restrained by mechanical or chemical means, where persons are coerced into taking psychotropic drugs and involuntarily forcibly injected with these toxic substances where persons clearly state negative side-effects impacts which destroys their health and well-being and causes major deleterious sickness.

4. The purpose of the present document is to contribute to the prevention of torture and cruel, inhuman and degrading treatment by setting out the Subcommittee's views on the rights of persons who are in detention owing to their health status.

II. Involuntary confinement and restraints in health-care settings

5. Involuntary confinement of any person is a ~~form of arbitrary detention~~ violation of human rights unless it is ordered by a competent and independent judicial authority through a legal, and not medical due process, which must include close and constant review. Such duly authorized competent and independent judicial authority MUST be solely bound by the human rights of any persons being treated and MUST clearly focus solely upon the rights of the person and NOT on the powers under the STATE authority of the treating Health/Medico regime or its arbitrary powers vested in ANY appointed psychiatric/medical practitioners. States should develop and make available alternatives to confinement, such as community-based ~~treatment~~ support programmes and not 'invasive-treatment' programmes~~,~~. Thes critical social- support programmes. ~~which are particularly appropriate for avoiding~~ ~~hospitalization~~ should not be an intervention in these cases when a physical condition or injury has not occurred and DOES NOT warrant intervention by trained medical practitioners if the person in crisis chooses not to be 'treated' medically. ~~and for providing care for persons upon their discharge from hospitals.~~

6. The Subcommittee has observed situations in which State agents represent confinement as voluntary and present arbitrary registries ~~or~~ and uninformed binding legal decisions to that effect. It is concerned that in some of those instances those safeguards were practiced as a mere formality and due to this intentional coercive failure obliterating true informed consent, these are deliberate 'practice-centric' human rights violations. Confinement and institutionalization are voluntary only when the person concerned has decided on it upon informed consent and retains the ability to exit the institution or facility whenever they so choose to do so.

7. If involuntary confinement seems to be appropriate and proportional on a legal basis, such a legal basis MUST 'solely' be that a criminal act (including but not limited to acts such as personal physical assault or harm) has been or will be committed. Involuntary confinement without intended or actual criminality IS ALWAYS incarceration or detention, it is total deprivation of human rights and rightful liberties and MUST solely be applied only law enforcement officers and only in relation to actual or intended criminal acts. There MUST never be any exceptions to the obligations of the State to uphold legal and human rights towards any citizens.

And this involuntary confinement should never directly include the formal arbitrary decision bestowed by ANY arbitrary powers vested in ANY State appointed psychiatric/medical practitioners' ~~right~~ authority for any medication to be administered without informed consent. Situations where criminality will or has occurred is solely a police enforcement matter for which apprehending/subduing practices and equipment are codified in all law. Psychiatric/medical personnel must never assume the role of police enforcement officers for any reason and arbitrary powers or decision for involuntary detention or enforced toxic psychotropic drugging may never be taken by them.

Such involuntary detention and/or psychotropic drugging undertaken by Psychiatric/medical personnel without actual or intended criminal acts occurring is a human rights violation and a crime itself. There MUST solely be a clear distinction made between intervening in last-resort 'extreme' cases where actual or criminal acts and law enforcement officers are involved and ordinary cases without such extreme and last-resort emergency conditions existing. There are well known fully documented cases where the involuntary confinement and toxic drug treatment intervention has been the first-resort action by State's agents and not at all in the mandatory last-resort 'extreme' cases of intended or actual criminal acts involving law enforcement officers.

These cases starkly reflect the fact that persons merely undergoing the normal emotional reactions to the very normal and difficult hardships that life presents to all humans; are immediately treated by State agents as last-resort, extreme psychiatric criminal acts cases. These cases are routinely unlawfully treated within non-informed consent regimes involving extreme deprivation of liberty, dangerous treatments with psychotropic toxins with immediate massive deleterious negative impacts to health and well-being and are absolute violations of all basic human rights.

This frequently occurring regime results in total removal and subjugation of human rights and permits regimes of torture to exponentially grow. The clinical practice abuses of extreme human rights violations and abuses in these cases frequently occurs as a first-resort practice merely because a person presents as emotionally impacted by independent or external trauma; and NOT because intended or actual criminal acts are tangible and real risks.

The frequent occurrence of these widespread human rights violations are a direct result of State agents' specifically vested legal powers, and a consequence of 'personal' decision making by individuals, a very dangerous risk to fundamental human rights citizens all have and are owed by the State to them. The application of such arbitrary powers must NEVER be bestowed in subjective declarations of 'degree' solely determined by any individual. Such powers MUST solely be governed by vital lawfully codified checks formally enforced by law.

