Parallel Report

The Right to Health
Art. 12 of the International Covenant on Economic, Social and Cultural Rights, General Comment No. 14

Bpe
Bundesverband Psychiatrie-Erfahrener e.V.
Federal Organisation of (ex-) Users and Survivors of Psychiatry in Germany

Member of ENUSP (European Network of (ex-) Users and Survivors of Psychiatry)
Member of WNUSP (World Network of Users and Survivors of Psychiatry)

Coercive psychiatric treatment of people with or without disability in Germany

Addressed to the Committee against Torture, 47th session

Addressed to the United Nations Committee on Economic, Social and Cultural Rights

Addressed to the United Nations Committee on the Rights of Persons with Disabilities

Bochum (Germany), February/October 2011

"The States Parties recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

Aware of the General Comment No. 14 and No. 15 of the ICESCR and the documents of the General Assembly of the United Nations: A/HRC/10/48 of January 26, 2009 and A/63/175 of July 28, 2008.
The Fifth State Report of Germany does not mention the quickly growing number of people in psychiatric treatment. Neither does it take into consideration the rising mortality rate (since 1970) of patients with a psychiatric diagnosis that were treated with antipsychotic medication by coercion[1] or without informed consensus.
The German government is aware of the strategy of the WHO (see p. 51 E/C.12/DEU/5, French version), but considers these issues as part of responsibilities of the Ministry of Health.
The German government reports further, that the populations access to water is secured over the whole country (see p. 53 E/C.12/DEU/5, French version), but forgets the small but growing group of people treated with fixation or seclusion, for whom this unrestricted access cannot be secured.

The report on psychiatric coercion[1] of the Federal Organisation of (ex-) Users and Survivors of Psychiatry in Germany (BPE e.V., member of the world association WNUSP) deals with children, adolescents, adults and elderly people. It is primarily concerned with people without disabilities, that are temporarily mentally handicapped or that have been and still are diagnosed wrongly. It is further concerned with people with long term mental disabilities, that they might have additional physical or intellectual disabilities.

In the light of new findings from independent pharmaceutical studies and epigenetics, and considering the high suicide rate and how long term pharmaceutical treatment probably increases the mortality rate of patients, the medicinal benefit has to be questioned. The current legislation has to be assessed and adapted, alternatives for coercive psychiatric treatment have to be established nationwide.

Approximately 150.000 people with or without disabilities underwent court-ordered compulsory psychiatric hospitalisations in Germany in 2008, that is about 175 people per 100.000.
This includes only compulsory hospitalisations that involved coercive psychiatric treatment with drugs[1]. Hospitalisations in case of emergency, that involve a brief coercive psychiatric treatment with drugs and are followed by a so called voluntary continuation[2], are not registered.
Affected are very often elderly women, unemployed people, young men and people that had been hospitalized repeatedly before, over-represented is also the diagnosis of schizophrenia.[3]
Statistically, women with disabilities are three times more likely to become a victim of violence than women without disabilities. Coercive psychiatric treatment, especially with antipsychotic medication, should be avoided[4], as it always leads to an

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1 Coercive treatment: forced medication whether orally or by injection, with or without the use of physical force
2 Pieters, V. (2003). Macht - Zwang - Sinn. Subjektives Erleben, Behandlungsbewertungen und Therapieerfolge bei gerichtlichen Unterbringungen schizophrener Menschen. Bonn: Psychiatrie-Verlag.
3 Bruns, G. (1997). Die psychiatrische Zwangseinweisung. In: Eink, M. (Hrsg.). Gewalttätige Psychiatrie, Bonn: Psychiatrie-Verlag, 62.
4 Pro Mente Sana Aktuell (2006). Gewalt und Zwang vermeiden, (1).

aggravation of symptoms and traumatisation[5], from which chronic psychosocial disabilities commonly arise in the long run.

