Joint Submission on Controlled Medicines Policy and Human Rights
Office of the High Commissioner for Human Rights
May 2015

In response to your letter of April 16, 2015, we are pleased to make the following submission to the Office of the High Commissioner of Human Rights (OHCHR) for consideration in the preparation of the study mentioned in Resolution A/HRC/28/L.22 for the UN General Assembly Special Session on the World Drug Problem.

As organizations active in the field of palliative care, our submission focuses on the need for countries to ensure people have access to controlled substances for medical purposes. As you may know, controlled substances play a critical role in the provision of healthcare around the world. At present, 12 medicines that are made of or contain controlled substances are on the World Health Organization (WHO) Model List of Essential Medicines which are used such diverse fields of medicine as analgesia, anesthesia, drug dependence, maternal health, mental health, neurology, and palliative care. In this submission we focus on access to opioid analgesics for pain management and palliative care.

The Human Rights Council (HRC) resolution recalls the international drug control conventions and notes the "need to promote adequate availability of internationally controlled narcotic drugs and psychotropic substances for medical and scientific purposes," echoing a core objective of the UN drug conventions. Under both the international drug control conventions and international human rights law, countries have a legal obligation to ensure patients with a medical need for these medicines have access to them.

A wealth of research from countries around the world, however, suggests that controlled substance regulations often interfere with the availability and accessibility of this group of medicines, especially strong analgesics. Regulations are frequently far more restrictive than required by the UN drug conventions, deterring their use. These kinds of regulations raise important questions about the fulfillment by countries of their obligations under the right to health as well as the obligation to protect individuals from exposure to cruel, inhuman, or degrading treatment.

Background

With life expectancy increasing worldwide, the prevalence of non-communicable diseases (NCDs), such as cancer, lung, and heart disease, is rising rapidly.[1] These and other chronic illnesses are often accompanied by pain and other distressing symptoms.[2] Palliative care focuses on relieving these symptoms and ensuring that people with life-limiting illnesses and their loved-ones can enjoy the best possible quality of life throughout the course of their disease up until their last moments.

An important aspect of palliative care is addressing chronic, severe pain. Pain has a profound impact on quality of life and can have physical, psychological, and social consequences. It can lead to reduced mobility and consequent loss of strength; compromise the immune system; and interfere with a person's ability to eat, concentrate, sleep, or interact with others.[3]

Most pain in palliative care patients can be controlled well.[4] The mainstay medication for the treatment of moderate to severe pain is morphine, an inexpensive opioid that is made of an extract of the poppy plant. For moderate to severe pain, the WHO has recognized that strong opioids, such as morphine, are "absolutely necessary".[5]

Human Rights Standards

The obligation of states to respect, protect, and fulfill the right to health includes an obligation to ensure access to pain medicines and palliative care.[6] Notably, the United Nations Committee on Economic, Social and Cultural Rights has identified providing essential medicines, as defined by the WHO, as a core obligation under the right to health.[7] The WHO has included morphine in its Model List of Essential Medicines, a list of the medications that should be available to all persons who need them, since it was first established.[8] The right to be free from torture, cruel, inhuman, or degrading treatment or punishment also creates a positive obligation for states to protect persons in their jurisdiction from unnecessary pain related to a health condition.[9]

In 2008, the U.N. Special Rapporteur on The Right to the Highest Attainable Standard of Health and the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment jointly recognized that a failure to address barriers to palliative care and pain treatment can be a violation of human rights:

> 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. International human rights law requires that governments must provide essential medicines—which include, among others, opioid analgesics—as part of their minimum core obligations under the right to health.[10]

Since 2008, there has been an increasing body of statements supporting the right to pain treatment and palliative care, including statements by the Committee on Economic, Social and Cultural Rights,[11] the Committee on the Elimination of all Forms of Discrimination Against Women,[12] and the Committee on the Rights of the Child.[13]

