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**OPEN-ENDED INTERGOVERNMENTAL EXPERT GROUP  
ON THE STANDARD MINIMUM RULES FOR THE  
TREATMENT OF PRISONERS**

**VIENNA, AUSTRIA, 25 – 28 March 2014**

**Submission on Revision of the Standard Minimum Rules on the  
Treatment of Prisoners<sup>1</sup>**

**Prepared by**

World Network of Users and Survivors of Psychiatry  
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<sup>2</sup> The opinions expressed in this report are those of the authors and do not necessarily reflect those of the United Nations Office on Drugs and Crime.

## January 2014 Submission on Revision of the Standard Minimum Rules on the Treatment of Prisoners\*

### Outline:

1. Preliminary comments
2. WNUSP perspective on alternatives to incarceration
3. Standard Minimum Rules are inadequate and contradict CRPD
4. Recommendations for specific areas of the Standard Minimum Rules
5. Response to 2012 Outcome Document

### 1. Preliminary comments

WNUSP considers that revision of the Standard Minimum Rules must follow the standards set out in the Convention on the rights of Persons with Disabilities (CRPD) and other core human rights treaties. As both the most recent and the most detailed binding international law on the rights of persons with disabilities, the CRPD sets the standard that must be followed throughout the UN system. Derogation from the high standards set by the CRPD would undermine not only the effectiveness of that treaty but the character of the human rights regime as a whole.

In existing domestic law and practice, there is a human rights emergency facing people with psychosocial disabilities both in the penal system and in society. Despite the CRPD's prohibition of civil commitment and criminal commitment to a psychiatric institution, these practices continue under color of domestic law. Some of the worst treatment meted out to people with psychosocial disabilities comes in forensic psychiatric institutions and in mental health units within jails and prisons – the very places that are upheld as the standard of good practice under rule 82 of the outdated SMR.

Consider the first-person testimony of Tristano Ajmone,<sup>1</sup> who experienced several places of incarceration as part of a forensic-psychiatric regime:

My name is Tristano Jonathan Ajmone, I'm 34 years old, I live in Italy and, between 1998 and 2003, I have been subjected to a forensic-psychiatric regime for a period of five and a half years following a court sentence that declared me "partly incapable of intending and willing" - which is the juridical means by which an offender is denied moral agency for the acts of which he is accused.

The court decided that I was mentally insane based on a five minute meeting with the court's psychiatric expert who visited me in prison. We didn't exchange many words, yet he decided that I was a psychotic and insane. (continued)

\* Information about organizations provided in Appendix.

<sup>1</sup> Excerpted from First Person Stories on Forced Interventions and Being Deprived of Legal Capacity (WNUSP/Bapu Trust publication 2006).

Anyhow, my state of mind was such that ordinary prison personnel did not manage to cope with me, so I was moved to a special psychiatric branch inside the prison facility of Le Vallette, in Turin.

In this special branch (at the time, called "Settima Sezione blocca A" "7th Branch of Block A"), I was locked in a very small cell. The cell was about 9 square meters; it had bars on the windows and on the inner cell door; the outer cell door was an iron door filled with cement, and in the middle it had a big three-layered soundproof glass window that made it possible to see inside the cell, but sound would not escape the cell, nor could I hear what was going on outside when the door was closed; the toilet was in an open space, so that I would always be visible to the prison guards; there was a small sink with no hot water; the bed was a metal cot cemented to the floor....

In the 7th Branch there were no four-point-restraints, the punishment system was ritual beating.

So, after four months of pain and horror in the Seventh Branch I was moved to a civilian hospital, as a convict under a regime of home arrests. The place was an ordinary private psychiatric institution which happened to house, from time to time, convicts for treatment.

Even though the place was comfortable and clean, and we were not subjected to any particular harassment, one thing was clear: the fee we had to pay for all this "paradise as an alternative to hell" was to take all drugs without protesting. The institute did not tolerate any questioning about the drugs they gave us, we only had to swallow and "rest". We were not even allowed to ask the nurses what drugs we were given.

I remember those 18 months as the period of my life in which I was most sedated. I gradually slipped in a state which was quite close to mental vegetation. Side effects were really harsh to cope with, my limbs would shiver all the time, and I got fatter and fatter, my mind confused, and I soon wasn't able to read a novel. Any disobedience to the staff would result in a forensic report to the custody judge, who would revoke the benefit of home arrests and send us to a prison facility. So I had to shut up and swallow all that I was requested from the staff, which mainly consisted of taking the neuroleptic injections without complaining.

