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

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

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

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

1. A new normative paradigm

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

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

2. Absolute ban on restraints and seclusion

63. The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint may constitute torture and ill-treatment (A/63/175, paras. 55-56). The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment (A/66/268, paras. 67-68, 78). Moreover, any restraint on people with mental disabilities for even a short period of time

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

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

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

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

may constitute torture and ill-treatment.[78] It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions. The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-consensual treatment, such as forced medication and electroshock procedures.

3. Domestic legislation allowing forced interventions

64. The mandate continues to receive reports of the systematic use of forced interventions worldwide. Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment.[79] Forced interventions, often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged "best interest" of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment (A/63/175, paras. 38, 40, 41). Concern for the autonomy and dignity of persons with disabilities leads the Special Rapporteur to urge revision of domestic legislation allowing for forced interventions.

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

65. Millions of people with disabilities are stripped of their legal capacity worldwide, due to stigma and discrimination, through judicial declaration of incompetency or merely by a doctor's decision that the person "lacks capacity" to make a decision. Deprived of legal capacity, people are assigned a guardian or other substitute decision maker, whose consent will be deemed sufficient to justify forced treatment (E/CN.4/2005/51, para. 79).

66. As earlier stated by the mandate, criteria that determine the grounds upon which treatment can be administered in the absence of free and informed consent should be clarified in the law, and no distinction between persons with or without disabilities should be made.[80] Only in a life-threatening emergency in which there is no disagreement regarding absence of legal capacity may a health-care provider proceed without informed consent to perform a life-saving procedure.[81] From this perspective, several of the 1991 Principles may require reconsideration as running counter to the provisions of the Convention on the Rights of Persons with Disabilities (A/63/175, para. 44).

5. Involuntary commitment in psychiatric institutions

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

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

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

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

[81] Ibid., para. 12.

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

68. Involuntary commitment to psychiatric institutions has been well documented.[83] There are well-documented examples of people living their whole lives in such psychiatric or social care institutions.[84] The Committee on the Rights of Persons with Disabilities has been very explicit in calling for the prohibition of disability-based detention, i.e. civil commitment and compulsory institutionalization or confinement based on disability.[85] It establishes that community living, with support, is no longer a favourable policy development but an internationally recognized right.[86] The Convention radically departs from this approach by forbidding deprivation of liberty based on the existence of any disability, including mental or intellectual, as discriminatory. Article 14, paragraph 1 (b), of the Convention unambiguously states that "the existence of a disability shall in no case justify a deprivation of liberty". Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished. This must include the repeal of provisions authorizing institutionalization of persons with disabilities for their care and treatment without their free and informed consent, as well as provisions authorizing the preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness (A/HRC/10/48, paras. 48, 49).

69. Deprivation of liberty on grounds of mental illness is unjustified if its basis is discrimination or prejudice against persons with disabilities. Under the European Convention on Human Rights, mental disorder must be of a certain severity in order to justify detention.[87] The Special Rapporteur believes that the severity of the mental illness is not by itself sufficient to justify detention; the State must also show that detention is necessary to protect the safety of the person or of others. Except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of "unsound mind".[88] As detention in a psychiatric context may lead to non-consensual psychiatric treatment,[89] the mandate has stated that deprivation of liberty that is based on the grounds of a disability and that inflicts severe pain or suffering could fall under the scope of the Convention against Torture (A/63/175, para. 65). In making such an assessment, factors such as fear and anxiety produced by indefinite detention, the infliction of forced medication or electroshock, the use of restraints and seclusion, the segregation from family and community, etc., should be taken into account.[90]

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

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

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

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

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

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

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

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

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

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

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

E. Marginalized groups

1. Persons living with HIV/AIDS

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

2. Persons who use drugs

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

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

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

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

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

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

[96] Ibid., p. 44.

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

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

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

3. Sex workers

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

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

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

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

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[99] Campaign to Stop Torture in Health Care, "Torture", p. 163; see also A/64/272, para. 85.

[100] WHO and the Global Coalition on Women and AIDS, "Violence against sex workers and HIV prevention" (WHO, 2005), p. 2.

[101] Campaign to Stop Torture in Health Care, "Torture", p. 163.

[102] CAT/C/AUT/CO/4-5, para. 22.

[103] PAHO, " 'Cures' for an illness that does not exist" (2012), p. 3.

[104] See HRW, *In a Time of Torture: The Assault on Justice in Egypt's Crackdown on Homosexual Conduct* (2003).

[105] PAHO/WHO, " 'Therapies' to change sexual orientation lack medical justification and threaten health", news statement, 17 May 2012; and submission by Advocates for Informed Choice to the Special Rapporteur on the question of torture, 2012.

[106] PAHO/WHO, " 'Therapies'".

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

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

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

5. Persons with disabilities

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

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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.

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

V. Conclusions and recommendations

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

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

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

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

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

[117] Committee on the Rights of the Child, general comment No. 12 (2009), para. 21.

[118] See A/HRC/20/5, para. 53 (d); A/63/175, para. 59.

[119] See Independent Expert for the Secretary-General's Study on Violence against Children, *World Report on Violence against Children* (2009).

[120] Open Society Foundations, *Against Her Will* (footnote 43 above), p. 6, A/64/272, para. 71.

[121] Open Society Foundations, *Against Her Will*, p. 6.

[122] Convention against Torture, art. 2, para. 2, International Covenant on Civil and Political Rights, art. 7.

[123] See International Criminal Tribunal for the Former Yugoslavia, *Prosecutor* v. *Furundzija*, case No. IT-95- 17/1-T, judgement (1998).

[124] See Committee on Economic, Social and Cultural Rights, general comment No. 14.

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

B. Recommendations

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

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

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

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

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

(e) Safeguard free and informed consent on an equal basis for all individuals without any exception, through legal framework and judicial and administrative mechanisms, including through policies and practices to protect against abuses. Any legal provisions to the contrary, such as provisions allowing confinement or compulsory treatment in mental health settings, including through guardianship and other substituted decision-making, must be revised. Adopt policies and protocols that uphold autonomy, self-determination and human dignity. Ensure that information on health is fully available, acceptable, accessible and of good quality; and that it is imparted and comprehended by means of supportive and protective measures such as a wide range of community-based services and supports (A/64/272, para. 93). Instances of treatment without informed consent should be investigated; redress to victims of such treatment should be provided;

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

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

1. Denial of pain relief

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

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

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

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

2. Compulsory detention for medical reasons

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

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

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

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

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

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

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

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

4. **Persons with psychosocial disabilities**

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

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

(b) Impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application. The obligation to end forced psychiatric interventions based solely on grounds of disability is of immediate application and scarce financial resources cannot justify postponement of its implementation;[127]

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

(d) Revise the legal provisions that allow detention on mental health grounds or in mental health facilities, and any coercive interventions or treatments in the mental health setting without the free and informed consent by the person concerned. Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished.

5. **Reproductive rights**

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

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

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

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