The Use of Lethal Force by Law Enforcement Officials on Persons with Mental, Cognitive, and Developmental Disabilities

STUDENT WORKING PAPER

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Report presented to Agnes Callamard, UN Special Rapporteur on extrajudicial, summary or arbitrary executions & Ambassador Valentine Rugwabiza, Rwanda’s Permanent Representative to the UN
I. Introduction*

Individuals with mental, cognitive, and developmental disabilities are disproportionately affected by police violence. As the global conversation on disability evolves, the treatment of people with mental, cognitive, and developmental disabilities by law enforcement has garnered increasing attention and poses a significant challenge to the international community. People living with a mental illness, for instance, are not more prone to violent or criminal behavior than anyone else, but when someone is experiencing a mental health crisis, law enforcement officers often serve as first responders. Without the proper training, these officials often exercise gratuitous (and sometimes lethal) force. However, people with these disabilities are entitled to protections that will ensure their enjoyment of the right to life on the equal basis with others, including measures designed to prevent the unwarranted use of force by law enforcement.

This report examines how current law enforcement practices affect those living with mental, cognitive, and developmental disabilities in the United States and Rwanda. The last segment of the report examines state-sponsored use of force through an intersectional lens by examining three countries which subject mentally disabled women to forced sterilization.

II. Nuances Surrounding the Conversation on “Disability”

A discussion on persons with mental, cognitive, and developmental disabilities first requires a discussion of what constitutes the term “disabilities.” The Convention on the Rights of Persons with Disabilities (CRPD) does not offer a specific definition for the term “disability,” though its preambular language recognizes “that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal environmental barriers that hinders their full and effective participation in society on an equal basis with others.”

In response to this vague definitional standard, this report will follow the terminology used in the United Nations Office on Drugs and Crime’s (UNODC) Handbook on Prisoners with

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Special Needs and by the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. Psychiatric disabilities range from major conditions (such as schizophrenia and bipolar disorder) to less severe mental health problems, such as mild anxiety disorders. Intellectual disabilities are defined as a “condition of...incomplete development of the mind characterized by impairment of skills and overall intelligence in areas such as cognition, language, and motor or social abilities,” sometimes also referred to as “cognitive disabilities.” Furthermore, the term “psychosocial disability” refers to people who have received a mental health diagnosis and experienced negative social factors including stigma, discrimination, and exclusion.

“Mental disability” as an umbrella term can encompass both psychiatric and cognitive disabilities, though distinctions will be made between the two when necessary. Notably, the term “mental disability” covers a wide spread of profoundly different conditions which are distinct in their origins and external manifestations. These differences have significant bearing on how persons engaged with law enforcement officials might be treated. Furthermore, due to the range of different treatment approaches available, the terms “mental healthcare” and “treatment” cover a range of treatment options, including psychosocial support, counseling, speech and occupational therapy, physiotherapy, behavioral therapy, and psychiatric and medical treatment, among other specialized healthcare options.

III. International Engagement

Disability rights are internationally recognized and supported. One hundred and fifty-nine countries have signed the UN Convention on the Rights of Persons with Disabilities (CRPD) and 173 countries have ratified it. This instrument recognizes that persons with disabilities are entitled to live as active members of society with certain fundamental rights, such as the rights to life, access to justice, and equal recognition before the law. The International Covenant on

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6 Id.
10 Id.
Civil and Political Rights (ICCPR) similarly does not discuss the rights of persons with mental, cognitive, or developmental disabilities in explicit terms. Despite this absence, these treaty obligations encompass all people, including individuals with mental, cognitive, and developmental disabilities.

This paper closely examines two case studies, the United States and Rwanda, in order to provide a survey of how law enforcement officials engage with individuals with mental, cognitive, and developmental disabilities. We selected these two countries to be used as case studies for their vastly differing histories, political cultures, and legal frameworks. As such, the discussion on the United States will focus on the “use of lethal force” by law enforcement, while the Rwanda utilizes the framing of “extrajudicial killing.” In the United States, the Torture Victim Protection Act defines extrajudicial killing as “deliberated killing not authorized by a previous judgment pronounced by a regularly constituted court affording all the judicial guarantees which are recognized as indispensable by civilized peoples.” However, in Rwanda, the government authorizes officials to use lethal force outside of the rule of law. While the two countries have addressed this issue to differing degrees, each faces its own unique challenges and requires novel solutions to improve practices regarding the interactions between law enforcement and people with mental and developmental disabilities.

A. United States
   1. Background

   In May 2017, three police officers broke into the Milwaukee home of twenty-two-year-old Adam Trammell and commanded that he leave the shower. A neighbor called the police after seeing him naked wandering the hallway. Adam, diagnosed with schizophrenia, was in the midst of a breakdown and often took showers to calm himself and soothe his anxieties. Though Adam did not respond to the officers and leave the shower, he was unarmed and did not behave in a threatening manner. But when he did not follow the officers’ instructions, they resorted to using force. The officers shot Adam with their stun guns fifteen times as he screamed and writhed in his bathtub from the pain of the electric shocks. More officers arrived soon after,
dragged him naked from his apartment, and forcefully injected sedatives. Moments later, Adam stopped breathing and was pronounced dead at the hospital.14

Unfortunately, these incidents are not rare. In the United States, law enforcement is often the first line of response for people in the midst of mental health crises. This is due, in part, to a lack of access to emergency psychiatric services. Approximately ten percent of police calls involve someone who is mentally ill, requiring officers to function as incidental mental health interventionists.15 For vulnerable citizens who may not otherwise be able to seek help, the police serve as a last resort and officers must make critical decisions about how to resolve encounters and whether to initiate formal interventions vis-à-vis the criminal justice system or social services. Sometimes, emergency situations do not leave time for this decision-making and police officers resort to using excessive, and sometimes lethal, force.