After coercive psychiatric treatment the right to health and other rights of the ICESCR are restricted, especially article 6, 9 and 11, which means that also the rights of family members are restricted.
Long term studies show, that the rate of therapeutic response did not improve significantly with the introduction of antipsychotic medication.[6]
In international comparison people with a diagnosis of schizophrenia living in developing countries (India, Nigeria, Columbia), where only 2,6% to 16,5% of those diagnosed are treated with antipsychotic medication, over all experience significantly less psychotic episodes and more full remissions.[7]
The World Health Organisation estimates that only 50% of the medications prescribed for chronic diseases are taken by the patients. Thus not taking a medicine is not the exception.[8] None the less patients with the diagnosis of schizophrenia are commonly supposed to generally have no insight into the illness and are therefore forced to take highly dosed drugs.
Recommendations: 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 13, 14, 16, 17 and 18.

According to the German Medical Association only 0,5% of medical malpractice suits apply to psychiatry. Tanja Afflerbach, damaged by antipsychotic medication[9], has filed a suit since 2005 on federal state level. The small number of legal suits has several reasons: It is caused by the traumatisation[5] of coercive psychiatric treatment or forced antipsychotic medication, by the poor quality of life of those addicted to antipsychotic drugs[10], by the extremely adverse legal conditions[11] and by the lack of alternatives to hospitalisation. Taking into consideration the very disadvantageous prospects of a lawsuit and further risks of health, a long term legal case is out of the question for most of the patients. **Recommendations: 4, 6, 10 and 11**

During involuntary detention[12], especially with fixation and seclusion, fundamental determinants of health such as the access to drinking water, adequate sanitation or the adequate provision of food are often neglected by medical staff. Symptoms of the illness are thus intensified. **Recommendations: 1, 2, 3, 4, 5, 6, 7, 11, 13 and 18**

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5 Rufer, M. (2005). Traumatisierung in der Psychiatrie. In: BPE-Rundbrief 2005 (4), 11. http://www.antipsychiatrieverlag.de/artikel/gesundheit/rufer_trauma.htm [03/27/2010]
Rufer, M. (2007). Its diagnostic methods, its therapies, its power. In: Stastny, P.; Lehmann, P. (Eds.). Alternatives beyond Psychiatry, Berlin, Eugene, Shrewsbury: Peter Lehmann Publishing, 382-399.
6 Bockhoven, J. S. ; Solomon, H.C. (1975). Comparison of two five-year follow-up studies: 1947 to 1952 and 1967 to 1972. American Journal of Psychiatry 132, 796-801.
7 Jablensky, A.; Sartorius, N.; Ernberg, G.; Anker, M.; Korten, A.; Cooper, J. E.; Day, R.; Bertelsen, A. (1992). Schizophrenia: manifestations, incidence and course in different cultures. A World Health Organization ten-country study. Psychological Medicine, Monograph Supplement (20), 1-97.
8 Sabaté, E. (2003). Adherence to Long-Term Therapies – Evidence for Action. WHO 2003.
9 Joeres, A. (2010). Aus Versehen verrückt. Berliner Zeitung, 28 (02/03/2010), 3.
10 Wagner, F.-J. (2009). Psychopharmaka – subjektiv erlebt. Kerbe 2009 (3), 28. Und: BPE-Rundbrief 2010 (1), 19.
Lehmann, P. (Ed.) (2004). Coming off Psychiatric Drugs: Successful Withdrawal from Neuroleptics, Antidepressants, Lithium, Carbamazepine and Tranquilizers. Berlin, Eugene, Shrewsbury: Peter Lehmann Publishing.
Lehmann, P. (Hrsg.) (2008). Psychopharmaka absetzen. Erfolgreiches Absetzen von Neuroleptika, Antidepressiva, Phasenprophylaktika, Ritalin und Tranquilizern. 3. aktualisierte und erweiterte Auflage. Berlin, Eugene, Shrewsbury: Antipsychiatrieverlag.
11 Seehafer, W. (1995). Typische Fehler bei der gerichtlichen Durchsetzung von Arzthaftpflichtansprüchen. In: Rundbrief der GesundheitsAkademie, 30-34. http://www.bpe-online.de/infopool/recht/andere/seehafer.htm [07/29/2010]
12 physical restraint: involuntary detention in a psychiatric hospital or home, hospitalisation by court order in a locked ward or half-open unit, fixation, seclusion, bed rails, restrictive organisation of daily routines, e.g. denial of food at night and thus neglecting the importance of natural sleep.
Seibt, M. (2004). Die Wichtigkeit des Schlafs. http://www.psychiatrie-erfahrene-nrw.de/wichtigkeitSchlaf.html [07/30/2010]