After a year at the psychiatric facility I was moved to a private "community" (*comunità*, as they are defined in Italian Mental Health System), which was a villa in the countryside (far away from my home and family).

The day I arrived I was immediately body searched and all of my luggage was thoroughly searched. All of our money was handled by the staff, and they would give us the fags according to the psychiatrists' dispositions. So, despite the fact that it was a relatively open place, it had many prison-like rules of conduct.

The people in charge of our rehabilitation program (psychologists and educators) would force us to participate in a lot of activities, most of which were childish in nature. For example, we had to play hide-and-seek in group, or organize treasure hunts, and other games of the type that carry out during early childhood in school. So the experience was like being in Alice in Wonderland, and we all were quite disoriented about our external

life and the problems that caused us to be there; but there was not much time to think since our daily life was scheduled in a detailed manner that left little time gaps to rethink our situation. It was like a kindergarten for adults, and was something quite odd since a few of the residents were there following serious offenses, like murder. Also, we were forcibly given strong psychiatric drugs in huge quantities (some people took up to six or seven drugs at the same time).

After a few months, I left the facility asking to go back to ordinary prison, because I could no longer stand the working rhythms, the massive drugging, and the endless sequence of false promises they would feed me regarding my social rehabilitation program and its coming steps. Since they didn't allow us to use or possess phones, and I was denied access to a fax machine to contact the judge or phone the police, I climbed the fence and ran to the nearest police station and asked them to take me back to ordinary prison. For my leaving the facility I was further charged with jailbreaking.

Shortly after going back to jail, my prison sentence expired and my period of Cure and Custody began in OPG. I was thus moved to the OPG of Montelupo Fiorentino, near Florence.

There are five OPGs prisons in Italy (Montelupo Fiorentino, Aversa Castiglione dell Stiviere, Barcellona Pozzo di Gotto, and Sant'Eframio). Only one of them has no bars and police guards (Castiglione dell Stiviere), the others are prison facilities. If it weren't for the fact that they give lots of drugs you wouldn't think that they are hospitals, yet they are called hospitals.

Life was really miserable there; most people lived in a state of total self-abandonment and simply lost any hope of getting free again. Young and old people alike were heavily drugged and had such strong side effects that you could notice them from a far distance. The place was really filthy and stinky. It took me a good amount of time to get used to its stench.

It's hard to describe how an inmate feels when his sentence is linked with a cure program which could last forever (indeed many people enter OPG with a 2 years period of cure and end up dying there after a whole life of "prorogations"). Unlike the man sentenced to death, a psychiatric hostage is tortured between the promise of imminent freedom and the risk of the request for another six months of cures. In such a state of uncertainty, it is very difficult to invest on anything. It's like trying to build a house on quicksand.

Violence was a normal part of our everyday life in OPG.

A man over 65 years old was put in a 5-point restraint for four days and four nights in a row, even though he had a bad lung disease. He was restrained because he insulted a doctor. Sometimes bed-restraining could last weeks.

My experience in the above mentioned psychiatric facilities has left an undeletable scar of sufferance in my soul, and for this reason I am always sad and unable to cope with life. Often I wake up in the middle of the night overwhelmed by the nightmares of memory: I dream of the tortures to which were subjected the people in psychiatric forensic facilities. I hear their desperate screams. Even though years have gone by, at

times it still happens that I wake up frightened, screaming for the help of a security guard or a nurse. Then I resurface from the maze of dreams and realize that I am in my flat alone, and that there is no longer any security guard or nurse in the corridor... I'm alone with my fears. The only cell that now restrains me is that of the alienation that follows the dehumanization I underwent in psychiatry. I hope that such places will be soon locked down and that they will never exist again.

## **2. WNUSP perspective on alternatives to incarceration**

WNUSP situates its advocacy on the rights of people in detention settings within a framework of understanding that deprivation of liberty inherently causes suffering. This is particularly of concern to people experiencing psychosocial disability when they enter prison or who experience such disability while in prison as a result of the treatment inflicted. Deprivation of liberty based on disability – that is, detention on the grounds of an apparent or diagnosed mental health condition or in mental health facilities – is never justified, since it is discriminatory and thus arbitrary. In other types of detention, such as criminal or immigration-related detention, alternatives that do not otherwise violate human rights should be sought wherever possible.