People living with mental illness and cognitive disabilities are disproportionally affected at every stage of the American criminal justice system. In prisons, for instance, the number of individuals suffering from serious mental illnesses now exceeds the number of those in state psychiatric institutions tenfold.16 Outside of prisons, law enforcement encounters with people with mental illness sometimes results in death. In 2018 alone, police killed 214 people with mental health disabilities.17 A broader range of data indicates that at least twenty-five percent of all police killings are of people in a mental health crisis.

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15 When Cop Calls Involve the Mentally Ill, Training Is Key, NATL. PUB. RADIO, INC. (June 14, 2014), https://www.npr.org/2014/06/14/322008371/when-cop-calls-involve-the-mentally-ill-training-is-key.
American police culture emphasizes a “command and control” approach to every situation, which helps to explain these alarming statistics. According to a report by the Police Executive Research Forum (PERF), police academies spend a median of fifty-eight hours on firearm training, but only eight hours on de-escalation and crisis intervention. PERF’s report subsequently identifies the need for different training programs and a different policing culture. Instead of predominantly focusing on firearm usage, officers should receive integrated training that better prepares them to consider all of their options in different scenarios, especially when they are interacting with people with mental, cognitive, and developmental disabilities. This case study on the United States considers the current policy landscape, the ways in which law enforcement agencies are currently gathering data to critically examine worrisome trends, and how agencies are recalibrating their trainings to meet the needs of individuals affected by mental illness.

18 Supra note 13.
20 Id.
2. Policy Landscape

Generally, the policies governing law enforcement practices around the use of lethal force in the United States are uneven, varying by state and sometimes local government. Under United States federal law, the use of deadly force by sworn law enforcement officers is legal where the officer reasonably believes that the subject poses a significant threat of serious bodily injury or death to themselves or others. For instance, deadly force applied by police officers is permissible under federal law when it is used to prevent the escape of a fleeing felon who presents a similarly significant threat of serious bodily injury or death to members of the public.21

“Use of force” is defined by the International Association of Chiefs of Police as the “amount of effort required by police to compel compliance by an unwilling subject,” but what this means in practice can vary from one jurisdiction to the next.22 Most law enforcement agencies establish a use of force continuum ranging from simple force to deadly force. Using this tool, police officers are supposed to control subjects using the minimum force necessary. However, since there is no universal definition of “use of force” in the United States, this leaves approximately 18,000 local police agencies to formulate their own policies on the matter.23

One way police departments have begun to reduce use of force complaints is by mandating crisis intervention, or de-escalation, training. De-escalation techniques give police officers the tools to slow down and use communication techniques to defuse a potentially dangerous situation.24 This type of instruction is valuable when dealing with people who are experiencing mental or emotional crises, or people with intellectual and developmental disabilities. The Dallas Police Department, for instance, saw an eighteen percent drop in use of force the year after it instituted de-escalation training, and excessive force complaints in the area have dropped by eighty-three percent since 2010.25

25 Id.
However, thirty-four states in the United States do not require officers to receive de-escalation training. Without a state-wide mandate, officer training varies widely from one jurisdiction to the next, even within a single metropolitan area. Although law enforcement experts say that police are far less likely to use their guns after they have received training on how to de-escalate a confrontation, only twenty-one states have implemented legislation that requires this. Police departments often cite cost and lack of qualified staff as two of the main reasons for de-prioritizing this type of training. Of the states that have policies requiring de-escalation training, these mandates take different forms and vary in time and depth from state to state. For instance, law enforcement officials in Massachusetts are required to attend four hours of training per year, while police officers in California need only attend two hours of de-escalation instruction every two years. Nationwide, police officers have differing levels of preparation on how to manage crisis scenarios without resorting to lethal force and endangering the lives of innocent civilians, including those living with mental, cognitive, or developmental disabilities.

3. Data Collection

Reliable data about fatal law enforcement encounters in general does not exist, much less data about the use of lethal force by law enforcement officials of people living with mental illness. In 2015, the Treatment Advocacy Center, a national non-profit dedicated to researching issues around lack of access to mental healthcare, conducted a survey on fatal law enforcement encounters and determined that none produced complete and reliable statistics. The report further noted that a number of news organizations, nonprofits, and individual bloggers created independent databases in the absence of reliable data, and these sources estimate that approximately 1,000 people are killed annually in shooting by law enforcement—more than double the number any federal agency had reported. However, even these databases fall short

26 Curtis Gilbert, Not Trained to Not Kill, APM REP. (May 5, 2017), https://www.apmreports.org/story/2017/05/05/police-de-escalation-training.
27 Id.
28 Id.
31 Id.
of exposing the true extent of the information gap because they primarily rely on crowdsourcing and published anecdotes, which obfuscates the magnitude of the problem.

To begin to address this issue, the Federal Bureau of Investigation (FBI) developed the National Use-of-Force Data Collection at the request of local, state, and federal law enforcement agencies in 2015 to increase transparency and analyze information related to use-of-force incidents. The scope of the use-of-force incidents covered includes actions by law enforcement officers that result in the death or serious bodily injury of a person and whether the officer discharged a firearm in the course of the altercation. It also includes information on the incident, the subject, and the individual officer(s) involved. Since it is a collective instrument that focuses only on readily known data about the incidents, it will not provide information on whether an officer acted lawfully in a given use-of-force situation. Notably, one of the elements of data to be recorded will be whether a subject had a mental health issue that was known or apparent at the time of the incident. A more complete list of the FBI’s data collection questions is located in Appendix A. If widely adopted, this tool can deliver an aggregate view of how people with mental illnesses are treated by different law enforcement agencies in communities across the country.

The FBI is working closely with major law enforcement agencies in the US to obtain support and forge commitments; however, submission to this database is voluntary as the FBI does not have the legal authority to mandate reporting. Training-wise, digital resources currently include “how-to” videos, compilations of frequently asked questions, and brief guides. The FBI has planned to develop additional trainings and informational resources to assist law enforcement agencies in the proper and complete reporting of this data. The FBI officially began accepting submissions to its database in 2017 and released initial findings from its pilot study in December of 2018. Subsequent findings will occur on a regular basis no less than twice a year. However, because the reporting is voluntary, it is unclear whether the database will successfully

fill the information gap and reveal the extent to which people with mental disabilities are harmed in encounters with law enforcement.