In 2011, in her opening statements at the Human Rights Council Panel on the Right to Health of Older Persons, Navi Pillay, the UN High Commissioner on Human Rights stated: "Adequate access to palliative care is essential to ensure that these people can live and—ultimately—die with dignity."[14] In that same year, in the Report of the Secretary General on the rights of older persons, the Secretary General noted: "The challenges to Member States, particularly low- and middle-income countries, include: ... [a] lack of specific measures to avoid pain and provide palliative care that allow the terminally ill to die with dignity."[15]

Impact of Controlled Substance Regulations on Access to Palliative Care and Pain Treatment

Opioid pain medicines are subject to control under the 1961 Single Convention on Narcotic Drugs.[16] Under the system set up by the Single Convention, states must monitor and regulate their distribution and use.[17]

Under international human rights law and drug control treaties, however, countries have a dual obligation with respect to these medicines: They must ensure their adequate availability for medical and scientific use while preventing their misuse and diversion.[18] The 1961 Convention specifically declares the medical use of narcotic drugs indispensable for the relief of pain and requires their adequate availability.[19]

As noted, however, despite the obligations outlined above, many states fail to properly ensure the availability of opioid pain medicines. According to the International Narcotics Control Board (INCB)—the body responsible for monitoring the 1961 Convention— "approximately 5.5 billion people, or three quarters of the world's population, live in countries with... inadequate access to treatment for moderate to severe pain...."[20] Due to limited access to essential medicines, the WHO estimates that tens of millions of people around the world, including around 5.5 million end-stage cancer patients and one million people with AIDS, suffer from moderate to severe pain each year without treatment.[21]

One reason for the limited availability of opioid pain medicines is the failure of countries to strike a balance between ensuring the availability of controlled medicines for legitimate purposes and preventing their abuse and diversion. Indeed, many states severely restrict access through onerous regulations.[22] In a 2011 discussion paper, the UN Office on Drugs and Crime enumerated the following examples of regulations that, among others, may impede medicines availability and are not required by international drug conventions:

> (a) Limitations on the number of days' supply that may be provided in a single prescription (with too short a period of time allowed);
> (b) Limitations on doses that may be prescribed in a single prescription (with allowed doses being too low);
> (c) Excessive limitations on prescription authority, such as only to some categories of medical doctors;
> (d) Special prescription procedures for opioids, for example, the use of specific prescription forms, which may be difficult to obtain....[23]

These unduly strict regulations frequently create complex procedures for procuring, stocking, and dispensing opioid pain medicines. The result is that pharmacies and health facilities do not procure or stock opioid pain medicines; doctors are deterred from prescribing them; and obtaining opioids is so impractical that patients cannot realistically hope to obtain a sufficient, continuous supply. Where these regulations unnecessarily impede the procurement and dispensing of these medications for medical purposes, they are incompatible with the right to health.

In our organizations' work, we routinely see the impact of these regulatory restrictions on patients. Human Rights Watch, for example, has found that people with untreated severe pain often describe their pain in exactly same terms as victims of torture—that is, as so intense that they would do anything to make it stop. These individuals often want to commit suicide to end the pain, pray for death, or tell doctors or relatives that they want to die.[24]

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We respectfully urge OHCHR to include access to opioid analgesics for pain management and palliative care in its study, giving voice to the millions of people who require controlled medicines for the relief of pain and suffering.

African Palliative Care Association
Asia Pacific Hospice Palliative Care Network
European Association for Palliative Care
Hospice Palliative Care Association of South Africa
Human Rights Watch
International Association for Hospice and Palliative Care
International Children's Palliative Care Network
Kenya Hospice and Palliative Care Association
Latin American Palliative Care Association
Pallium India
Union for International Cancer Control
Worldwide Hospice and Palliative Care Alliance