Alternatives to incarceration cannot include transferring a person to a discriminatory detention setting – i.e. transfer to a locked mental health facility rather than a jail or prison – or imposition of forced medical interventions with mind-altering drugs aimed at changing the person's behavior. We take an unequivocal position, supported by the CRPD, that mental health detention and compulsory treatment always violate the individual's human rights, and amount to ill-treatment and torture. As clarified recently by the Committee on the Rights of Persons with Disabilities, no detention is permitted in any kind of mental health facility.<sup>2</sup> This applies not only in civil commitment but also as a diversion from criminal detention, as the Committee urged a State Party:

To ensure that persons with psychosocial disabilities are ensured equal substantive and procedural guarantees as others in the context of criminal proceedings and in particular to ensure that no diversion programs are implemented that transfer individuals to mental health commitment regimes or that require the individual to participate in mental health services rather than providing such services on the basis of the individual's free and informed consent.<sup>3</sup>

Alternatives to incarceration should be promoted under a framework that includes reasonable accommodation for disability. For example, a person who commits a crime in order to satisfy some need that is not understood or accepted as valid by those around them can be engaged in dialogue to find a solution that would respond to the need without having to resort to a criminal offense. Such a solution may require that the community take action or expend resources that are reasonable under the circumstances. This can also be understood as an application of restorative justice principles from a social-model disability perspective; a gender perspective must similarly be incorporated.

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<sup>2</sup> CRPD Concluding Observations on Austria, CRPD/C/AUT/CO/1, 30 September 2013, paras 29-30; CRPD Concluding Observations on Australia, CRPD/C/AUS/CO/1, 21 October 2013, para 34.

<sup>3</sup> CRPD Concluding Observations on Australia, para 29.

In addition, we consider it imperative to ensure that there are procedural and substantive safeguards to help prevent wrongful conviction, and to prevent and challenge unfair sentences.

### **3. Standard Minimum Rules are inadequate and contradict CRPD**

The existing Standard Minimum Rules are not only inadequate to protect the human rights of persons with psychosocial disabilities in detention settings; the Rules are detrimental to our human rights and condone human rights violations. This is particularly the case with Rules 82-83, which require the transfer of individuals from ordinary prison to mental health facilities inside or outside the prison, and Rule 33(b), which permits the use of restraint based on a “medical” determination. In addition the Rules fail to guarantee the right to free and informed consent in all health-care related matters, including mental health services and including medical and psychological examinations. These standards are in contradiction to the Convention on the Rights of Persons with Disabilities<sup>4</sup> and to the recommendations of the Special Rapporteur on Torture, who calls for an absolute ban on the application of restraint, solitary confinement, or the nonconsensual administration of psychiatric drugs or electroshock to persons with psychosocial disabilities.<sup>5</sup> We are furthermore concerned that the existing Rules make no provision for alternatives to the medical model of mental health, that the Rules fail to respect the right to self-determination of all persons deprived of their liberty, and that the Rules make no provision for reasonable accommodation<sup>6</sup> of disability as required by the CRPD.

WNUSP welcomes the report of the Special Rapporteur on Torture on the Standard Minimum Rules,<sup>7</sup> which has adopted a similar perspective. In particular we draw attention to the recommendations regarding respect for the self-determination of all prisoners,<sup>8</sup> abolition of Rule 33(b),<sup>9</sup> incorporation of the right to free and informed consent by the person concerned to all health care services and to medical and psychological examinations,<sup>10</sup> and replacement of Rules 82-83 with a provision that applies to all persons with disabilities and that articulates rights enshrined in the CRPD. We also strongly agree with the recommendation in paragraph 38 to not cite in a new Preamble outdated standards such as the Principles for the Protection of Persons with Mental Illness and for

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<sup>4</sup> CRPD Articles 12, 13, 14, 15, 17, 19 and 25. See Concluding Observations of the Committee on the Rights of Persons with Disabilities: CRPD/C/AUS/CO/1, paras 25, 29, 30, 31, 34, 36; CRPD/C/AUT/CO/1, paras 28, 29, 30, 31, 33; CRPD/C/SLV/CO/1, paras 32, 35, 36, 51-52; CRPD/C/PRY/CO/1, paras 31-32; CRPD/C/CHN/CO/1, paras 23, 24, 28, 38; CRPD/C/HUN/CO/1, paras 26, 28; CRPD/C/ARG/CO/1, paras 41, 42; CRPD/C/PER/CO/1, paras 31-32; CRPD/C/ESP/CO/1, para 36; CRPD/C/TUN/CO/1, paras 28-29. See also previous WNUSP submissions in this process.