4. Investigations and Prosecutions

Research shows that police officers are very rarely charged in connection with homicide and are even more rarely convicted. Of the estimated 1,000 or more incidents in which people are killed by law enforcement, reports suggest that only about four or five police officers are criminally charged for fatal on-duty shootings. The number of police officers charged with killings in general, not just shootings, is higher. Between 2005 and 2011, there were 126 cases of murder and non-negligent manslaughter, and 64 more cases of negligent manslaughter. In the absence of reliable federal data sources, these reports relied on data collected using Google Alerts for media coverage. These reports do not specify the extent to which the charges involved people living with mental illness or the instances where people were killed but not reported. Additionally, the cases described above do not indicate the instances where the district attorney or federal prosecutor decided not to bring a case by exercising their prosecutorial discretion, received an indictment but chosen not to prosecute the case, or received a non-conviction and decided not to appeal the result.

There are a number of other obstacles that stand in the way of obtaining convictions against police officers for fatal incidents. Comprehensive statistics on prosecution efforts, rationales for prosecutorial decisions, and success rates are typically unavailable to the public, and district attorney’s offices do not routinely maintain information about the number of cases prosecuted by police officers. Even when cases against law enforcement officials are brought, they are very difficult to prove in court and clear the reasonable doubt standard. According to University of Pennsylvania law professor David Rudovsky, “a prosecutor needs a very strong case before a jury will say that someone we generally trust to protect us has so seriously crossed the line as to be subject to a conviction.”

36 Id.
37 Id.
Reporting Project supports this theory, finding that of the 3,238 criminal cases brought against police officers from April 2009 to April 2010, only thirty-three percent were convicted. Of those convicted, only thirty-six ended up serving prison sentences. Both of these numbers are approximately half the rates at which members of the public are convicted or incarcerated. These statistics indicate that law enforcement officials are rarely held liable in lethal force cases.

Furthermore, there is a natural conflict of interest between district attorneys and law enforcement. Since prosecutors typically work closely with the police to bring cases against suspected criminals, there may be a reticence in bringing charges against officers who have been “productive” in supporting the work of the district attorney’s office. Prosecutors control whether a case goes forward and there are no checks on this process, other than public opinion and reelection pressures. When a police officer kills an individual, prosecutors often do nothing and allow the police department procedures handle the issue. In order to overcome these barriers, it may be useful to pass legislation, such as the Police Training and Independent Review Act of 2015, that requires external and independent investigations of police killings, particularly when they involve the deaths of individuals living with mental illness. Failing to hold officers liable for these deaths leaves families with no remedy and impedes change to the status quo.

5. Diversion Practices

To decrease the number of arrests of people in the midst of a mental health crisis, police officers should instead redirect them to the appropriate resources. The two predominant diversionary tactics used to support persons with mental disabilities in the United States are specialized mental health courts and Crisis Intervention Team (CIT) policing. Both techniques seek to support people with mental disabilities early in the criminal justice process, before resources are expended on prosecution, conviction, and incarceration. By connecting people with the support they need early on, correctional facilities will also be relieved of the responsibility to provide mental health care—a task for which prison guards are ill-equipped.

40 Id.
41 Id.
Mental health courts are byproducts of the larger trend towards “problem-solving courts,” which seek to work with the defendant to address the underlying issues at hand instead of defaulting to punishment. Other variations of problem-solving courts include drug courts, veterans’ courts, and domestic violence courts. In mental health courts, cases are diverted when it is determined that the defendant would benefit more from community-based mental health care treatment than incarceration. The social service agencies providing the treatment screen and evaluate the needs of the candidates, and the presiding judge typically has specialized knowledge regarding mental illnesses and their associated challenges. At the end of the process, the court approves a treatment plan and, if the defendant agrees to comply, the criminal charge is suspended. The court monitors the defendant’s progress through follow-up hearings and will ultimately dismiss the charges if the defendant honors his obligations. Participation in mental health courts is voluntary, and the defendant must consent to participation before being placed in the program. In order to participate, people must be living with a “demonstrable mental illness” to which their involvement in the criminal justice system can be attributed, and this bar varies by jurisdiction.

Over 400 mental health courts have been established in the United States thus far. Findings have shown that mental health court participation results in comparatively fewer new bookings into jail compared to the period before the program was implemented. Additionally, persons living with mental illnesses received greater numbers of treatment episodes and participants in mental health courts spent fewer days in jail than individuals in districts without a mental health court. Participation also increased the frequency of treatment services compared with involvement in the traditional criminal court system. However, data on these outcomes is limited and more research needs to be done to compare practices across programs.

CIT policing, on the other hand, focuses on the role of law enforcement in working with people with mental disabilities. These initiatives are local and designed to improve the way communities respond to people experiencing a mental health crisis by directing affected

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47 Id.
48 Specialized Courts, supra note 45.
50 Id. at 14.
51 Id.
individuals to the appropriate mental health resources and away from the criminal justice system. CIT programs aim to create strong partnerships between law enforcement, mental health providers, hospital emergency services, and individuals affected by mental illness. In CIT trainings, police departments educate their officers on the nature of various forms of mental illness, the ways these illnesses may manifest, known treatments that will allow people with mental illness to function safely, and techniques to communicate with a person in an acute psychiatric crisis.

Currently, CIT programs serve over 2,700 communities in the United States. These initiatives have shown to reduce the number of arrests of people living with mental illness while concurrently increasing the likelihood that those individuals will receive the mental health services they need. Research on four police districts in Chicago indicated that CIT-trained officers directed a greater proportion of persons living with mental illnesses to mental health services. CIT programs also benefit communities by keeping law enforcement’s focus on crime—by reducing the amount of time officers spend responding to mental health calls, police officers are more quickly able to return to the community while individuals experiencing mental health issues are guided to the appropriate resources. A variety of materials are available to localities interested in building and implementing their own sustainable CIT models, which will have the effect of re-directing people in crisis away from the criminal justice system and to the appropriate health care resources.