Also, the incomprehensible language in legal correspondents to issue forced medication orders can aggravate symptoms. The legal support, necessary for patients to exercise legal capacity, is usually denied to the patients. **Recommendations: 1, 2, 4 and 7**

During hospitalisation in locked wards or half-open units, usually based on a court order for coercive psychiatric treatment, the treatment of somatic illness often is not possible for organisational or economic reasons and is ignored by doctors.[13]
Recommendations: 1, 3, 17 and 18

Until now there is no adequate education of psychiatric medical staff in Germany that involves also the relationship between health and human rights.
Recommendations: 5 and 7

One of the intentions of the WHO regional office Europe is to improve the health of the population until 2020 and lower the suicide rate by a third... This goal can be reached, when human rights are respected and the quality of life for people with mental health problems, especially with chronic disorders, is improved.[14]
According to official statistics[15] around 10.000 people kill themselves in Germany every year: The suicide figure for men is about 19,7 per 100.000, for women about 6,6 per 100.000. The number of suicide attempts is even ten times higher.
Individuals with a diagnosis of schizophrenia are almost thirteen times more likely to commit suicide than the general population (SMR 12,86).[16]
Comparable epidemiological studies do not exist yet for Germany, even though they could help future improvements in the psychiatric health system. A central register of suicides[17], that illustrates the relationship between suicide rate and coercive psychiatric treatment, has not been established. Illegal treatments such as non-authorized coercive psychiatric treatments and restraints or off-label[18] medication should be taken into account. **Recommendation: 9**

Antipsychotic medications often provoke depression and thus cause or aggravate suicidal tendencies.[19] Depression, suicidal tendency, excitation states and deliria caused by antipsychotic medication often happen, even though the patient has taken

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13 Kempker, K. (2004). Diskriminierung von Psychiatriebetroffenen im Gesundheitswesen - Eine europäische Studie. Mitgliederrundbrief des Bundesverbands Psychiatrie-Erfahrener e.V., 2004 (3), 20-22.
http://www.antipsychiatrieverlag.de/artikel/recht/harassment.htm [08/03/2010]
Harassment and Discrimination Faced by People with Psycho-Social Disability in Health Services.
http://www.enusp.org/documents/harassment/recommendations.htm [07/29/2010]
14 WHO: Health 21- Health for all in the 21st Century (1998). Target 6. Geneva: UNO.
15 Finzen, A. (1988). Der Patientensuizid. Bonn: Psychiatrie-Verlag.
16 Saha, S.; Chant, D.; McGrath, J. (2007). A systematic review of mortality in schizophrenia. Is the differential mortality gap worsening over time? In: Archives of General Psychiatry, 64 (10), 1123 -1131.
National Association of State Mental Health Program Directors (NASMHPD) (2006) Medical Directors Council: Morbidity and mortality in people with serious mental illness. 13th Technical Report. http://www.nasmhpd.org [Oct./2006]
17 World Health Organization / European Commission (1999). Balancing mental health promotion and mental health care: a joint World Health Organization / European Commission meeting. Brochure MNH/NAM/99.2, Brussels: World Health Organization, 9. http://www.peter-lehmann-publishing.com/articles/others/consensus.htm [07/30/2010]
Lehmann, P. (2010). Das betroffenenorientierte Suizidregister als Maßnahme der Suizidprävention. In: Hahn, S.; Schulz, M.; Schoppmann, S.; Abderhalden, C.; Harald, S.; Needham, I. (Hrsg.) (2010). Depressivität und Suizidalität Prävention – Früherkennung – Pflegeinterventionen – Selbsthilfe. Unterostendorf: Ibicura Verlag, 152-157.
http://www.antipsychiatrieverlag.de/artikel/gesundheit/pdf/suizidprophylaxe_2010.pdf [07/30/2010]
Lehmann, P. (2010). Ein Suizidregister unter Mitwirkung von Psychiatriebetroffenen? BPE-Rundbrief, 2010 (3), 7-9.
http://www.antipsychiatrieverlag.de/artikel/bpe-rundbrief/2010.3.7-9.pdf [11/03/2010]
18 Off-Label-Use means the practice of prescribing pharmaceuticals beyond the indication, that has been described in the application for drug registration and for which it has been approved by national and European public authorities.
19 Müller, P. (1981). Depressive Syndrome im Verlauf schizophrener Psychosen. Stuttgart: Enke Verlag.

