TCI ASIA PACIFIC
'CLASSIC EDITION' PLENARY
A REPORT

August 27-29, 2018
Bali, Indonesia
Program documentation and report writing: Shreshtha Das

Content editing: Bhargavi Davar, Ph.D.

Proofing and report design support: Richa Sharma Dhamorikar

Program design inputs: TCI Steering Committee and country lead members

Program Technical support: Alexandre Cote

National partner support: Indonesian Mental Health Association, Jakarta

Program partners: Bapu Trust for Research on Mind and Discourse, International Disability Alliance, DFAT and CBM Australia.

ISBN: 978-81-944995-1-0

Suggested citation:

Copyright notice: All rights reserved. No part of this publication may be reproduced, distributed, or transmitted in any form or by any means, including photocopying, recording, or other electronic or mechanical methods, without the prior written permission of the publisher, except in the case of brief quotations embodied in critical reviews and certain other non-commercial uses permitted by copyright law. For permission requests, write to the publisher: Transforming Communities for Inclusion (TCI) Asia Pacific at tciasia.secretariat@gmail.com

© Transforming Communities for Inclusion (TCI) Asia-Pacific 2020

Supported by:
A note from the Secretariat, TCI Asia Pacific

Two significant developments emerged out of the Bali "Classic edition" TCI Plenary meeting and thereafter, consolidating the position of TCI Asia Pacific and its dogged focus on Article 19 ("Right to live independently and be included in the community") of the Convention on the Rights of Persons with Disabilities\(^1\). Several actors are working globally in present times as "mental health activists", "global user networks", "human rights reformists", "users and survivors of psychiatry" and so on, entering to influence spaces where global disability policies are drafted. However, this is confusing for stakeholders including policy makers.

TCI clarified through the Bali Plenary Meeting, that there are 3 doorways to enter into the policy or program action spaces with respect to persons with psychosocial disabilities: a rather small "mental health" doorway; a larger Development doorway (SDGs) and an universal Human Rights doorway (CRPD). All persons with psychosocial disabilities, without exception, must have access to entry through the human rights and Development doorways, on equal basis with others and on the basis of personal will and preference. Instead of a "biopsychosocial" mental health approach, a "human rights based psychosocial" approach, with ample doses of development and human rights solutions, is prescribed by TCI. The Plenary has insisted on "reframing" the debate from "mental health" to "inclusion", implying a fundamental shift in articulation of policy, research and practice agendas.

Another significant momentum the Plenary brought, is to define our movement in the Asia Pacific as the "Inclusion movement of persons with psychosocial disabilities". This implies that we work from the center of the disability rights movement, aligning our actions with the overall CRPD-SDGs advocacy of the cross disability movements. From the learnings in the "Classic Edition Plenary, 2018", received from 21 countries and over 80 participants in the Asia Pacific regions, it is evident that our needs range from inclusion in development and in the SDGs (\textit{all the targets, and not only the one on health and wellbeing}); to the full realization of all human rights as provided for in the CRPD, without exception. Therefore, our advocacy is different from and broader than various movements that debate on the rights of, or their denial of, psychiatric users and survivors. TCI, since the last 8 years, has learnt that for many countries in the region, bereft of any services whatsoever, transforming communities for the inclusion of persons with psychosocial disabilities is the way forward, with the full and effective participation of emerging leaders and organizations of persons with psychosocial disabilities.

We are very grateful to all the partners, trainers, facilitators, researchers, support agencies and others which have through the years, supported to make TCI happen. We cherish the partnership of the Bapu Trust for Research on Mind & Discourse and the International Disability Alliance, for being 2 of the strongest support partners and allies in building our movement in the Asia Pacific regions.

Bhargavi V. Davar, Ph. D.
Convenor, TCI Asia Pacific

---

TABLE OF CONTENTS

INTRODUCTION ............................................................................................................. 4
A. REFRAMING THE MOMENTUM: FROM 'MENTAL HEALTH' TO 'INCLUSION' ................................................. 7
B. UPDATES FROM THE REGIONAL AND GLOBAL LEVEL ..................................................................................... 10
C. KEY NOTE: 'SPECIAL RAPPORTEUR’S REPORT ON LEGAL CAPACITY' .......................................................... 13
D. HUMAN RIGHTS BASED SERVICES FOR INCLUSION ...................................................................................... 16
E. PACIFIC TIME ..................................................................................................................................................... 21
F. SOCIAL PROTECTION .......................................................................................................................................... 24
G. WORKSHOP ON SELF-PRESERVATION ........................................................................................................... 26
H. REGIONAL FOCUS AND COMMITMENTS ......................................................................................................... 27
PARALLEL SESSIONS .................................................................................................................. 29
A. ADVOCACY FOR CHANGE .............................................................................................................................. 29
B. COMMUNITY SUPPORT SYSTEMS .................................................................................................................. 31
C. WORK AND EMPLOYMENT ............................................................................................................................... 33
D. HEALTH ........................................................................................................................................................... 35
E. WOMEN WITH DISABILITIES .......................................................................................................................... 36
F. HEARING UNHEARD VOICES ............................................................................................................................ 39
G. NATIONAL OPD FORMATION .......................................................................................................................... 43
H. CROSS DISABILITY SUPPORT TO NATIONAL OPDs .................................................................................... 45
I. LEGAL HARMONIZATION ................................................................................................................................. 46
ORGANISATIONAL MATTERS .................................................................................................................. 49
ANNEXURE A: BALI DECLARATION ................................................................................................................. 50