These codified checks and balances MUST solely be 1. Intended and/or actual criminal acts are imminent/witnessed, 2. Extreme emergency last-resort intervention needs. Such decisions MUST NEVER be allowed by a single or group practitioner and MUST always involve authorized legal practitioners AND always involve a formal process of fully-informed consent.

8. When a person who is detained by the State suffers serious mental disorders, involuntary confinement may be judicially ordered solely in cases of witnessed or feared imminent intended criminal acts, to provide timely access ~~to~~ for appropriate law enforcement responses.

Such involuntary treatments MUST never involve arbitrarily declared removals of enduring power of attorney by sole or group practitioners or allow such involuntary treatments to be defined as expert care ~~and~~ or specialist medical treatment without the incidence of actual or imminent criminality.

In ~~such~~ all cases, placement in a psychiatric facility deemed by practitioners as 'may be necessary to protect the detainee from discrimination, abuse and health risks stemming from illness', must solely be provided ensuring ~~that~~ all human rights guarantees are ~~respected~~ upheld and that the treatment offered is solely under fully informed consent and equal to that offered to other non-psychiatric patients and corresponds to the health needs of the person ~~and~~.

Such involuntary treatments must solely be applied in reference to feared or witnessed criminal acts fully involving authorized law enforcement officials and that the placement of the person MUST solely be subject to constant authorized judicial review. With respect to feared or threatened suicide by a person, such interventions MUST solely arise only in cases where such fears or threats are fully documented and assessed by a panel involving authorized legal opinion as extreme, imminent, repetitive and tangible. Such involuntary treatments must never involve isolation, physical restraint, prolonged incarceration/detention or enforced treatments of electric shock or psychotropic medications. As specified in Article 14(b) of the Convention on the Rights of Persons with Disabilities, the existence of a disability should not be the justification for a deprivation of liberty.

9. Restraints, physical or pharmacological, are ~~forms of~~ deprivations of liberty and, subject to all human rights safeguards and procedures applicable to the latter, and should be considered only as measures of law enforcement response to actual/imminent criminality and/or as extreme and/or emergency treatments of last resort for safety reasons.

The State must take into account, however, that there is an inherently high potential for abuse of such restraints and as such these must be applied, if at all, within a strict judicial framework outlined in foregoing paragraph 'criminal act' incident types that sets out the criteria and duration for their use, as well as procedures related to supervision, monitoring, review and appeal. Restraints must never be used for the convenience of staff, next of kin or others. Any restraint has to be recorded precisely and be subject to administrative accountability, including independent complaint mechanisms and authorized judicial review.

10. Solitary confinement or any isolation must never be used. It segregates persons with serious or acute illness and leaves them without constant attention and access to medical and human rights and services. It should be differentiated from medical isolation. Medical isolation requires daily monitoring with the presence of trained medical staff and must not deprive the person of any personal liberties whatsoever or contact with others provided that proper precautions are taken. Any isolation has to be made for the shortest possible period of time, recorded precisely and be subject to administrative accountability, including independent complaint mechanisms and authorized judicial review.

11.In connection with deprivation of liberty and health-care settings, the Subcommittee recognizes that States parties should revise outdated legislation and practices in the field of mental health in order to avoid arbitrary detention. Any deprivation of liberty must be ~~necessary~~ last resort emergency response and proportionate, for the purpose of protecting the person in question from imminent harm or preventing any criminal act injury to others. It must take into consideration less restrictive alternatives, and must be accompanied by adequate procedural and substantive safeguards established by law.[1]

III. Medical treatment of persons deprived of liberty and informed consent

12. Informed consent is a decision made voluntarily on the basis of comprehensible and sufficient information regarding potential effects and side effects of treatment and the likely results of refraining from treatment. Informed consent is fundamental to respecting an individual's autonomy, self-determination and human dignity.

13.Every person deprived of liberty who requires medical treatment should be fully informed about the diagnostic reasons for recommending a particular medical treatment and about existing alternatives, and given the opportunity to decline or receive the suggested treatment or other form of intervention.

14.Exceptionally (and outside of the imminent/witnessed criminal acts cases already cited in the foregoing); it may be necessary to medically treat a person deprived of liberty in extreme medical emergency cases without her or his consent. The terminology of 'medically treat' itself is profoundly misleading in such cases, as it carries an implied compelling need for immediate 'acute emergency conditions' interventions by 'trained medical professionals' in these cases when this is almost always NEVER the case.

For the true human rights values-based society we claim to be, terminology use (such as medically treat) by its use that subjugates fundamental human rights, is extremely dangerous and must be utterly rejected as it falsely implies 'acute emergency conditions' are present when they are almost always not.