6. Conclusion

The use of lethal force against persons with mental disabilities by law enforcement is a documented problem in the United States. The policy landscape regarding use of force, reporting

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53 Stephanie Franz & Randy Borum, Crisis Intervention Teams May Prevent Arrests of People with Mental Illnesses, POLICE PRACTICE AND RESEARCH 265 (Oct. 21 2010).
57 Crisis Intervention Team Core Elements, The University of Memphis (Sept. 2007), http://www.citinternational.org/resources/Pictures/CoreElements.pdf.
requirements, de-escalation trainings, and diversionary practices is uneven and varies greatly by state and locality. Due to the absence of uniform reporting mechanisms, there are no reliable databases which capture the full extent of the impact on people living with mental and developmental disabilities, but from the information that is available, it is clear that this community is disproportionately affected. Many states and cities are working towards solutions to this problem which can and should be adopted nationwide. People living with mental and developmental disabilities can be better served through the mandated de-escalation training of police officers and the implementation and use of diversionary practices such as CIT policing and mental health courts.

**B. Rwanda**

1. **Introduction**

   After the Rwandan genocide in the mid-1990s, Rwanda became one of the fastest developing countries in the world. However, nearly twenty-five years after the conflict, its effects are still shaping government policies and people’s lives within Rwanda. One prime example is the exacerbated need for mental health services. Though the country pursued a revamped policy in 2012 aimed at improving mental health facilities and services, these remain limited. This, taken with incredibly severe police tactics, presents a threat to the life, safety, and security of those with mental, cognitive, and developmental disabilities.

2. **Background and the 1994 Genocide**

   Rwanda is a presidential republic that became independent from Belgium in July 1962. Prior to independence, many of the leadership positions left vacant by the German and Belgian colonial authorities were held by members of the Tutsis, a minority ethnic group. Tutsis represented approximately fourteen percent of the population, while Hutus comprised eighty-five percent and Twas the remaining one percent. Prior to independence, the Hutu political movement’s attempts to place more Hutus in positions of power resulted in violence. Post-

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59 *Id.*
61 *Id.*
independence, the departing Belgian authorities abruptly designated political power, not to the Tutsis, but to the Hutus.62 As a result, many Tutsis fled the country for fear of violence.63

On April 6, 1994, a plane carrying the Rwandan President Juvénal Habyarimana and the Hutu Burundian President Cyprien Ntaryamira was shot down.64 What followed was one of the most horrifying genocides of the twentieth century. For the next 100 days, Hutus, prompted by organized radio and political incitements, attempted to exterminate Tutsis within Rwanda and beyond. Estimates of the number of Tutsis killed within the genocide are disputed, but the safe number remains around 500,000 Tutsis killed within that time period. During this time, Hutu moderates were also murdered for their opposition to genocidal policies. Meanwhile, civil war raged as the Rwandan Patriotic Front (RPF) attempted to take over the country. When the RPF eventually did win the civil war, they ended the genocide. In doing so, many lost their lives, including a significant number of non-combatant Hutus. After the civil war, RPF leader Paul Kagame became president. He continues in that role today and was re-elected for a third term in August of 2017 by a reported ninety-nine percent of the popular vote that the government reports represents ninety-six percent of the country.65

3. Modern Mental Health Policy

After the Rwandan genocide ended, there was little to no assistance for the mental health crisis that resulted in the mid-to-late 1990s. Though a mental health policy was written in 1995, it did not gain traction until its update in 2012.66 Today, however, mental health is beginning to gain the recognition it needs. According to the National Health Policy, “the problem of psycho-trauma poses major challenges and adds to the suffering of our citizens in mental health. This burden is mainly due to the violence generated by the genocide in 1994 and the consequences that ensued.”67 As a result, there are large amounts of the population who suffered severely during the genocide, who now suffer from different forms of mental illness, and who do lack access to mental health services they need.

62 Id.
63 Id.
64 Id.
67 Id at 5
Statistics help give a better idea of the scarcity of mental health services in Rwanda. As of 2015, lack of access to care has been described as “overwhelming” nationwide.68 There are 0.01 centers per 100,000 people because there is only one mental health out-patient center in the entire country.69 There is a single day treatment facility and seventy-two psychiatric beds available in all of Rwanda.70 However, forty-three district hospitals do offer basic mental health services.71 In addition, the University of Rwanda continues to develop its mental health and psychiatry training programs in an effort to support additional mental health care providers in the country.72

Other serious indicators of the need for treatment within Rwanda post-genocide are the number of individuals seeking mental healthcare but unable to access it. There were 5,560 reported cases of individuals desiring treatment for mental illness and trauma; however, with little structure to provide that care, much of the need was not met.73 This does not include the number of unreported cases of patients seeking care and unable to get it.

The Rwandan Minister of Health notes her initial report on the 2012 policy that “one has to be aware of the context in which the action to be undertaken will occur.”74 Considering Rwanda’s context and history, it is hard to believe that no mental health policy existed before now. While there was an initiative in 1995, it bore little to no fruit and failed to gain traction with local NGOs or receive significant fiscal support from the international community. It is unclear why this is the case, though the country was recovering from the massive conflict at the time. The twenty-first-century health initiative was spurred by the Millennium Development Goals and intends to “adequately respond to the challenge of mental health within the Rwandan community.”75 The new policy aims to do so by “coordinating initiatives in [the health sector], ensure the implementation of national policy in mental health[,]” and also hopes to safeguard