List of figures

Figure 1: From 'mental health' to 'inclusion' ................................................................................................. 9
Figure 2: Inclusion in social movements ...................................................................................................... 9
Figure 3: Laws to be reviewed...among others ............................................................................................ 15
Figure 4: Person flourishes: Strategies for Inclusion .................................................................................... 20
Figure 5: Scoping social protection .............................................................................................................. 24
Figure 6: Approaches to Disability Assessment ............................................................................................ 26
Figure 7: Soft Stones ......................................................................................................................................... 40
Figure 8: How HGV helps people who hear voices to rebuild their lives .................................................... 41
Figure 9: Some strategies for inclusion used by the Bapu Trust Pune .......................................................... 42
INTRODUCTION

The 'Classic Edition Plenary' of TCI Asia Pacific was held at Bali, Indonesia from 26th to 29th August 2018.

TCI Asia Pacific has the practice of organizing a Plenary meeting once every 2 years. The Plenary provides an opportunity to showcase achievements, share and learn, invite and educate new members, establish co-operations with the cross disability movement and other supporters; take key decisions and finally, bring out important advocacy issues until the next plenary. Typically, a plenary meeting has:

- Learning sessions
- Sessions on building vision, advocacy practices and the peer community
- Mobilizing country members and sharing country experiences
- Organizational development
- Strategic / policy decision making with the membership
- Building strategic partnerships with key stakeholders, especially the cross disability movement

In preparation of the plenary, the Steering Committee members of TCI Asia Pacific worked for 6 months, brainstorming on the purpose of the plenary and the outcomes. It was strongly recommended that the plenary should bring as many country members as possible, and that the learning sessions should be on the inclusion of persons with psychosocial disabilities within Development. Housing, work and employment, social protection, intersectional discrimination and discrimination within health care were highlighted as priority areas for sharing of experiences and information. While globalising psychiatry through the Global Mental Health Movement and its variants, was considered as a concern, however, it was felt that expanding the scope and canvas of advocacy to disability inclusive development would be more useful strategy for national groups to share and take forward. The focus of the Plenary therefore, was more about 'reframing' from 'mental health' to 'inclusion ‘and a 'Bali Declaration' was the expected outcome.

The Classic Edition Plenary held at Bali was broadly aimed at the following:

- Inducting new members to TCI Asia
- Presentation of country status reports on status of persons with psychosocial disabilities
- Capacity building and learning cycles on Inclusion
- Conducting TCI Asia organizational matters
- Creating a platform for dialogue with technical assistance agencies and other stakeholders from the cross-disability movement
- Arriving at a 'Bali Declaration' that would, amongst other things, feed into the global mental health summit, that focus on psychiatry as a key point of intervention

The Bali Plenary had participation from 21 countries from the Asia and Pacific Region, namely, Malaysia, Singapore, Nepal, Japan, Indonesia, Philippines, Sri Lanka, India, China, Pakistan, South Korea, Bangladesh, Hong Kong, Taiwan, Vietnam, Thailand, Fiji, Myanmar, Tonga, Maldives and Timor Leste. Country representation, regional representation, involvement of Pacific Island countries, leaders of the cross
disability movements at the national and regional levels, technical support agencies and observers were all considered in the planning.

The Plenary (27th to 29th August, 2018) was organized into thematic sessions to encourage learning on different subjects and to delve deeper into the overall frame of 'Inclusion' within which TCI Asia Pacific works. The thematic sessions were organized into 8 Plenary Sessions as well as numerous parallel sessions highlighting the status of Inclusion of Persons with Psychosocial Disability in different country contexts as well as sharing efforts of members to make Inclusion a reality.
PLENARY SESSIONS

The Plenary sessions opened with an introduction to the values and mission of TCI Asia Pacific. Central to TCI-AP is the idea that the identity of persons with psychosocial disability is framed not just in relation to their relationship with the mental health system, or psychiatry, as ‘users’ and ‘survivors’. Their identity is more life encompassing, including a range of their human rights in every area of Development. Therefore, inspired by the UNCRPD (United Nations Convention on the Rights of Persons with Disability), TCI-AP works towards the Inclusion of Persons with Psychosocial Disabilities in different aspects of their life- from education, employment, social protection and health, to political participation, home and family, etc.

The opening message also emphasized the centrality of choice and freedom in being able to choose health care services and called upon governments to ensure diversity in the range of services available, going beyond the medical model.