the dose prescribed by a doctor.[20] However, antipsychotic drugs do not medicate the cause of the mental health problem, which are usually profound conflicts. They provoke a positive symptom, which is the postsynaptic block.[21]

Risks like irreversible tardive diskinesia, neurodegeneration, overweight[22], diabetes mellitus, metabolic syndrome and cardiotoxicity[23] are underrated. Serious consequences like the increased mortality[24] are ignored.
Because of the research, publicity, training and lobbying[25] financed by the industry, society underestimates the risks and dangers of antipsychotic drugs and misjudges them as a cure. Appropriate health information[26] regarding these issues are not accessible for the majority of the population. **Recommendations: 10 and 17**

On the 16th of October 2002 the charter of patients´ rights in Germany was provided to implement valid rights into practice. The charter describes the rights of patients to advisory, provision of medical care, Information and instruction. The patient takes part of the responsibility for his health and can prevent or overcome disease or disability by leading a healthy lifestyle, by participating in health prevention programs and by active compliance to therapies and rehabilitation. As a basic principle the patient has the right to choose freely or change doctor and hospital.

Before and during coercive psychiatric treatment it is usually denied to the patients to choose freely doctor and hospital. They are not informed about the serious effects and the remote damages of antipsychotic medication. Guidelines for dosage are ignored or avoided by poly-medication. There exist no gender-related limits for dosage. Epigenetical issues and factors for health risk are not taken into consideration.
Serious health risks are accepted. Even though it is more efficient[27] and less dangerous, psychosocial therapy without pharmaceuticals is not offered to patients,

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20 Benkert, O.; Hippius, H. (1980). Psychiatrische Pharmakotherapie. 3. Auflage. Berlin, Heidelberg, New York: Springer Verlag, 258.

21 Aderhold, V. (2008). On the necessity and possibility on minimal use of neuroleptics 2. http://psychrights.org/Research/Digest/NLPs/AderholdMinimalNeuroleptics-2008.pdf [09/25/2010]

22 Alvarez-Jiménez, M.; González-Blanch, C.; Crespo-Facorro, B.; Hetrick, S.; Rodríguez-Sánchez, J. M.; Pérez-Iglesias, R.; Vázquez-Barquero, J. L. (2008). Antipsychotic-induced weight gain in chronic and first-episode psychotic disorders: a systematic critical reappraisal. CNS Drugs, 22 (7), 547-562.

23 Correll, C. U.; Frederickson, A. M.; Kane, J. M.; Manu, P. (2006). Metabolic syndrome and the risk of coronary heart disease in 367 patients treated with second-generation antipsychotic drugs. Journal of Clinical Psychiatry, 67 (4), 575-583.