70 Id.
72 University of Rwanda Centre for Mental Health, (accessed on April 5 2019) https://cmhs.ur.ac.rw/cmh/.
74 Id at IV.
75 Id at 8
“the quality of mental healthcare, respond to the needs of citizens as close to them as possible, and promote community mental health.”76 While these are broad goals to achieve, it seems that mental health has become a true priority for the Ministry of Health. However, even with these increased efforts in the past five years, disabilities continue to be viewed as a curse.77 This belief seems to originate out of a stigma associated with mental illness throughout the country.78

The goal of the 2012 policy was to integrate mental healthcare into primary care and focused on addressing substance abuse, trauma following the genocide, and epilepsy.79 Additionally, it included directions to university programs to include mental health training to healthcare professionals; provide mental healthcare professionals with the technology they need to provide care; support the legal framework of mental, cognitive, and developmental disability rights; and supply affordable psychological medications.80

In addition, Rwandan national law prohibits discrimination on the basis of disability. The Rwandan Constitution guarantees equality among all people, including those with mental, cognitive, and developmental disabilities.81 Additional federal laws protect the rights of people with disabilities.82 Article 10 specifically designates the Rwandan National Human Rights Commission with the task of monitoring the respect for rights of people living with disabilities.83 However, accessibility to services and resources continues to be problematic in Rwanda and individuals with disabilities continue to face stigma and discrimination.84

4. Visual Representations

76 Id at 9
80 Id.
81 Constitution of the Republic of Rwanda and its Amendments of 2 December 2003 and of 8 December 2005, 4 June 2003, Article 11 (“Discrimination of whatever kind based on, inter alia, ethnic origin, tribe, clan, colour, sex, region, social origin, religion or faith, opinion, economic status, culture, language, social status, physical or mental disability or any other form of discrimination is prohibited and punishable by Law”)(emphasis added)
83 Id at Article 10.
Below are a number of visualizations that represent the current status of mental healthcare in modern day post-genocide Rwanda. These graphics illustrate both the need for and lack of resources, even almost twenty-five years after the conflict. The statistics represented in these graphics are qualitatively supported by studies of civilians and care providers within Rwanda.\textsuperscript{85}

Map B: Rwandan Districts by Population Density

Map B portrays the population density throughout Rwanda. This contextualizes the following maps that describe the lack of mental health resources in the country. By showing the

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areas with the most people, this map gives a sense of where the largest number of people live, work, and need access to care.

Map C: Rwandan Population Density by Sector

Map C overlays the population by density by sector. This map portrays a more detailed analysis of the number of people living in Rwanda.

Map D: Rwandan Mental Healthcare Resource Availability by District

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Map D displays the availability of mental health care designated centers. As of 2014, when ArcGIS data was last available, Burera was the only district with a certified mental health care center to provide services to the population living there.
Map E: Rwandan Population Density with Mental Healthcare Availability by District

Map E depicts the population density by district overlaid with the availability of mental healthcare centers. This map brings together all of the other preceding maps to reveal the number of densely populated areas of the country that need access to mental healthcare centers. While the district with the country’s only dedicated mental healthcare center, Burera, is quite populated, there are many other equally populated areas of the country that lack access to care centers. This map provides an illustration of the lack of mental healthcare clinics described above, which the 2012 policy attempts to address.

Today, the facilities are still failing to meet the needs that Rwanda’s population requires. Since the production of the above charts, mental healthcare resources remain exceedingly limited. There are a total of six care facilities in the entire country, but there are over 45,000 diagnosed cases of mental, cognitive, and developmental disabilities. So, while the 2012 policy represents an improvement in providing care and legal protection for people who live with these disabilities, the availability of on-the-ground care remains incredibly limited.

5. Recent Developments in Extrajudicial Killing

Over the past three years, Rwanda has drawn significant attention for its official policy of extrajudicially killing individuals for the commission of petit offenses. In the thirty-seven cases identified, the victims were indiscriminately seized, arrested, and/or shot. Reports indicate that these actions were sanctioned by the state.

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91 Human Rights First, *All Thieves Must be Killed, Extrajudicial Killing in Western Rwanda* (July 13 2017) [https://www.hrw.org/report/2017/07/13/all-thieves-must-be-killed/extrajudicial-executions-western-rwanda](https://www.hrw.org/report/2017/07/13/all-thieves-must-be-killed/extrajudicial-executions-western-rwanda) (“These killings were not isolated events, but appear to be part of an official strategy. In most of the cases documented by Human Rights Watch, local military and civilian authorities told residents after the execution, often during public meetings, that they were following “new orders” or a “new law” stating that all thieves and other criminals in the region would be arrested and executed. In several cases authorities cited the identity of a recent victim and justified his or her killing based on the fact that he or she was a suspected criminal.”)
92 *Id.*
Of the documented cases of extrajudicial killing, the murder of Claude Barayavuga exemplifies the targeting of individuals, in part, for their mental, cognitive and developmental disabilities. Barayavuga was a nineteen year-old resident of Bahimbia, Rubavu district and was diagnosed with cognitive disabilities.94 On April 23rd, 2017, the Bahimbia chief announced to community members that thieves should be punished severely, reportedly under the direction of the Rwandan government.95 The Bahimbia chief specifically identified Barayavuga by name in this speech stating if he was caught stealing then community members had the authority to kill him.96 After this meeting, Barayavuga allegedly stole two lightbulbs from a Bahimbia resident who chased and brutally murdered Barayavuga with a hammer.97 The resident was arrested and detained but quickly released from police custody.98 Less than a week after Barayavuga’s death, the Secretary of Nyundo sector announced in a public meeting that Barayavuga’s murder “should be ‘an example for all thieves.’”99

The Rwandan government attempted to discredit any and all reporting on extrajudicial killings of individuals, which encompasses those who have cognitive, mental, and developmental disabilities.100 Much of the government’s response denied the findings of the original Human Rights Watch report, and the government never addressed Barayavuga’s murder specifically. The government contends that its investigation is ongoing, but no new reports have been released since 2017.101