The Bali plenary was opened with a video message by the Chief Executive Director of International Disability Alliance (IDA), Vladimir Cuk. IDA has been a strong facilitator and partner for the development of TCI. Mr. Cuk drew attention to the need to strengthen the movement of persons with psychosocial disability and to ensure stronger commitments and responses. The Asian region being a place where there are a lot of human rights violations, both within and outside of mental health institutions, his message highlighted the need for a more cohesive and stronger response to support the rights of persons with psychosocial disability. He also alerted TCI AP to the growing Global Mental Health movement, the need to respond to that and the role that TCI AP could play.
A. **Reframing the Momentum: From 'Mental Health' to 'Inclusion'**

Bhargavi Davar, Yeni Rosa Damayanti, Alexandre Cote

This session introduced the 'reframing' advocated by TCI Asia Pacific, from 'mental health' to 'inclusion'. It articulated the key steps that are required to reframe the political, program and movement discussions in 'mental health', towards inclusive development and inclusive communities. The session emphasised the imperative of working on the inclusion of person with psychosocial disabilities in all areas of social and economic development. The following re-formulations have been crucial to TCI’s journey of advocating for inclusion:

1) **Reframing from colonial frameworks to decolonisation of laws and policies:** TCI recognizes that mental health laws are a replica of colonialism and its coercive legal frameworks, passing through unaltered within the Commonwealth. In some states which were not colonized, there is no mental health law, even though, informally, social care institutions may exist in open communities. Therefore, it is important for us to question the assumption that has been forced on us, originating from the WHO (World Health Organization) in the 80s and 90s, that having a mental health law is a sign of 'modernisation' of mental health care; that having such a law is in fact the precondition for providing mental health care. This is negated by the experiences of -
   (i) Countries which do not have a mental health law; and yet have a good social infrastructure to support persons with psychosocial disabilities, with minimum or no support from governments.
   (ii) Countries which do have a mental health law invariably and predictably have high rates of institutionalization, the terrors, traumas and abuses thereof, with the laws only getting more and more sophisticated and inaccessible, in terms of access to justice by the incarcerated persons. Large public bursaries mobilized for mental institutions and costly regulatory mechanisms has not ensured zero violence within the system.

2) **Reframing from 'user survivor' to 'person with psychosocial disability':** On the question of whether it is more empowering to call ourselves 'users or survivors of psychiatry', TCI Asia Pacific², found that the terminology of 'persons with disabilities' to be more closer to our lived experiences in the region. The Asian movement was born after the CRPD came in; in the wake of CRPD trainings received; and the CRPD created new identity pathways and allowed one to claim space through the identity of a 'person with disabilities'. In contrast, the 'user/ survivor identity' pitches us solely against the medical system and formulates all advocacy questions in terms of binaries (psychiatry or anti-psychiatry).

**Key Message:** The arena of entry, play and intervention of TCI Asia Pacific is the development sector, inclusive of, but not restricted to the healthcare sector.

3) **Reframing from consent to choice:** However, this is not to negate the role of the right to health care, only to keep it within perspective, as one small part of human life and development. The social sector needs to shift from 'voluntary consent' and the debate whether this should be allowed or

---

²In 2013, at the Plenary of the 'Strategy group for the inclusion of persons with psychosocial disabilities', held in Pune.
disallowed (a typically medical debate). In reality, this is often only about consenting to medication or institutionalisation, and is disqualifying of all else. It is conditional to agreeing anyway, under threat of losing all rights, which is experienced as a ‘Catch 22’ situation by users and survivors. The service sector needs to shift the discourse from 'consent' to 'choice', that includes a number of life choices, including each and every one of the rights provided for in the CRPD and amplified by the SDGs (Sustainable Development Goals), especially employment, social protection and housing.

4) Changing a thought process pervading policy

The Bali plenary raised some questions, which for TCI, is rhetorical, viz.

1. Does institutionalization bring us inclusion?
2. Does medication/treatment bring us inclusion?
3. Does CBR bring us inclusion?
4. Does 'Recovery' bring us inclusion?

How do we move from a narrow view of community, involving a high restriction of participation and being confined to just 'treatment', to a more diverse, rich community life that we want for ourselves? Zero coercion must inform future laws and policies and the CRPD requires preparing communities for inclusion. This is a whole new range of questions and learnings, foisting the pressure to change a thought process on society, especially the policy makers. Therefore, a re-framing based on TCI's guiding advocacy principles would require:

• An overhaul in the thought process and attitudes of service providers, hereby 'institutionalization' is recognized as not just a physical structure, but a mentality permitting service providers to be gatekeepers, curtailing will and preference.

• Providing multiple, accessible, affordable, formal and non-formal services of care as well as various services such as housing, education, social protection and employment, expanding and enabling choice and the right to live independently.

• It is important to create enabling environments within communities, neighbourhoods and families, collaborating with and allowing other development actors and services to come in as needed by the person.