<sup>5</sup> Report of the Special Rapporteur on Torture, A/HRC/22/53, 1 February 2013, paras 63 and 89(b).

<sup>6</sup> CRPD Article 2 defines reasonable accommodation as follows:

“Reasonable accommodation” means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.

<sup>7</sup> Interim Report of the Special Rapporteur on Torture, A/68/295, 9 August 2013.

<sup>8</sup> A/68/295, paras 39-40.

<sup>9</sup> A/68/295, para 58.

<sup>10</sup> A/68/295, paras 50, 51, 54.

the Improvement of Mental Health Care (1991), which has been superseded by the CRPD. We quote in the full the comments by the Special Rapporteur on Torture on Rules 82-83, and urge all parties to the review process to follow this approach:

Rules 82 and 83 should be replaced with a provision that applies to all persons with disabilities. Such a provision should state explicitly that inmates with disabilities are entitled to be eligible for all programmes and services available to others, including voluntary engagement in activities and community release programmes, and to be housed in the general prison population on an equal basis with others without discrimination. It should also provide a clear articulation of certain rights enshrined in the Convention on the Rights of Persons with Disabilities: the duty to provide reasonable accommodation (arts. 5 and 14); the duty to work towards creating an accessible environment (art. 9); the duty to ensure that persons with disabilities have access to all amenities without having to rely on assistance from fellow inmates (e.g., arts. 5, 20 and 28); the duty to respect the choices of persons with disabilities and to establish effective mechanisms to support decision-making in order to enable people with psychosocial or intellectual disabilities to exercise their legal capacity on an equal basis with others (see arts. 12 and 13).<sup>11</sup>

#### **4. Recommendations for specific areas of the Standard Minimum Rules**

- Introduction
  - There is too much leeway for deviating from standards. There should be minimal standards that must be respected without deviation even when a country is experimenting with new practices. The Special Rapporteur on Torture states that most countries don't comply with the Standards.<sup>12</sup>
- Section 36(3)-requests or complaints
  - "Without censorship...but in proper form" is too strict because "proper form" should not be required for persons with or without disabilities and may be particularly difficult for persons with disabilities.
  - Paragraphs 76-82 of the report of the Special Rapporteur on Torture should also be incorporated.
- Section 37-communicating with outside world
  - "Regular intervals" should be specified to include a minimal interval.
  - Prisoners should be able to communicate with advocacy organizations at "regular intervals," which should also be specified to include a minimal interval.
- Section 39-receiving news
  - To be informed "regularly" should specify a minimal interval.
  - It gives too much power to administrator for news to be "authorized or controlled by administrator."
- Section to be added on paper and writing utensils
  - Prisoners should be provided with paper and a writing utensil every day so that they may take notes, write grievances, keep a journal, write letters, or

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<sup>11</sup> A/68/295, para 72.

<sup>12</sup> A/68/295, para 22.

do any other writing or drawing that they may wish to do without defacing any property.

## 5. Response to 2012 Outcome Document

WNUSP has concerns about deficiencies in the initial decisions taken by the Expert Group as reflected in the Outcome Document of the meeting in December 2012.

First, abolition of Rule 33(b) and replacement of Rules 82-83 by a provision that is fully in line with the CRPD and guarantees equality, non-discrimination and reasonable accommodation to all persons with disabilities, has not been placed on the agenda. It is both insufficient and offensive to merely replace outdated terminology in Rules 82-83 without replacing the outdated standards that derogate the human rights of persons with disabilities as enshrined in the CRPD.