In addition to the thirty-seven reported extrajudicial killings for petty crimes, extrajudicial killings continued in 2018. One significant death was of Mr. Hubert Gashagaza, a
senior police officer with the RNP.\textsuperscript{102} Chief Superintendent Gashagaza was found strangled with computer cords.\textsuperscript{103} Rwandan lawyer Didas Gasana stated that “he was strangled using ropes, sort of TV cables, [and] the modus operandi fit[] in the pattern of the way the government of Rwanda has been assassinating.”\textsuperscript{104} The Rwandan Investigation Bureau responded to the death by opening an investigation but no further public statements have been released.\textsuperscript{105}

The United States State Department’s 2018 report on Human Rights in Rwanda noted an additional extrajudicial killing of a defendant in custody, Me Donat Mutunzi,\textsuperscript{106} in April 2018.\textsuperscript{107} Mutunzi was a Rwandan lawyer known to have posted commentary critical to President Kagame and was shortly thereafter accused of rape.\textsuperscript{108} Initially, Mutunzi’s family believed him to have disappeared, but later discovered he was arrested by the police.\textsuperscript{109} The Rwandan police then reported that Mutunzi committed suicide in his cell, but, upon viewing his body, family members and human rights activists argue that he was murdered while in custody.\textsuperscript{110}

Human Rights Watch is not alone in calling for an end to extrajudicial killings in Rwanda. Over the past three years, many organizations have echoed this concern.\textsuperscript{111} While not

\begin{flushleft}
\textsuperscript{103} Id.
\textsuperscript{104} Id.
\textsuperscript{105} The Express News, \textit{Retired police officer Hubert Gashagaza dies} (Sept. 18 2018) \url{http://expressnewsrwanda.com/hubert-gashagaza-dies-retired-police-officer}.
\textsuperscript{106} N.B. In some reports the individual is referred to as Me Donat Mutunzi and in others as Donat Mutunzi. In an effort to maintain a complete record, this report will refer to him as Me Donat Mutunzi.
\textsuperscript{108} Id. See also Gakwerere, \textit{Me Donat Mutunzi a Rwandan lawyer was found dead in police custody}, The Rwandan (April 23 2018) \url{http://www.therwandan.com/me-donat-mutunzi-a-rwandan-lawyer-was-found-dead-in-police-custody/} (stating skepticism that Mutunzi committed suicide); Placide Kayitare, \textit{Me Donat Mutunzi}, Inyenyeri News (May 1 2018) \url{http://www.inyenyerinews.org/human-rights/me-donat-mutunzi/} (furthering skepticism about the fact that Mutunzi committed suicide rather than was murdered).
\textsuperscript{110} Id. See also Gakwerere, \textit{Me Donat Mutunzi a Rwandan lawyer was found dead in police custody}, The Rwandan (April 23 2018) \url{http://www.therwandan.com/me-donat-mutunzi-a-rwandan-lawyer-was-found-dead-in-police-custody/}; Placide Kayitare, \textit{Me Donat Mutunzi}, Inyenyeri News (May 1 2018) \url{http://www.inyenyerinews.org/human-rights/me-donat-mutunzi/}.
\end{flushleft}
all of these extrajudicial killings can be tied to mental, cognitive, and/or developmental
disabilities, the lack of access to mental health resources indicates that many of the victims of
these murders may have been individuals living with undiagnosed or untreated mental
disabilities.

6. Data Availability

The amount of data available on this issue in Rwanda pales in comparison to the data
available in the United States. However, each study informs the other. The documentation and
general availability of data in the United States indicates the likelihood that many extrajudicial
killings in Rwanda may have gone unreported due to the lack of robust reporting mechanisms.
Even for the extrajudicial killings that are reported, it is unclear whether the individuals killed by
state authorities were suffering from a mental, cognitive, or developmental disorder because of
the paucity of mental health resources and corresponding reporting requirements.

7. Rwandan Policing and Misconduct

The Rwandan government has taken actions to address some extrajudicial killings. For
example, in Rubavu, an RDF soldier was imprisoned and fined in August 2018 for the attempted
killing of two civilians and successful extrajudicial killing of a third civilian.112

The United Nations Human Rights Committee urged the Rwandan government to
investigate and “take all measures to prevent” the use of force against civilians outside the rule of
law.113 This includes “any possible complicity in those acts by members of the police and
security forces, and identify the perpetrators with a view to bringing them to justice.”114 The
Committee Against Torture recognized similar levels of impunity for torture, particularly of
individuals in custody, and urged the Rwandan government act to address this.115

112 United States Department of State, Rwanda 2018 Human Rights Report, 6 (2018)
113 International Covenant on Civil and Political Rights Human Rights Committee, Concluding observations on the
fourth periodic report of Rwanda, 5, May 2, 2016.
114 International Covenant on Civil and Political Rights Human Rights Committee, Concluding observations on the
fourth periodic report of Rwanda, 5, May 2, 2016.
115 Convention against Torture and other Inhuman or Degrading Treatment or Punishment Committee Against
The Rwandan government has made efforts to address general police misconduct in recent years. In 2017, the Rwandan National Police announced that they had dismissed a total of 198 police officers “as a result of professional malpractice including lack of discipline, corruption, and other criminal offenses.” President Kagame himself chaired press conferences on these dismissals. The Assistance Commissioner of the Police, Theos Badege, stated that officers were dismissed for “going against the usual discipline that is required of each officers and offences that are criminal in nature,” but did not elaborate further on what crimes officers were dismissed for or if criminal charges would be brought other than to say some of the charges were due to corruption. News reports chronicle the initial firing of the officers which led to much larger dismissals in later years. In 2018, twenty-one police officers and thirty-six prison guards were reportedly dismissed for misconduct. Three months later, President Kagame reportedly fired thirty-five RNP officers, and 154 additional officers were fired by the Ministry of Justice. As of September 2018, some estimate that a total of 230 officers have been dismissed. Reports indicate that officers have been convicted, punished, and will not be allowed to re-enter the security forces. While the government contends that it was addressing corruption, some news sources point to this bulk dismissal as the government’s attempt at eliminating opposition within its police forces.