• Understanding that while the CRPD gives persons with psychosocial disabilities the compass or full guidance, the CRPD alone cannot ensure inclusion.

• The CRPD is strengthened by the movement of persons with psychosocial disabilities. Not being contained within the disability movement but also reaching out to and taking our message to other social movements that cater to the different identities of persons with psychosocial disabilities, is crucial.
Figure 1: From 'mental health' to 'inclusion'. (Source: Alexandre Cote, Bali Plenary, 2018)

This session highlighted some key questions that the TCI Asia Pacific community would have to ponder: **All of us want to live in the community**, but how do we get there. Traditional methods to 'access mental health services' have not necessarily led to opening the doors to life. The CRPD is a bridge, along with the SDGs, to reach an outcome of inclusion.

Figure 2: Inclusion in social movements (2018) (Source: Alexandre Cote, TCI AP Bali Plenary)

**Going beyond laws, the implementation of CRPD requires preparing communities for inclusion.**
B. **Updates from the Regional and Global Level**

Speakers: Yeni Rosa Damayanti, Janice Cambri, Kirihara Hisayuki, Bhargavi Davar

Although TCI Asia Pacific is a regional group, absent, an inclusive global movement of persons with psychosocial disabilities, TCI AP has intervened in several global spaces, which affect the region and regularly engage with global platforms, including the UN (United Nations) to ensure the full realization of rights of Persons with psychosocial disabilities. Since 2016, TCI AP has had an active presence in the Conference of States Parties (COSP), participates as a Steering Committee member of the Coordination Mechanism (SCCM) which IDA presides over. COSP has provided an excellent platform for showcasing and disseminating the unique advocacial position of TCIAP, with respect to Article 19.

Speakers also shared the various 'instruments' created by TCI towards mobilization of the movement in the Asia Pacific regions. Strategically,

- **'Country Missions'** Mobilization visits to countries involving CRPD trainings for persons with psychosocial disabilities, facilitation of OPD (Organization of Persons with Disabilities) formation, developing memberships and partnerships with TCI.

- **'Multi-stakeholder meetings'** towards bringing the message of inclusion of persons with psychosocial disabilities, to the cross disability leadership within countries, sub regionally and regionally, engagement with a number of civil society organizations (human rights, women's movement, movement on voting rights and political participation, etc.), government ministries and departments, mental health service providers, family groups and technical support agencies (donor, research, other).
• 'Fellowships' are offered for 2 fellows per year, to support the national work, under 2 streams - advocacy work as well as community support work.

The session also recapped the updates related to TCI’s engagement at global level including contributions and key messages to UN processes last year (UN Human Rights and Mental health resolution\(^3\); exciting receipt of the Report on 'Highest standard of health and wellbeing' from the Special Rapporteur (Health)\(^4\); COSP 11, (a side event there\(^5\) and speaking at 1 of the Round Tables)\(^6\); participation in various academic and other platforms (University of Galway, Trieste); and dialogues with the global mental health movement in Amsterdam, reviewing the WHO Quality Rights Training Kit and also, engaging the global community of users and survivors of psychiatry through 3 ‘global convenings’\(^7\). Outcomes of these efforts were shared briefly, to refresh on the status of the movement of persons with psychosocial disabilities worldwide. Importantly, even though an independent regional body, TCI has contributed substantively to global dialogues, and has used many opportunities when the voice of persons with psychosocial disabilities needed to be heard. Efforts to co-operate with other global players are strewn with challenges, so TCI has chalked out its own pathway into global spaces on its clarion call of "Inclusion".

At the national level, TCI Fellows have taken up lead roles in advocacy around the mental health legislation (Philippines), work, voting rights, inclusive education and against social care institutions (Indonesia), national advocacy, parallel reporting and forming independent peer support groups (Thailand). Contributions were coming in, on the #WhatWE Need campaign, from several member countries, planned for the World Mental health Week in October of 2018.

**Key messaging:**
- Advocacy at country level can impact global advocacy.
- TCI positioning on Inclusion is globally interesting.

**WHO Quality Rights Training**

One of the key developments in the global space is the WHO Training Module titled, *Quality Rights Tool Kit*\(^8\) (QR) that is increasing in visibility and being used in trainings by the WHO worldwide. The WHO QR is aimed at bringing in a ‘CRPD compliant human rights approach to recovery in mental health and social