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[1] UNDESA Population Division, "World Population Prospects: The 2012 Revision," 2013, p. 4 http://esa.un.org/wpp/Documentation/pdf/WPP2012_%20KEY%20FINDINGS.pdf (accessed March 31, 2015).
[2] Katrien Moens, MSC, et al., "Are There Differences in the Prevalence of Palliative Care-Related Problems in People Living With Advanced Cancer and Eight Non-Cancer Conditions? A Systematic Review," *Journal of Pain and Symptom Management*, vol. 48, No. 4, (2014), pp. 667-669.
[3] F. Brennan, D.B. Carr, and M.J. Cousins, "Pain Management: A Fundamental Human Right," *Anesthesia & Analgesia*, vol. 105, no. 1 (2007), pp. 205-221.
[4] WHO, "Achieving Balance in Opioid Control Policy: Guidelines for Assessment," 2000, p. 1, http://whqlibdoc.who.int/hq/2000/who_edm_qsm_2000.4.pdf (accessed April 28, 2014).
[5] Ibid.
[6] International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993; Convention on the Rights of the Child, adopted Nov. 20, 1989, G.A. Res. 44/25, Annex, 44 U.N. GAOR, Supp. No. 49, U.N. Doc. A/44/49, at 167 (Sept. 2, 1990); Convention on the Elimination of All Forms of Discrimination against Women, adopted Dec. 18, 1979, G.A. Res. 34/180, 34 U.N. GAOR, Supp. No. 46, U.N. Doc. A/34/46, at 193 (Sept. 3, 1981); International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, G.A. Res. 61/106, Annex, U.N. GAOR, 61st Sess., Supp. No. 49, U.N. Doc. A/61/49, at 65, entered into force May 3, 2008.
[7] UN Committee on Economic, Social and Cultural Rights, "Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights," General Comment No. 14, The Right to the Highest Attainable Standard of Health, E/C.12/2000/4 (2000), para. 43, http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument (accessed April 28, 2014).
[8] WHO, "WHO Model List of Essential Medicines: 18th list," April 2013, http://apps.who.int/iris/bitstream/10665/93142/1/EML_18_eng.pdf?ua=1 (accessed March 31, 2015).
[9] Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, A/HRC/22/53, February 1, 2013, para. 54, http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf (accessed April 28, 2015); International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, art. 7; Universal Declaration of Human Rights (UDHR), adopted December 10, 1948, G.A. Res. 217A(III), U.N. Doc. A/810 at 71 (1948); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture), adopted December 10, 1984, G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, art. 16.
[10] United Nations Special Rapporteur on the Prevention of Torture and Cruel, Inhuman, or Degrading Treatment or Punishment & Special Rapporteur on Right of Everyone to the Highest Attainable Standard of Physical and Mental Health, "Letter to Chairperson of the Commission on Narcotic Drugs," U.N. Doc. G/SO 214 (52-21) (Dec. 10, 2008), p. 4, http://www.hrw.org/sites/default/files/related_material/12.10.2008%20Letter%20to%20CND%20fromSpecial%20Rapporteurs.pdf (accessed April 28, 2015).
[11] UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health, November 8, 2000, para. 34.
[12] UN Committee on the Elimination of Discrimination Against Women (CEDAW), General recommendation No. 27 on older women and protection of their human rights, CEDAW/C/GC/27, December 16, 2010, para. 45, http://www2.ohchr.org/english/bodies/cedaw/docs/CEDAW-C-2010-47-GC1.pdf (accessed April 28, 2015).
[13] UN Committee on the Rights of the Child (CRC), General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), CRC/C/GC/15, April 17, 2013, para. 25, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fGC%2f15&Lang=en (accessed April 28, 2015).
[14] UN Office of the High Commissioner for Human Rights (OHCHR), Opening Statement by Ms. Navi Pillay United Nations High Commissioner for Human Rights : Geneva (September 13, 2011), http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=11531&LangID=E (accessed April 28, 2015).
[15] Report of the Secretary General, Social development: follow-up to the International Year of Older Persons: Second World Assembly on Ageing, A/66/173, July 22, 2011, http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N11/428/83/PDF/N1142883.pdf?OpenElement (accessed April 28, 2015).