24 Aderhold, V. (9/2010). Neuroleptika zwischen Nutzen und Schaden – minimale Anwendung von Neuroleptika – ein Update. http://www.bgsp-ev.de/pdfs/Aderhold 09_10.1.pdf [10/23/2010]
Waddington, J. L.; Youssef, H. A.; Kinsella, A. (1998). Mortality in schizophrenia. Antipsychotic polypharmacy and absence of adjunctive anticholinergics over the course of a ten-year prospective study. British Journal of Psychiatry, 173, 325-329.
Joukamaa, M.; Heliovaara, M.; Knekt, P.; Aromaa, A.; Raitasalo, R.; Lehtinen, V. (2006). Schizophrenia, neuroleptic medication and mortality. British Journal of Psychiatry, 188 (2), 122-127. http://ahrp.org/risks/antipsychotic/joukamaa2006.pdf [07/30/2010]
Henderson, D. C.; Nguyen, D. D.; Copeland, P. M.; Hayden, D. L.; Borba, C. P.; Louie, P. M.; Freudenreich, O.; Evins, A. E.; Cather C. Goff D.C. (2005). Clozapine, diabetes mellitus, hyperlipidemia, and cardiovascular risks and mortality: results of a 10-year naturalistic study. Journal of Clinical Psychiatry, 66 (9), 1116-1121.
Straus, S. M.; Bleumink, G. S.; Dieleman, J. P.; van der Lei, J.; 't Jong, G.; Kingma, J. H.; Sturkenboom, M. C.; Stricker, B. H. (2004). Antipsychotics and the risk of sudden cardiac death. Archives of Internal Medicine, 164 (12), 1293-1297.

25 Rosenheck, R. A. (2005). The growth of psychopharmacology in the 1990s: evidence-based practice or irrational exuberance. International Journal of Law and Psychiatry, 28, 467-483.
Memorandum der Deutschen Gesellschaft für Soziale Psychiatrie zur Anwendung von Antipsychotika (1/2010). http://psychiatrie.de/data/pdf/68/0a/00/Broschuere_Neuroleptika.pdf [06/26/2010]

26 Self help information from Bundesverband Psychiatrie-Erfahrener (Federal Organisation of (ex-) Users and Survivors of Psychiatry in Germany): http://www.bpe-online.de
Peter Lehmann's International Internet Portal. Self-help & Alternatives beyond Psychiatry: http://www.peter-lehmann-publishing.com/info1/alternatives.htm [07/30/2010]
Socialpsychiatry: http://www.psychiatrie.de/dgsp/

27 Aderhold, V. (2007). Antwort auf die Stellungnahme der Arbeitsgruppe „Biologische Psychiatrie“ der Bundesdirektorenkonferenz, Enttäuschung über die Atypika.
http://psychiatrie.de/data/pdf/24/07/00/Aderhold_Antwort_an_BDK_Langversion.pdf [03/27/2010]

because it is not permitted by the cost accounting system of the German health care. Interactions with other pharmaceuticals have rarely been investigated and are hardly calculable. There is a higher risk of mortality with antipsychotic poly-pharmacy.[28] Neither patients nor their court-ordered official or voluntary assistants nor the responsible judges are able to consent with competence to the coercive psychiatric treatment and make a qualified decision.
Therefore the decision which risks are considered to be serious, and which are not, completely depends on the doctors. Serious mental and somatic side effects, the denial of sexual self-determination and tardive damages are usually considered as acceptable risks. The so called psychiatric psychotherapy serves to secure insight into the illness (psycho-education) and the long term consumption of pharmaceuticals (compliance).
Doctors are not acquainted with the basic recovery oriented approaches.[29] The traumatic experience of coercive psychiatric treatment and the difficult living conditions afterwards are rarely taken into consideration. Patients are usually not informed about the devastating consequences of discontinuing or reducing antipsychotic medication.[30] Most doctors avoid talking about how to discontinue medications in a qualified and enduring way.[31] Health insurances put pressure on hospitals to release patients, a lot of them have to be resumed.
Recommendations: 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 13, 14, 17 and 18