6[https://undocs.org/CRPD/CSP/2018/5](https://undocs.org/CRPD/CSP/2018/5) for a full account of COSP 11. Yeni Rosa Damayanti spoke in the RoundTable 3, on ‘Political participation and equal recognition before the law’  
7 Alexandre Cote (Edited). 2019. 'Turning the tables: The imperative to reframe the debate towards full and effective participation and inclusion of persons with psycho-social disabilities. Trieste-Galway Conversations'.  
8[http://www.whatweneed.in/?p=844](http://www.whatweneed.in/?p=844)  
[http://www.whatweneed.in/?p=859](http://www.whatweneed.in/?p=859)  
[http://www.whatweneed.in/?p=862](http://www.whatweneed.in/?p=862)  
[http://www.whatweneed.in/?p=872](http://www.whatweneed.in/?p=872)  
[http://www.whatweneed.in/?p=877](http://www.whatweneed.in/?p=877)  
8 WHO. 'Mental health, human rights & legislation: A global human rights emergency in mental health'  
[https://apps.who.int/iris/handle/10665/70927](https://apps.who.int/iris/handle/10665/70927)
care institutions’. It is welcoming to see that a multi-country UN agency is invoking the CRPD and actively including human rights within the mental health system. The manual focuses on good practices around the world and exposes the human rights violations in mental institutions. The manual also provides practical interventions, for example, a template for advance directive, guidance on how to start a peer support group or your own organisation etc. The WHO has also withdrawn their earlier advocacy on mental health legislation, as those resources were pre-CRPD.

However, though at the outset it may seem progressive, on greater scrutiny, many crucial problems can be seen with the WHOQR training kit:

- The training material downplays problems with the medical model by overemphasizing the idea of diagnosis. The kit lists ‘good standards of living’ in mental institutions, which is directed at creating better conditions of stay in mental institutions, but not questioning the coercive design and system. Mental institutions are a place of involuntary detention and not a 'place of residence'. This subverts the meaning of Article 19.
- The kit is for psychiatrists to improve mental health services, especially institutional reform, and improving staff - patient relationships, as the trainings being held in different countries show. This projects the view that problems are in the individual service providers, and not in the system. WHO QR kit is being seen as a solution to all the problems faced by persons with psychosocial disabilities. It does not mention jobs, education, housing, social protection, etc. It does not even mention process that could be adopted by governments for de-institutionalization. It limits the lives of persons with psychosocial disabilities, to a small circle of institution based psychiatric care.
- It fails to give back the voice to persons with psychosocial disabilities. A common trend in the trainings is that they have been conducted, organized and attended by mostly psychiatrists.

**Key Dilemma:** What is TCI AP response to WHOQR? Will it support this effort?

It was resolved that TCI Asia’s stance on the WHO QR would become a part of the Bali Declaration.

**Other regional and global advocacy actions of TCI include-**

1. The Japan Group of Mentally Disabled People (JGMDP) presented in detail, their advocacy efforts at the UNESCAP, which is critical as they have a monitoring role on the implementation of SDGs, in our regions.
2. Conference of State Parties (COSP) is a platform for OPDs to exchange their work, network and to influence policy makers. A Side Event was organized by TCI Asia Pacific, in partnership with IDA and Human Rights Watch, at COSP with the key message of inclusion within development. The partnerships included the Office of the High Commissioner for Human Rights, Human Rights Watch Indonesian Mental Health Association, Disability Rights Fund and the Pacific Disability Forum, supported by the International Disability Alliance.

---

3. TCI Asia Pacific also made submissions draft around General Comment under Article 19 of UNCRPD, later released as GC 5\textsuperscript{12}. TCI Asia Pacific also made a statement on the Day of General Discussion, towards GC5.

4. TCI Asia Pacific supported and participated in several country reviews facilitating the processes and sharing experiences (Philippines).

5. Office of the High Commission for Human Rights (OHCHR) started a process of creating a resolution on mental health and human rights, and held consultations in Geneva. Members from TCI Asia Pacific attended this meeting with the key messages of 'inclusion, a human right in mental health' rather than, 'mental health and human rights'.

C. KEY NOTE: 'SPECIAL RAPPORTEUR'S REPORT ON LEGAL CAPACITY'

Speaker: Alberto Vasquez, from the Office of the Special Rapporteur on Disabilities

Support for the session: Jenny Rosa Damayanti

In the keynote, the United Nations framework was used to introduce the idea how human rights monitoring happens at the international level through the human rights mechanisms, starting with the Human Rights Council, up to the CRPD Monitoring Committee, and the various windows of opportunities for engaging the UN system. Alberto Vasquez joined the Bali Plenary on behalf of the Office of the Special Rapporteur (Disabilities), which is a special procedures mechanism within the UN human rights monitoring system. The session introduced the debates around legal capacity, the recent developments from the Office of the Special Rapporteur- Disabilities; and discussed the Legal capacity report recently released by the SR's office in detail\textsuperscript{13}. (\textit{Ed. Also refer to General Comment No. 1 on legal capacity issued by the CRPD monitoring committee}\textsuperscript{14}.)

The session started with introducing the idea of legal capacity, the right to make legal decisions and have them respected.

The term legal capacity encapsulates 3 key ideas:

1. It is an international human right and therefore, has to be recognized. In many countries, it is a normalized form of discrimination, where decisions are always made by others on behalf of Persons with psychosocial disabilities, but this discrimination is against human rights.