[16] United Nations Economic and Social Council (ECOSOC), "Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs, 1961," https://www.unodc.org/documents/commissions/CND/Int_Drug_Control_Conventions/Ebook/The_International_Drug_Control_Conventions_E.pdf (accessed March 31, 2015).

[17] Ibid.

[18] INCB, "Report of the International Narcotics Control Board on the Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes," 2011, http://www.incb.org/documents/Publications/AnnualReports/AR2010/Supplement-AR10_availability_English.pdf (access July 11, 2014); INCB, "Availability of Opiates for Medical Needs: Report of the International Narcotics Control Board for 1995," http://www.incb.org/pdf/e/ar/1995/suppl1en.pdf (accessed June 28, 2014), p. 1.

[19] ECOSOC, "Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs, 1961," preamble.

[20] INCB, "Report 2014," March 3, 2015, p. 3, https://www.incb.org/documents/Publications/AnnualReports/AR2014/English/AR_2014.pdf (accessed March 23, 2015).

[21] WHO Briefing Note, "Access to Controlled Medications Programme," April 2012, http://www.who.int/medicines/areas/quality_safety/ACMP_BrNote_Genrl_EN_Apr2012.pdf?ua=1 (accessed March 31, 2015).

[22] WHO and World Hospice and Palliative Care Association, "Global Atlas of Palliative Care at the End of Life," p. 28, http://www.who.int/nmh/Global_Atlas_of_Palliative_Care.pdf (accessed April 28, 2015); Pain and Policy Studies Group, University of Wisconsin School of Medicine and Public Health, "Improving Global Opioid Availability for Pain & Palliative Care: A Guide to a Pilot Evaluation of National Policy," http://www.painpolicy.wisc.edu/sites/www.painpolicy.wisc.edu/files/Global%20evaluation%202013.pdf (accessed April 28, 2015).

[23] Commission on Narcotic Drugs, Discussion Paper, Ensuring availability of controlled medications for the relief of pain and preventing diversion and abuse: Striking the right balance to achieve the optimal public health outcome, E/CN.7/2011/CRP.3, March 17, 2011, para. 37, http://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_54/4_CRPs/E-CN7-2011-CRP3_V1181366_E.pdf (accessed April 28, 2015).

[24] Human Rights Watch Report, "Please, Don't Make Us Suffer Anymore…, " (New York: Human Rights Watch, 2009), http://www.hrw.org/sites/default/files/reports/health0309webwcover_1.pdf

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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.

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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.

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

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[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.

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.

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

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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.

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.

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.

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.

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.

[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).

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

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[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.

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;

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

(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.

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.