Additionally, in 2018, the Rwandan police instituted a health training within the RNP in an effort to address the aftermath of the genocide. The four-day training was meant to provide

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120 Id.  
122 Id.  
resources for improving awareness, share interviewing skills, establish “mental health first aid services,” and serve as a source of intervention for trauma victims. In reference to the training, RNP Assistant Commissioner of Police Elias Mwesigye stated that “[w]e are in a country that is rebuilding itself after the tragic 1994 Genocide against the Tutsi, which left many people traumatized... As Police officers, we need to be in a position to handle such cases professionally.” The RNP has instituted some trainings for young people that discuss mental illness, but mainly in the context of drug use prevention. But most of the documented trainings center around crime prevention, specifically drug usage, rather than an effort to destigmatize mental illness within the community as well as provide law enforcement officials the training and resources they need to better serve individuals who live with mental, cognitive, and developmental disabilities.

8. Access to Justice Within Rwanda

Access to justice for victims of extrajudicial killings, including victims with mental disabilities, appears limited. According to a 1996 report by the African Union Special Rapporteur on Extrajudicial, Summary, or Arbitrary Executions, witnesses are not likely to come forward—let alone testify in court—out of fear for their personal safety. The report found that there is “much reticence on the part of witnesses to extrajudicial executions, who fear reprisals against their families or friends.” Since then, the Rwandan government has strengthened access to justice mechanisms. The Ministry of Justice’s Access to Justice Bureau and an inspection department created by the Rwandan Supreme Court review and advise on the rule of law in Rwanda. When either department identifies malpractice or unfair treatment,
government officials according to a report to the African Union, “attend[] to” the discrepancies. However the mechanics of this process are not transparent.

Furthermore, there are no known diversion programs to support people with mental, cognitive, and developmental disabilities, and access to remedies is limited to the Rwandan justice system. While it is progressive for a post-conflict country, remedies remain limited with respect to any government-conducted or sanctioned extrajudicial killing. Oftentimes, inquiries into actions that may be deemed as a miscarriage of justice are suppressed at the investigation stage and do not move on.

IV. Intersectionality of Gender and Disability

1. Introduction

The preceding case studies discuss the use of force by law enforcement officials on persons with mental disabilities in the United States and Rwanda. However, in order to fully examine the nuance of the term “use of force,” our analysis must be intersectional. This section will focus on the gender lens, specifically, forced sterilization practices on women with mental disabilities. Forced sterilization occurs when a person is sterilized without the requisite knowledge or opportunity to provide informed consent. Coerced sterilization practices utilize incentives, misinformation, and/or intimidation tactics to compel individuals to undergo the procedure. Given the degree of overlap, these terms are used interchangeably. The UN Special Rapporteur on the Rights of People with Disabilities, Catalina Devandas, reported in 2017 that forced sterilization “infring[es] on sexual and reproductive integrity” and constitutes “a pattern of ‘systematic violence’ being carried out on girls and young women with disabilities.” This

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129 Id.
130 See generally reports on investigations of extrajudicial killings noted above.
132 Id.
state-sanctioned use of force against women with disabilities is analyzed below across three countries.

2. India

Girls with disabilities in India are often at risk of forced hysterectomies when they begin menstruation. The sterilization of women with disabilities occurs, in part, because their families and communities view them as incapable of managing both menstrual hygiene and motherhood.\(^\text{134}\) According to the 2011 census, there are 26.8 million people living with a disability in India, 11.8 million of whom are women and girls.\(^\text{135}\) The practice of forced sterilization came to light in a 1994 report that revealed eleven women with cognitive disabilities underwent state-sponsored hysterectomies.\(^\text{136}\) The state government of Marashtra made the decision to conduct the irreversible surgeries on these women who were residents of a government shelter.\(^\text{137}\) In response to an outcry from women’s groups and activists, the administration insisted that such operations were “standard medical procedure…[for] severely retarded women.”\(^\text{138}\) Another study surveyed twelve districts of the eastern Indian state of Odisha and found that of 729 disabled women, eight percent of women with intellectual disabilities were subjected to forced sterilization.\(^\text{139}\)

Sterilization is also seen as a protection against sexual abuse, though this rationale may have the opposite effect should a man decide to rape a woman because he knows she’s incapable of becoming pregnant. The State offered this justification in an infamous 1994 case where the government coerced women with intellectual disabilities to receive hysterectomies in Pune.\(^\text{140}\) In this case, guardians provided consent for the intrusive surgery, in part due to misconceptions

\(^{134}\) International Disability Alliance, \textit{Submission on India by Disabled People’s India} (Sept. 16, 2013) \url{https://www.internationaldisabilityalliance.org/sites/default/files/migrated/DPI%20India_CEDAW%20Report.doc}.


\(^{137}\) Id.

\(^{138}\) Id.

\(^{139}\) Sruti Mohaptra & Mihir Mohanty, \textit{Abuse and Activity Limitation: A Study on Domestic Violence Against Disabled Women in Orissa, India}, Oxfam Trust, \url{http://swabhiman.org/userfiles/file/Abuse%20and%20Activity%20Limitation%20Study.pdf}.

surrounding the procedure, mental disability, and rape.\textsuperscript{141} In addition to being a professed safeguard against rape-related pregnancy and concerns around menstrual hygiene, the right to reproduction is viewed as dangerous for mentally disabled women who are seen as lacking the maturity and intellect needed to take care of a child.\textsuperscript{142} The fear of transmission of the disability is also common and contributes to the use of forced sterilization.\textsuperscript{143}

At the national level, the Indian government has affirmed the rights of women with disabilities. The Indian Supreme Court recognized in \textit{Suchita Srivastava v. Chandigarh Admn.} that “persons who are found to be in a condition of borderline, mild or moderate mental retardation are capable of being good parents” and set aside the High Court’s decision to terminate the pregnancy of a woman with a cognitive disability without her consent.\textsuperscript{144} It regarded the forced sterilization of women with mental disabilities to be “anti-democratic and violative of the guarantee of ‘equal protection before the law’ as laid down in Article 14 of the Constitution.”\textsuperscript{145} Despite this acknowledgement, forced sterilizations are still occurring in India and the concerns of mentally disabled women remain marginal. Coerced sterilization amounts to the state-sponsored use of force against women with disabilities, violates their fundamental rights, and must be rectified.