2. It pertains to decision which have a legal effect.

3. It is important that both state and private actors respect them.

Having legal capacity is the most important human right: People cannot exercise other rights without legal capacity. However, throughout history, many groups have been totally or partially denied their right to exercise legal capacity.

This right to exercise legal capacity is explicitly protected under the UNCRPD.

\textsuperscript{12} CRPD/C/GC/5
\textsuperscript{13} Human Rights Council, A/HRC/37/56
\textsuperscript{14} Human Rights Council, CRPD/C/GC/1
Since the adoption of the CRPD, many States have started or completed law reforms directed at abolishing guardianship for good; limiting guardianship (removal of plenary guardianship, co-decision-making, periodical review, time limits, etc; adopting measures of support, such as advance directives, supported decision-making regimes, as well as independent advocates.

However, many states continue to adopt mental health laws. There are various ways in which OPDs and mental health rights activists can pushback against this:

1. Awareness raising and capacity building.
2. Promote law reform processes for CRPD-compliance.
3. Challenge denial of legal capacity at national courts and administrative bodies.
4. Produce evidence and data on human rights violations related to denial of legal capacity.
5. Implement supported-decision making demonstration projects.
6. Use the international human rights mechanism available.

The UN is a beneficial ally in this process. Besides the CRPD monitoring process, the UN has many experts working with independent mandate, for example, the Special Rapporteurs. The Special Rapporteurs provide support to the movement in many ways, including technical support. Individuals and organisations can also directly connect with the Special Rapporteurs. While states have lesser obligation to implement recommendations of Special Rapporteurs as against the committee’s recommendations, they can be used very effectively in advocacy, as they would have done extensive country visits and gathered reliable information for their comprehensive reporting. The report of the Special Rapporteur on Health is a damning indictment of the biomedical model and calls for a human-rights based approach to mental health, based on principles of participation, accountability, services free from coercion, and support beyond psychiatry.

The opportunity to interact with Alberto Vasquez, from the Special Rapporteur’s Office on Disability, provided activists and organisations a valuable time for mutual learning and exchange:

- There are complaint mechanisms available in case a country has not ratified the Optional Protocol. At present, in the UN, there is greater cooperation between different committees and different mechanisms can be used to raise complaints. The only way to put pressure on countries into ratifying the Optional Protocol is through the mechanism of Universal Periodic Review (UPR), where other states make recommendations to the government.
- Build knowledge on the different CRPD compliant responses to situations of distress and crisis, to advocate with the government. This has to be backed by documentation of good practices, and other evidence base, ensure better, more effective and human rights compliant responses. Well documented community work can provide a strong evidence basis to back legal action.
Figure 3: Laws to be reviewed...among others
(Source: Alberto Vasquez, TCI Plenary, Bali, 2018.)

- Build capacity of judges, lawyers and academics to understand CRPD, so that there is a network of support for Persons with psychosocial disabilities going beyond the traditional groups of lawyers and psychiatrists. It is also important to do an ongoing analysis of the players with whom advocacy is required, to ensure that persons with psychosocial disabilities have the right to decide for themselves.
- Entering the international human rights monitoring spaces, through multiple mechanisms within the UN (OHCHR, SRs, UPR, etc.) as well as the various treaty monitoring mechanisms.
- Having a strong disability movement can also go a long way in putting pressure on governments, especially to ensuring that countries submit a report. Most countries have national human rights Institutions (NHRIs) which support the state in reporting. Also, OPDs could identify why states are not submitting reports. If lack of capacity is the primary reason, the OHCHR mechanism can be drawn on, to build capacity of states to comply with reporting requirements.

It is important for civil society to understand what each CRPD article says and the level of implementation by national governments. Compliance with CRPD can be strengthened through better mechanisms, better trainings and capacity building.
D. HUMAN RIGHTS BASED SERVICES FOR INCLUSION

Facilitation: Jillian Ferguson

Speakers: Vincent Cheng, Shivani Gupta and Kavita Nair

Many countries are working on CRPD compliance but it appears there is either a lack of understanding or confusion on the exact requirements to achieve such compliance in mental health services. There are numerous instances of good intention to align with the CRPD, but, in practice it was seen that they end up contradicting the CRPD, for example, the overt focus on institutionalization or improving institutional care.

This session addressed the requirement of human rights based services, for all persons with disabilities and especially those most marginalized within communities. The session focussed on exchange between participants on trends and the move to identify best practices to ensure that newly developed services are truly grounded on human rights and happening in service settings.

i. The Challenges of Integrating 'Human Rights' and 'services' in Hong Kong

Key themes highlighted were as follows:

- **Power struggles between traditional mental health services and rights based approaches**

Hong Kong has had medical services since 1950 and they are becoming sophisticated and professional over the years. There is a presence of a community mental health approach, which has a care and control paradox writ large over it. In the name of providing ‘care’ these services severely limit the freedoms of persons with psychosocial disabilities and do not respect a person’s human rights. As alternatives to the mental health movement, many movements have emerged under the rubric of human rights movements. These are movements such as the self-help movement; survivors movement, which provides a powerful alternative to psychiatry; hearing voices movement, which gives a phenomenological understanding of the hearing voices experience; the disabilities rights movement on disability inclusive development and various professional self-care, self-improvement modalities within the service model.