The German law maker's intention to avoid hospitalisation as much as possible has been undermined in the last ten years, as most doctors do not know about preventive sociotherapie[32] (socialtherapy) and health insurances have contracted only a few providers.
Some hospitals use so called sociotherapeuts to secure outpatients` adherence to antipsychotic medication. According to article 74 no.19 of the German Constitution the job title sociotherapeut is not standardized.[33] **Recommendations: 12 and 17**

Law makers have facilitated the Integrated Care (Code of Social Law V), that allows alternatives to stationary care. This could develop to a user-oriented Therapy in permanently reliable structures, that are built in a coordinated, close meshed cooperation of the different institutions. Such alternatives have only started and are financed by only a few health insurances.
Following the compulsory long term care insurance (Code of Social Law XI) Soteria concepts[34] and approaches of preventive, qualified home-based treatment (that take

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28 Aderhold, V. (2007). Antwort auf die Stellungnahme der Arbeitsgruppe „Biologische Psychiatrie" der Bundesdirektorenkonferenz, Polypharmazie.
http://psychiatrie.de/data/pdf/24/07/00/Aderhold_Antwort_an_BDK_Langversion.pdf [03/27/2010]
29 Baker, K. (2007). Families: a help or hindrance in recovery? In: Stastny, P.; Lehmann, P. (Eds.). Alternatives beyond Psychiatry. Berlin, Eugene, Shrewsbury: Peter Lehmann Publishing, 254-260.
Watkins, P. N. (2007). Recovery: a Guide for Mental Health Practitioners. Philadelphia: Elsevier Health Sciences.
30 Aderhold, V. (2008). On the necessity and possibility on minimal use of neuroleptics. Therapeutically guided reduction and withdrawl attempts. http://psychrights.org/Research/Digest/NLPs/AderholdMinimalNeuroleptics-2008.pdf [09/25/2010]
31 Positive Experience with tapering the medication:
Südland, N. (2003-2005). Optimized Medication due to the Law by Weber And Fechner.
http://www.norbert-suedland.de/English/Medicine/Medication.pdf [07/30/2010]
32 Reumschüssel-Wienert, C. (2002). Soziotherapie in Recht und Psychiatrie. Bonn: Psychiatrie-Verlag, 156-159.
33 Crefeld, W. (2010). Alarmruf der Soziotherapeuten. Psychosoziale Umschau, 25 (1), 31.
34 Aderhold, V.; Stastny, P.; Lehmann, P. (2007). Soteria: an alternative mental health reform movement. In: Stastny, P.; Lehmann, P. (Eds.). Alternatives beyond Psychiatry. Berlin, Eugene, Shrewsbury: Peter Lehmann Publishing, 146-161 ff.
Krisenpension: http://www.krisenpension.de [05/14/2010]
Aderhold, V. (2006). Soteria – a treatment model and a reform movement in psychiatry:
http://psychrights.org/articles/VAderholdOnSoteria%282006%29.pdf [07/30/2010]

need-adapted treatment[35] and open dialogue[36] into account) are rarely offered, because only a little number of health insurances have signed contracts according to the Code of Social Law.
Until now the budget spent for alternative treatments is marginal in comparison to the budget for stationary care. The medication of clients[37] could be reduced.
Educated recovery assistants are neither financially nor professionally acknowledged, a need-adapted assistance that is critical towards psychiatry (peer support[38]) is rarely possible yet. The possibility of participation in the development of peer support education is not sufficient.
Recommendations: 1, 3, 7, 8, 12, 13, 14, 15, 16 and 17

The high requirements on the professional competence of court-ordered official and voluntary assistants have not been regulated yet by law makers. Such directions would be of great importance to conciliate legal practice with legal status and to keep things in proportion. **Recommendations: 2 and 13**