3. Canada

Indigenous women\textsuperscript{146} in Canada, including women who live with mental disabilities, were systemically sterilized based on government policies. The Supreme Court of Canada recognized the right to consent to sterilization in the 1980 case of \textit{Hopp v. Lepp}, for the first time providing legal recognition for the bodily autonomy of women.\textsuperscript{147} However, the Supreme Court did not criminalize compulsory sterilization until 1986.\textsuperscript{148} The Supreme Court’s delay to address this issue has resulted in a deferral in addressing violence against indigenous Canadian women, and particularly those suffering from mental disabilities. By that time, sterilizations in Canada

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\textsuperscript{142} Id.

\textsuperscript{143} Id.

\textsuperscript{144} Rights of Women, supra note 141.

\textsuperscript{145} Id.

\textsuperscript{146} N.B. Women here refers to people with vaginas, uterus’, and/or birthing people.


had already “been used historically [by the state] to justify…structural violence like racism, ableism and sexism.” 149 The Canadian Truth and Reconciliation Commission recognized this as a form of structural violence both perpetrated by and funded by the government with genocidal intent. 150 The Sexual Sterilization Acts, which were effective from the late 1920s to the early 1970s, specifically targeted indigenous women. 151 Under these acts, approximately 2,800 indigenous women and girls were coercively sterilized over this fifty-year period. 152

Even after these acts were held to be unconstitutional by the Canadian Supreme Court, women continued to be sterilized. Researchers indicate that up to 580 women were coercively sterilized until 1974. 153 These programs violate the rights of disabled indigenous women in Canada. Human rights activists continue to call for an end to these sterilizations. 154

4. Japan

Under the Gender Identity Disorder Special Cases Act, Japanese policy mandates the sterilization of transgendered individuals. Requiring the sterilization of all transgendered

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151 Sexual Sterilization Act of Alberta and the Sexual Sterilization Act of British Columbia, c. 59, s1, 1933.


individuals amounts to state sponsored violence. Transgendered individuals in Japan are found
to suffer at disproportionately higher rates of mental illness. The Japanese government
maintains that individuals living with Gender Identity Disorder are more likely to be diagnosed
with mental illnesses. However, transgendered people are not mentally ill a priori, but due to
the stigma associated with being transgendered, they tend to develop higher rates of mental
illness. Thus the sterilization requirement in Japanese law is an intersection between state
sponsored violence against bodily integrity and transgender rights, but also indicates state
sponsored violence against a population that experiences disproportionately higher rates of
mental illness.

First, individuals who wish to undergo gender reassignment surgery, under Japanese law,
must be diagnosed with Gender Identity Disorder as laid out in the Gender Identity Disorder
Special Cases Act. Such a diagnosis must be administered in family court to individuals who
are at least twenty years old, are unmarried, and do not have any underage children. These
tests are an unfair standard that “amount[s] to cruel and inhumane treatment, and to a violation of
transgender people’s right to health.” In addition, the law requires transgendered people to be

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155 Nicholas Ripley, Forced Sterilization of Trans People in Japan, Human Rights Brief (March 7 2019)
156 Human Rights Watch, Japan’s Abusive Transgender Legal Recognition Process (March 19 2019)
see also Human Rights Watch, Japan: Compelled Sterilization of Transgender People (March 19 2019)
157 Human Rights Watch, Japan’s Abusive Transgender Legal Recognition Process (March 19 2019)
see also Human Rights Watch, Japan: Compelled Sterilization of Transgender People (March 19 2019)
158 Human Rights Watch, Japan’s Abusive Transgender Legal Recognition Process (March 19 2019)
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160 Human Rights Watch, Japan’s Abusive Transgender Legal Recognition Process (March 19 2019)
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161 Human Rights Watch, Japan’s Abusive Transgender Legal Recognition Process (March 19 2019)
see also Human Rights Watch, Japan: Compelled Sterilization of Transgender People (March 19 2019)
sterilized in order to attain gender reassignment surgery.\textsuperscript{162} Essentially, this law requires sterilization in order to exercise their fundamental human rights, including the rights to marriage and employment.\textsuperscript{163}

In 2018, Takakito Usui, a transgender plaintiff, brought suit arguing that the coerced sterilization mandated under the Gender Identity Disorder Special Cases Act violates the Japanese constitution.\textsuperscript{164} However, the Japanese Supreme Court ruled in 2019 that the Act and the sterilization requirement are constitutionally valid.\textsuperscript{165} The Court found a “need to avoid abrupt changes in a society where the distinction of men and women have long been based on biological gender” even while admitting that the law “impinges on freedom from invasion of bodily [integrity].”\textsuperscript{166} However, human rights groups continue to implore the Japanese government to repeal the law and set out standards to treat transgendered people with dignity and respect.\textsuperscript{167} Failing to do so constitutes an assault by the state on the bodily integrity of


transgendered individuals, including those transgendered individuals who live with mental disabilities.

V. Conclusion

This paper set out to examine the use of lethal force by state officials against people who live with mental, cognitive, and developmental disabilities. The case studies of the United States and Rwanda represent different approaches to legal redress and law enforcement training on the use of lethal force against individuals with these disabilities. This analysis reveals the extent to which members of the international community are still learning how to address and prevent such harms. By examining the intersection of gender, disability, and the state-sponsored coercive violation of bodily integrity, this paper also highlights that disabled individuals do not have a singular identity or experience. Thus, it is crucial to provide specialized trainings and resources to law enforcement officials who interact with people living with mental, cognitive, and developmental disabilities.