However, although all these alternative models are present, these movements are marginalized. The survivor movement and the services movement have struggled for power over the years and survivors have not been integrated.

- **Strategies for co-production between the two**

As a kind of mid-way, in many countries peers (individuals with lived experiences) have also become professionals, called the 'recovery movement'. This category of peer professionals act as a bridge between the survivor’s voices and the service providers. It ensures that there is a dimension of lived experiences and at the same time appeals to professionals as well. Yet, they were meant to retain the shared vision that persons with psychosocial disabilities have a right to lead fulfilling lives in the community.

---

15 CBM Australia
16 From Hong Kong Advocacy Network
17 Director, AccessAbility, India
18 Assistant Director, Seher, Community Mental health and Inclusion program
19 For example, police may be involved in ensuring compliance to medication, by making home calls, surveillance, etc.
Some of the initiatives that were operationalized under the Recovery Movement were Well-being Toolbox, Peer Support Workers, The Hearing Voices Group and Recovery College, where peers and professional workers together advocated with the communities.

However, from this integration it has been our experience, that there was co-optation by the professionals, such that persons with lived experiences ended up losing their vision and voice and adapted the ethos of professionals.

Hearing voices is a part of human diversity. Community members have to learn how to respond to the needs of diverse people. Voice hearers are no less human. We all have the rights to interpret our own experiences. We all have the rights to determine the ways of coping.

Vincent Cheng, Hong Kong, TCI Plenary, Bali, 2018

- Integrating human rights into mental health services.

The work of human rights activists has been to combat abusive and coercive procedures, abolish institutionalisation and promote social inclusion and participation.

Some of the strategies through which this has been sought to be achieved are as follows:

1) Developing local, community based alternatives for psychosocial wellbeing, instead of the western services based approach.

2) Negotiating power with professionals, in face of a huge power imbalance in favour of the professionals and service providers. One strategy for this has been through the peer practitioners, which is still an ‘in-system’ recovery approach. This has to be supplemented by an ‘out-system approach’ of integration in communities, which would require collaboration between different stakeholders, including survivors and service providers.

However, where traditional mental health systems exist, there is always a possibility of co-optation by psychiatry. The professionals propose a move from co-optation to co-production. However, such moves have to be based on following principles:

1. Realizing citizenship, equal civil rights, opportunities and recognition of legal capacity.
2. Realizing Inclusion so as to facilitate community based, self-chosen living and where full community participation is enabled.
3. Realizing Participation at all levels where lived experiences of persons contributes to cultural and systematic change as well as in training and education.
4. Co-production process genuinely treasures and utilizes experts with lived experiences, in order to improve policies and measures.
5. There is substantial learning between the two kinds of experts and power is hopefully shared in the process. It goes beyond tokenism to ensure that there is peer support and empowerment in the process.
6. Genuine co-production must ensure that there is reasonable accommodation to enable the full and effective participation of persons with psychosocial disabilities.

ii. Human Rights Based Services in Low Resource Settings such as Rural India

Services close to residence of persons with psychosocial disabilities are required to enable the right to live an independent and self-determined life, in a manner they choose within their communities. This includes both disability specific services as well as community services, which are required to be inclusive and accessible to persons with disabilities.

Using a case study from India, the presentation looked at how the CRPD is being translated into practice in rural and low income setting communities in India. The experience shows that CRPD is not being implemented at all in rural India.

In the context of rural India many challenges exist in terms of availability and accessibility of services:

1. Disability is seen as a curse and it is difficult to find people to provide support. It is considered a dirty job. Primary caregivers are women who are often disempowered and therefore have limited ability to support women with disabilities. Their own opportunities and participation in decision making are so limited.
2. With regard to community based services, it can be seen that even basic services are absent. Where basic services are present, they are not accessible. Even the development organisations that work on providing services are not inclusive of persons with disabilities.

Therefore, to make services a reality for persons with disabilities in rural areas, it is necessary to target the negative attitude around disabilities in India. There is also a need to include the concerns of this group within the broader disability rights advocacy agendas.

Enhancing the choice and control of persons with disabilities in an inclusive environment is an important outcome for all human rights based services. To achieve in true spirit the meaning of Article 19 requires addressing the community as a whole.

Disability cannot be looked at in isolation. It is, therefore, important to have a wide range of partnerships with community based programs, development organisations, government, etc. Inclusion is about partnerships.

iii. Applying the CRPD- Seher Community Mental Health and Inclusion Program

One of the key focus areas for the inclusion of persons with psychosocial disabilities is to identify program models which can be used as evidence base, to advocate with governments. The Seher program by Bapu Trust offers a case study of what zero coercion and inclusion in community entails. Seher is based on Article 19 of the UNCRPD, with focus on living independently in the community, participation on an equal basis with others, access to services near the place of residence, choice and an explicit aim to be compliant with the Convention on providing human rights based services.