To the good people of the United Nations Human Rights Council;It is with great regret that we even have to go outside our own country to seek help,but people here are dieing,being forced to endure great physical pain,thus suffering.Our own government has been deaf to the voice of justice conscerning us.When in the course of human history it becomes are duty and necessary for a people who are suffering and dying to dissolve their attachment to the government agency who is perpetrating the physical pain and suffering. .It is proven that mankind are more disposed to suffer,whilest evils are sufferable,than to right themselves by abolishing the forms their accustomed to.,But when a long train of abuses and usurpations,pursuing invariably the same Object evinces a design to reduce them under absolute Despotism,it is their right,it is their duty,to throw off such a GovernmentAgency,and to provide new Guards for their security.Such has been the PATIENT sufferance of all us Chronic Pain Peoples.The D.E.A. of America has a long history of human abuses..The suffering and deaths of all these chronic pain people could of been prevented if this witch hunt was not in play in our country.We are endowed by our creatore with certian unalienable rights,among these rights are to be free of forced physical pain and sufferering.In order to secure this right,Whenever any form of governments becomes destructive with their ,"just powers,"it is the right/duty to alter or abolish it,since this power is derived from the governed.We have sent petition after petitions,letters afters letters to our government officials and they have ownly been answered by more injurey, death and sufferring.Since 2008,our own Government/D.E.A., has purposely targeted our medicines,are Doctors and us,ie,Chronic Physical Pain Patients with false lawsuits,false allegations,and god awful media propaganda.and pretend offences..They have willfully demonized anything and anyone associated with the treatment of Chronic Pain,,They have literally destroyed innocent lives,again and again,and again.We compare it to the literal witch hunts of 1692's,,and the race propaganda of innocent Black men and women of the 1950's,,Thee Agency responsible for this harmful witch hunt is the D.E.A.,,the Drug Enforcement Agency of the United States of America,,,Thru their media propaganda, arrest of hundreds of our lawful good Doctors,our Pharmacist,and even our patients of chronic pain,they have instilled an atmosphere of fear..Fear if you're a good Doctor willing to help these good people in physical pain,you will be arrested,charged falsely,lose your liscence to practice medicine ,face jail time,spend your lifes worth of money defending yourself,basically you will loose everything you work sooo hard for,you home,your ability to work ever again if you choose to help people in physical pain,,This reality also applies to all Pharmacist as well,,,The outcome of these witch hunts has forced 1000's of legitimate chronic pain suffers to forced endurement of their physical pain because they can no longer get their MEDICINES,, Doctors are dropping their chronic pain patients by the 1000's,,,,,some have sadly even chose death .as their only means to stop the physical pain,They know this will be their last prescription for medicine,soo they choose SELF EUTHANIZATION,We have asked our government officials for help,thru letters,petitions and phone calls,,,but all have become petitions,letters of no consequence..The D.E.A. continues their assault everyday here,,on people in physical pain,.There media propaganda campaign goes on everyday..Propaganda like,referring to our medicines as terrible street drugs,like cocaine[real white powder]herion,meth,,Referring to the cause of all O.D.'s as happening from our ,"drugs" like oxycontin or methadone,,,not medicines,,,but terrible drugs,,,Media

propaganda about our good doctors ,,calling them,"the candy man,"' or ,"candy land",,which is actually a Veterans Hospital in Tomah Wisconsin,,the good doctor there,, Dr,Houlihan resigned in protest,,stating he was helping veterans with lost limbs,who had chronic physical pain from war,,The consequence of this witch hunt has now reached our VETERANS,who can't even get MEDICINES,,to help relieve their physical pain!!..Another casualty of this ,"war on legitimate pain medicine," was a Dr,name Dr,Ibsen....he was helping what he called ,"narcotic refugee's,",,,because sooo many Dr.s were dropping all their chronic pain patients,,he was picking a lot of them up,,,they all had legitimate causes for the physical pain,,but as you can imagine his quantities of medicines went up..The D.E.A,, pounced on him,arrested him and he is now fighting for his ability to ever feed his family again,,,This is just 2 examples of 100's of Doctors who are targeted by the D.E.A. every year...These are GOOD MEN,,there our doctors,,,No other country in the world prosecutes Doctors for doing their job of helping people in physical pain,,,No other country prosecuted Dr.s,,who has 1 patient who is an ADULT,,who chooses on his/her own to not obey their Doctors orders,and chooses to sell their prescription for money,,,here in the U.S.A...they blame the Doctors for this Adults wrongful behaviour,,,they don't blame the stupid Adult who chooses to use his medicine illegally,,,,they blame the Doctor,,,no other country does this,,,not 1!!!Its not the Doctors fault for an ADULT humanbeing to use their medicine illegally,,but again,,that 1 person out of 1000's who those 1000 use their medicine correctly,,,but we are being blamed and hurt physically for that 1 idiot who uses his medicine illegally,That is like blaming a car manufacturer for a drunk driver..The D.E.A, will twist anything as an excuse to demonize our medicines and anyone who treats us.,,,,Please keep in mind,,not 1 patient of these good doctors ever complained about their Doctors,,not 1....It was a disgruntled employee's who claimed some sorta wrong doing,,,not any patient..This is the reality here in the U.S.A.,,but the terrible consequences of this D.E.A, witch hunt is 1000's of us chronic pain humanbeings are being forced to endure pain,suffering,imprisonment and death,and our government does not care to actually stop the witch hunt.The D.E.A. will claim its not there fault,but it is there fault,,None of this was happening until the D.E.A. started arresting legitimate Doctors,,By the D.E.A. living in this illusion,thus denial,that its not there fault,the assault continues every day here.If you ask ANY pain management Doctor here,,they will tell you ,they fear the assault from the D.E.A...