The Bundesverband Psychiatrie-Erfahrener (BPE) e. V. recommends, that the Committee against Torture takes up the following topics for a list of issues and for the dialogue with the German government:

1 Construction of an effective network of legal and social support, that paves the way for a contemporary and adequate health care system, that enables recovery[29], rehabilitation and empowerment and that is consistent with the articles 2 and 12 of the ICESCR and the articles 12(3), 13, 14, 19, 25, 26(1) of the CRPD (see also article 74, sec. 1, no. 7 German Constitution)

2 Assessment of the legal practice of restraint for coercive treatment in accordance the laws relating to guardianship §1906 and § 1631b of the German Civil Code as well as to the 16 Mental Health Laws and Laws of involuntary commitment of the Laender. Plus the specification of their concepts of law to facilitate rehabilitation and empowerment and to conciliate the mentioned laws with article 12 of the ICESCR and with the articles 4, 5, 12(3), 13, 14, 16, 19, 25, 26(1) of the CRPD (article 74 sec.1 no. 7 German Constitution).

3 Assessment of all forms of coercive treatment (Fixation, seclusion, coercive medication and restricted freedom of movement), whether they are consistent with a contemporary and adequate health care system, and creation of a nationwide network of coercion-free retreating spaces that are also outdoors[39] in accordance with article 12 of the ICESCR and the articles 4, 5, 16, 19, 25 of the CRPD and article 74 sec.1 no. 7 of the German Constitution.

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29 Baker, K. (2007). Families: a help or hindrance in recovery? In: Stastny, P.; Lehmann, P. (Eds.). Alternatives beyond Psychiatry. Berlin, Eugene, Shrewsbury: Peter Lehmann Publishing, 254-260.
Watkins, P. N. (2007). Recovery: a Guide for Mental Health Practitioners. Philadelphia: Elsevier Health Sciences.
35 Alanen, Y. O. (1997). Schizophrenia: its Origins And Need-Adapted Treatment. London: Karnac.
36 Seikkula, J.; Alakare, B. (2007). Open dialogues. In: Stastny, P.; Lehmann, P. (Eds.). Alternatives beyond Psychiatry. Berlin, Eugene, Shrewsbury: Peter Lehmann Publishing, 223-239.
Greve, N. (2009). Offener Dialog und eigene Verantwortung. Soziale Psychiatrie, 33 (2) 14-18.
37 BGSP-Projekt: Abschlussbericht über die Erhebung der verordneten Medikation von Psychopharmaka an Klientinnen und Klienten des außerklinischen psychiatrischen Hilfesystems der Eingliederungshilfe in Berlin 2009. http://www.bgsp-ev.de/pdfs/Abschlussbericht.pdf [27.11.2010]
38 Mead, S. (2006). Peer Support: an Alternative Approach. Plainfield: self publication.
39 See project of the European Union COST E39

4 Nationwide establishment of patient's lawyers that are specialized in medical malpractice law, in the right to health and in independent pharmaceutical research, that are thus able to help people with disabilities or temporary disabilities to assert their right to health in accordance with the articles 2 and 12 of the ICESCR and the articles 5, 12(3), 13, 14, 25, 26(1) of the CRPD.

5 Nationwide securing of the education and secondary training of mental health personnel on human rights, research on psychiatric drugs that is funded independently from pharmaceutical companies and the social importance of the right to health in accordance with articles 2 and 12 of the ICESCR and the articles 4, 14, 16, 25, 26(1) of the CRPD.

6 Nationwide securing of the training of the judical system personnel including police and penal system on the human right to health and independent pharmaceutical research in accordance with the articles 2 and 12 of the ICESCR and the articles 4, 13, 14, 26(1) of the CRPD.

7 Nationwide securing of qualified, enduring reduction and tapering of antipsychotic medication, of recovery-approaches and peer-support, and of human rights in practice in the curriculum and the education of doctors in accordance with the articles 2 and 12 of the ICESCR and the articles 25 and 26(1) of the CRPD.