Second, although we applaud the inclusion of a principle of free and informed consent in the doctor-patient relationship, such a principle would be strengthened by incorporating the standard applied under the CRPD, “free and informed consent of the person concerned.”<sup>13</sup> Too often, persons with psychosocial or other disabilities are deemed incapable of giving or withdrawing consent, so that they are in effect subjected to forced treatment based on the substituted consent of another person or entity (such as a court or tribunal). The CRPD disallows all forced treatment including that based on substituted consent, and in addition requires provision of support for decision-making, where desired by the person, in a manner that respects his/her autonomy, will and preferences.<sup>14</sup>

We also consider that the limitation of confidentiality of medical information based on a determination of possible harm to the person or to others<sup>15</sup> is vague, arbitrary and inherently prejudicial to persons with psychosocial disabilities in light of the alarming stereotypes that fail to differentiate between psychosocial disability and actual violent conduct or threats. It is thus contradictory to CRPD Article 22, which requires that the privacy of persons with disabilities, including medical records, be respected on an equal basis with others. This limitation on medical confidentiality should be removed. A duty to report and take action with regard to actual threats of violence against another individual must not be confused with the broad discretion to disclose medical information based on a judgment that to maintain confidentiality would result in harm.

With respect to the risk of suicide and self-harm, we consider that it is counter-productive to conduct intrusive assessments or to restrict the person’s freedom in order to prevent such acts. As David Webb has argued, there is an urgent need for safe spaces where people can talk about their suicidal feelings honestly and openly, with no fear of psychiatric lock-up

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<sup>13</sup> CRPD/C/AUS/CO/1, paras 25, 34, 36; CRPD/C/AUT/CO/1, paras 28, 31, 33; CRPD/C/SLV/CO/1, para 32; CRPD/C/CHN/CO/1, paras 28, 38; CRPD/C/HUN/CO/1, paras 26, 28; CRPD/C/ESP/CO/1 para 36.

<sup>14</sup> CRPD/C/AUS/CO/1, para 25; CRPD/C/AUT/CO/1, para 28; CRPD/C/SLV/CO/1, para 28; CRPD/C/PRY/CO/1, para 30; CRPD/C/ARG/CO/1, para 20; CRPD/C/CHN/CO/1, para 22; CRPD/C/HUN/CO/1, para 26; CRPD/C/PER/CO/1, para 25; CRPD/C/ESP/CO/1, para 34. See also A/HRC/22/53, paras 85(e) and 89.

<sup>15</sup> Outcome Document, para 9(e).



and 'treatment'. Louise Pembroke has outlined a non-judgmental and practical approach to self-harm.<sup>16</sup> This approach is sometimes called harm minimisation and defined this way:

It is about accepting the need to self harm as a valid method of survival until survival is possible by other means. This does not condone or encourage self-injury, it's about facing the reality of maximising safety in the event of self-harm. If we are going to harm it is safer to do so with information. Information on basic anatomy, physiology, first aid, wound care, correct usage of dressings and safer ways to harm.

This includes

- respecting people's need to self-harm (so they don't have to hide it, justify it, or make bargains or promises they can't keep).
- providing practical information to maximise safety.
- offering non-judgmental support: a space where people can make sense of the meanings and role of self-harm in their life histories & build up a range of strategies for survival that reflect their definitions and experiences.

Prisons should make possible peer support groups on self-harm, and the same with respect to suicide. According to one peer support group dealing with suicide:

There are many myths and fears around this sort of group and around suicide in general. However, as a community we have found strength in coming together to talk about many 'taboo' topics and to support one another in our times of greatest distress. Our collective wisdom and individual stories have taught us that the space to come together in this way can be powerful and healing.<sup>17</sup>

Third, we object to the distinction made between persons with disabilities and persons with mental health-care needs, in paragraph 12 of the Outcome Document. Persons with mental health-care needs are entitled to all the human rights guarantees enshrined in the CRPD, and to be treated according to a social model of disability rather than a medical model of mental health. We have found that when persons with psychosocial disabilities or those who express a need for mental health services are singled out for differential treatment in a human rights context, the result is inferior, medical model standards that derogate our human rights. As observed by the Special Rapporteur on Torture, the outdated Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, a document based in the medical model, has been superseded by the CRPD.<sup>18</sup> Not only must the outdated document not be referred to in any preamble to the revised Rules, the substantive standards must reflect the CRPD and not those that have been superseded.

Fourth, we strongly urge the Expert Group to incorporate the changes urged by the Special Rapporteur on Torture with respect to the prisoner's right to individual self-determination, and the revisiting of concepts such as "rehabilitation" and "correction" that can objectify inmates and disrespect their value as human beings.

It is important to consider that the deprivation of the right to individual self-determination is not incidental to criminal punishment or any other form of custodial care. The current phrasing of Rule 57 can be misunderstood as meaning

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<sup>16</sup> <http://www.dbdouble.freeuk.com/harmminimum.htm>.