The documents included in this complaint hopefully will help all of you understand how bad it has become here.You can further look for yourselves on the internet..As far as some of the documents I got off the internet,,,its not the media article I copied them for,,,I copied them for the ,"comments," by humanbeings with chronic pain,,Their comments are heartbreaking,,,,if you don't shed some tears reading them,,then u have no business being in humane rights,,,,there aweful,their heartbreaking and their the cruel reality that has come to all chronic pain people,,,, in America,,Hopefully with your superior understanding of human rights, you will be able to speak to those who participated in theD.E.A. Governments meetings,and ask the 90% of people who voted against any ,"new" laws against our medicines,,but again the D.E.A. did not honor the 90% and put their own ,"new" laws against chronic pain patients,,,this document is included in our complaint,and theD,E.A. will not give these names out to the public.Despite being governed by the people.Now anyone on opiate medicines now

have to see their doctors every 90 days,some have to see their doctors every 30 days,,,its seems minor,,but those of them living at the poverty line, cannot afford 3 visits,or 12 visits,,at 2,000 a piece,,,when your deductibles for insurance is 7,000,,,its money we don't have,,,now we can opt out,,but we have to give all our private medical history to the D.E.A,,,90% of all chronic pain patients voted against this ,"new" law,,,but our government did not care,,and passed it anyways,,,now we will be with-out our medicines again,because if we don't comply,no medicine,,It use to be 1nce a year,,,that we can barely afford,,,This is just 1 of 100's new ideas put into law the D.E.A,,,has come up with..The huge elephant in the room here,,is the D.E.A,,,are NOT doctors,,,,yet they are now controlling all aspects of our medicines,with propaganda,our doctors, with fear of imprisonment,our pharmacies with prison,ie fear,,,,,,In the state of Florida certain pharmacies will not fill any opiate medicines,,This is why,when it comes to MEDICINES,only DOCTORS not government agencies,,only doctors should make decisions on medical issues.

The bottom line here are people,good people are dying,suffering,enduring physical pain cruelly,which is conscidered torturous,,,,when there are medicines that have worked for 100's of years,,,Medicines,,, not terrible street drugs,,,,Medicines designed to help people stop cruel suffering from the physical pain,,,but this is no-longer happening in America!!What the D.E.A,, under Michele Leonhart lacks in compassion she makes up with cruelty and torture.She brings only suffering and death.She is totally unworthy of this position in a civilized world..We the good people of America have attempted to reason w/the Michele Leonhart to no avail..just more tortuous physical pain..The D.E.A's ideology of ,"war on drugs," has created a long line of human abuses from this agency,and we,the good people in chronic pain are the ;latest victims of this D.E.A. ideology,,,they have abused human rights before,,and they will continue to do so,,unless they are stopped,,The D.E.A is writing all kinds of ,"new" rules against the use of pain management MEDICINES,but no-one is writing laws to protect those of us who need those MEDICINES,nor are there laws protecting the doctors who help us..Laws like no Doctor can be held legally responsible for what their ADULT patient does illegally w/those medicine,,or a law stating we chronic pain people have a legal right to no forced pain and suffering and the legal right to opiate MEDICINES without infringements .If u put such restriction on insulin for diabetics they too would be dying.This is the D.E.A'S fault,100 %%and that is where this needs to start..Please help us,,before 1 more good person has to choose death,as their only means of stopping their physical pain,,