And it dangerously implies that emergency interventions by 'trained medical professionals' are critical, when such interventions have been demonstrated worldwide to be the cause of ongoing lifelong harm and death.

[1] Human Rights Committee, general comment No. 35 (2014) on liberty and security of person.

This term ‘medically treat’ MUST NEVER be applied in any other cases other than in reference to ALL medical conditions and NEVER apply solely in what is defined as ‘mental-health’ cases. ‘Mental health’ is a destructive and pejorative term, labeling and demonising normal human ranges of emotional responses to life trauma. It carries destructive and negative connotations of physical illness, when no such measure of physical ailment have ever been demonstrated, measured or recorded in any medical tests whatsoever.

Such extreme interventions MUST solely apply in extreme cases where there is acute, imminent risk of serious harm and/or death, identical to immediate blood transfusions immediately needed in motor accidents where severe injuries and trauma have occurred. The application reference to ALL medical cases can only mean the assessed risks are identical in both mental health cases and say to severe motor accident physical injury trauma cases (e.g. massive blood loss or amputations), where non-intervention would cause immediate harm or death.

This means a ‘medical treatment’ to be used in a termed ‘mental health’ case MUST ONLY be applied where there is extreme emergency intervention required, such that immediate massive physical harm or death will result if such imminent life-threatening extreme interventions do not occur. And all such intervention must be directly comparable to those risks existing in a physical road trauma case where life threatening massive injury will cause lifelong disability, harm or immediate death if not immediately performed. These assessments can only apply if the person concerned is not able to:

(a) Understand the information given concerning the characteristics of the threat to her or his life or personal integrity, or its consequences;

(b) Understand the information about the medical treatment proposed, including its purpose, its means, its direct effects and its possible side effects; and

(c) Communicate effectively with others.

15. However, such situations MUST be solely as specifically outlined in foregoing paragraph of ‘witnessed/imminent criminal act’ incident types involving formal, codified procedures related to supervision, monitoring, review and appeal, and subject to administrative accountability, including independent complaint mechanisms and authorized judicial review.

In such ~~a~~ situations, such legally authorized interventions should only be made where the withholding of medical treatment would in itself constitute inappropriate practice and could amount to a form of cruel, inhuman or degrading treatment or punishment. ~~It~~ Or it may also constitute a form of discrimination. The measure decided must be a last resort to avoid irreparable damage to the life, integrity or health of the person concerned or others, and must be mandated by a competent duly authorized legal authority within a strict framework that sets out the criteria and duration for the treatment and judicial review and supervision mechanisms.

16. Medical treatment without informed consent should be subject to authorized legal review before an independent judicial authority and/or a complaint mechanism as soon as this is practicable. It must never be used for the convenience of staff, next of kin or others. Further, the administration of any medication without informed consent must never occur in any circumstances. ~~be precisely recorded and subject to administrative accountability and judicial review~~.

17. Only in the situation of emergency care may the decision about any necessary intervention be made by the medical professional alone.

18. An expert decision regarding alleged psychiatric disease cannot in itself override the informed consent right to refuse any and all medical treatment.

19. A person deprived of liberty who has been subjected to treatment without informed consent and to restraints ~~must be debriefed by a medical doctor as soon as her or his condition permits it; she or he~~ is a victim of unlawful human rights violations by a practitioner or State agent and must have unimpeded access to the medical record and must be informed of complaint mechanisms and means of redress.

No arbitrary declaration of Privacy Act law must EVER deprive ANY person from full and unimpeded access to all case history and files by any practitioner or any State agent for any reason whatsoever. Such a refusal is in itself a human rights violation.

IV. Duties of States parties

20. State parties are encouraged to review their mental health legislation and public policies with respect to the legality of involuntary interventions for persons with mental disability, with the following human rights objectives:

(a) Developing very ~~restrictive~~ restricting criteria for the use of involuntary interventions, clearly distinguishing the sole applications of such involuntary interventions must only occur in cases of imminent/actual criminal acts, which must include that their use is also limited to cases ~~in which less intrusive means are not likely to be effective and~~ where it is solely determined by fully authorized legal authority, the person is incapable to provide informed consent;

(b) Promoting appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity;

(c) Establishing procedures designed to protect the rights of persons alleged to have ~~with~~ mental disabilities, including authorized impartial judicial or administrative review of decisions regarding findings of alleged incapacity and requests for involuntary hospitalization and involuntary treatment, as well as a system of periodical duly authorized judicial review of these decisions;

(d) Providing mechanisms to investigate improprieties and abuses in the use of involuntary interventions, with fully codified analysis of alleged misconduct and/or negligence involving appropriate legal penalties.