8 Securing of the revision of the national health regulations for the treatment of schizophrenia taking into account recovery-approaches, peer-support and new findings of independent pharmaceutical research in accordance with the articles 2 and 12 of the ICESCR and the articles 4, 5, 12(3), 14, 16, 19, 25 and 26(1) of the CRPD.

9 Introduction of a national patient-oriented suicide register in cooperation with independent former psychiatric patients, that takes into account the involvement of pharmaceutical medication, electric shocks, isolation, fixation and other forms of previous psychiatric treatment, including illegal treatments in accordance with article 12 of the ICESCR and the articles 14, 16, 25, 26(1), 31 of the CRPD.

10 Introduction of a research register for quality assurance of pharmaceuticals to publish the negative results in accordance with the articles 2 and 12 of the ICESCR and the articles 16, 25, 26(1), 31 of the CRPD.

11 Drafting a national patient's law, that secures that psychiatric patients have the same rights as patients with non-psychiatric diagnoses in accordance with the articles 2 and 12 of the ICESCR and the articles 2, 12(3), 16 of the CRPD.

12 Nationwide securing of the norming of the quality standards for home based treatment, of the professional title and of the quality standards for socio therapists and recovery assistants[38] in accordance with the articles 2 and 12 of the ICESCR and the articles 14, 16, 25, 26(1) of the CRPD.

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38 Mead, S. (2006). Peer Support: an Alternative Approach. Plainfield: self publication.

13 Nationwide obligatory regulation of the professional competence of court-ordered official and voluntary assistants taking into account new findings of independent pharmaceutical research and the human right to health in accordance with the articles 2 and 12 of the ICESCR and the articles 5, 12(3), 16, 26(1) of the CRPD.

14 Development of a national law for prevention that introduces a nationwide network for help, that reduces handicaps and enables recovery[26], rehabilitation and empowerment in accordance with the articles 2 and 12 of the ICESCR and the articles 5, 16, 19, 25, 26(1) of the CRPD.

15 Development of a national plan of action to build a coordinated, nationwide, close meshed cooperation of the different institutions for an integrated care that reduces handicaps and that enables recovery[29], rehabilitation and empowerment in accordance with the articles 2 and 12 of the ICESCR and the articles 2, 14, 16, 19, 25, 26(1) of the CRPD.

16 Nationwide allocation of funds to private and non-governmental organisations to build a patient oriented preventive health network in accordance with the articles 2 and 12 of the ICESCR and the articles 16, 19, 26(1) of the CRPD.

17 Adjustment of the standards and putting into practice the guidelines of the Federal Joint Committee as outlined in the Code of Social Law, book no. 5, book no. 9 and book no. 11 according to the article 12 of the ICESCR and the articles 2 and 25 of the CRPD.

18 Instant establishment of a federal commission for the nationwide prevention of violence, abuse and degrading treatment and punishment in hospitals that are under responsibility of the Laender in accordance with the articles 15 and 16 of the CRPD.

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26 Self help information from Bundesverband Psychiatrie-Erfahrener (Federal Organisation of (ex-) Users and Survivors of Psychiatry in Germany): http://www.bpe-online.de
Peter Lehmann's International Internet Portal. Self-help & Alternatives beyond Psychiatry: http://www.peter-lehmann-publishing.com/info1/alternatives.htm [07/30/2010]
Socialpsychiatry: http://www.psychiatrie.de/dgsp/

29 Baker, K. (2007). Families: a help or hindrance in recovery? In: Stastny, P.; Lehmann, P. (Eds.). Alternatives beyond Psychiatry. Berlin, Eugene, Shrewsbury: Peter Lehmann Publishing, 254-260.
Watkins, P. N. (2007). Recovery: a Guide for Mental Health Practitioners. Philadelphia: Elsevier Health Sciences.