<sup>17</sup> <http://www.westernmassrlc.org/alternatives-to-suicide.html>.

<sup>18</sup> A/68/295, para 38.

that deprivation of liberty results in the withdrawal of individual self-determination. It may be pertinent to redraft Rule 58 in order to clarify that only reasonable boundaries inherent to the regime in the places of detention apply. Likewise, Rule 69 could be amended to omit the reference to the conduct of a study of the personality of prisoners, as potentially in conflict with the right to personal self-determination.

As a principle of general application, the Rules should explicitly consider all inmates as subjects of rights and duties and not objects of treatment or correction. Given that mental ill-treatment may be inflicted under the name of remedial, educational, moral, spiritual and other forces and forms of assistance, the review process offers an opportunity to revisit Rule 59 in order to limit the applicable methods to those respectful of the prisoners' inherent dignity and value as human beings. In this respect, there is a need to revisit the concepts of "rehabilitation" and "re-education", as well as of "corrective" and "correctional", among others, in order to protect persons deprived of liberty from arbitrary intervention or treatment that may amount to torture or other ill-treatment.

This approach is important to WNUSP, since people with psychosocial disabilities have been disrespected as objects of intervention in both medical and correctional institutions. It should be noted that detention in any kind of mental health facility is itself arbitrary and unlawful under the CRPD. We agree with the Special Rapporteur that all prisoners should be treated as subjects of rights and duties, and add that prisoners must be allowed to retain their full legal capacity.<sup>19</sup>

Lastly, we are concerned about the proposed new scope of the Rules. If they are indeed meant to cover all places where persons are in fact deprived of their liberty, including psychiatric institutions where persons are deprived of their liberty under color of domestic law in violation of human rights under the CRPD, it is necessary to include a specific provision stating that no one shall be detained in any kind of mental health facility or based on grounds related to an actual or perceived psychosocial disability. This could be done by including in a replacement of Rules 82-83 as proposed by the Special Rapporteur on Torture, an additional provision "to ensure that no one is deprived of their liberty based on an actual or perceived disability, either alone or in combination with other factors (Art. 14)." If the revised Rules are not in line with the CRPD in all respects, the result will be a conflict in the standards to be applied, with resulting confusion and derogation of the CRPD standards.

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<sup>19</sup> See Committee on the Rights of Persons with Disabilities, draft General Comment on Article 12, paragraph 21. While restriction of legal capacity based on a criminal conviction does not discriminate based on disability, it is contrary to the universal right to recognition as a person before the law. Restriction of such a fundamental right is not incidental to the deprivation of liberty. As pointed out by a previous Special Rapporteur on Torture (A/63/175, para 50), deprivation of legal capacity facilitates acts of torture and ill-treatment; we believe that such nullification of personhood also amounts to ill-treatment or torture in itself.

## **Appendix: Information about Organizations**

The **World Network of Users and Survivors of Psychiatry (WNUSP)** is an international organisation of users and survivors of psychiatry, advocating for human rights of users and survivors, and representing users and survivors worldwide.<sup>20</sup> The organisation has expertise on the rights of children and adults with psychosocial disabilities, including on the latest human rights standards set by the CRPD, which it played a leading role in drafting and negotiating. WNUSP is a member organisation of IDA and has special consultative status with ECOSOC. WNUSP supports its members to advocate before UN treaty bodies, and has provided expertise to UN bodies including the Special Rapporteur on Torture, the Subcommittee on Prevention of Torture and the Committee on the Rights of Persons with Disabilities. WNUSP is currently engaged with processes for review of the Standard Minimum Rules on the Treatment of Prisoners and for the development of an instrument on the rights of older persons.

Jolijn Santegoeds and Salam Gomez, Chairs

[www.wnusp.net](http://www.wnusp.net)

The **Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP)** provides strategic leadership in human rights advocacy, implementation and monitoring relevant to people experiencing madness, mental health problems or trauma. In particular, CHRUSP works for full legal capacity for all, an end to forced drugging, forced electroshock and psychiatric incarceration, and for support that respects individual integrity and free will. CHRUSP provides technical support to the World Network of Users and Survivors of Psychiatry (WNUSP) through the work of the CHRUSP President as WNUSP International Representative.

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<sup>20</sup> In its statutes, “users and survivors of psychiatry” are self-defined as people who have experienced madness and/or mental health problems, or who have used or survived mental health services.