The Seher program for community mental health and inclusion uses simple, people inclusive, social support based methods for healing and inclusion. They facilitate inclusion in the community by offering
non-formal psychosocial care giving, offering simple daily practices that are practical and doable with available resources, partnerships, circles of care and increasing social capital.

It is operationalized as follows:

1) The person is at the centre, all decisions shall be taken by the person. When people enter the Seher program, there is always a dialogue on whose choice it is to opt for the program. There is repeated check-in with the person to ensure that their choices are being respected within the range of services that are provided. Based on the person’s choice, services are either provided directly or through linking with service providers, offering the desired service. The role of team is that of a facilitator, so that people are able to participate as people, and not as a person with a ‘special need’ or as a ‘patient’.

2) Respect for a person’s right to live in open communities and not being confined to institutions, rehab homes, hospitals, counselling rooms etc. This requires constant negotiation with care givers. This has entailed raising moral questions with the family, setting up peer support systems for crisis and involving the larger community in dialogue to ensure that the person is not put in an institution. Peer systems and volunteer systems ensure that care giving is shared. There is also prior training on care giving before the crisis. Family empowerment is an important part of the intervention, so the program talks about the 'privilege' of care and not the 'burden' of care.

3) Inclusion is best practiced in open societies which have a wide range of services and support networks. This requires working with the entire ecosystem of the person, through training and capacity building or inserting people back into the ecosystem, in their own pace and time. This ensures that there is a circle of care around the person, which meets not just emotional needs, but also various socio-economic and developmental needs. Inclusion programs address an ecosystem and don't target an individual.

4) The person is not just a beneficiary of services but an active collaborator; and can contribute to the services and to the communities that they are a part of.

5) Matching the full psychosocial spectrum (many different kinds of personal experiences from stress and tension to disabilities) with a support and intervention spectrum enables choice and an expansive range of psychosocial support actions for enabling recovery.

6) In terms of sustainability, it is not dependant on experts or organisations, as it relies on a huge cadre of non-formal community caregivers, who have experiences of psychosocial disability. This non-formal cadre is developing as local leaders and psychosocial anchors who can continue to provide care and support, even if the program discontinued.

7) The program thrives on a huge number of partnerships and collaborations with different kinds of organisations.

8) It relies on non-medical methods of safety, wellbeing, and recovery that are safe, playful, non-violent and non-intrusive, including integrated arts based therapies, basic counselling, breath practices, nutritional inputs, pursuit of fitness, comprehensive health care, etc.
Seher attempted responses to some challenging questions it encountered in making the CRPD transition.

- Keeping the core program as 'non-formal support' and involving recovery experts, only in case of higher support needs.
- People with psychosocial disabilities run the program, planning, making decisions, and owning the program.
- The difference between 'service provider' and 'beneficiary' is reduced a lot, as people who provide services also come from the same communities where the services are delivered.
- Trainings on peer support, crisis support and dialogue systems within families are the essentials of the program and these approaches are embedded within community systems. Seher program understands 'crisis' as a serious failure in the participation of persons with psychosocial disabilities. Overcoming the 'crisis' involves invoking the circle of care for the person.
- Partnerships with a wide range of communities and community based services and support systems help in sustaining the circle of care.
- Through dialogue processes, collaborations can be established between different parties with no perspective or opposing perspectives.

Being mindful and questioning of habitual responses of service providers, especially in case of crisis, and deconstructing habit is a critical practice in which the Seher team excels.

The presentation led to discussions, as follows:

1) Although, it more difficult to work with families than individuals, it is important to work with them to bring down resistance and to ensure that people are not institutionalized; or if families choose to institutionalize them, the person comes out in the shortest time possible. These requires different strategies, such as dialogue and negotiation skills, repeated visits by different groups (volunteers, people from the community) to the family, bombarding them with messages against institutionalization and violation of rights and providing them evidence of what sort of support families can give. This can exert moral pressure on the family to enable the person to come out.
2) The question of job/ income is addressed better, when working in open communities, as there is access to a lot of resources. However, it is crucial to check back with the person about what sort of work they would like to do and the reasonable accommodations required by them (number of hours and support services required). From an organisation stand point this can take the form of scouting for a potential local employer and acting as a bridge between the employer and the person.

3) One of the biggest problems of getting people out of institutions is that they have no place to go outside of the institutions. This can be dealt with by people staying in shared homes, where possible; and if they would like to stay individually, then that is enabled through the relationship building work activated through the work of the organisation in the community.

4) Independent living is not about living by oneself, but a matter of having choice and control over one’s lives and the needed support systems. To live by oneself, one of the primary determinants would be economic independence. It would be equally important to ensure that the person understands that there is responsibility attached and the person is aware of what that entails.

Inclusion is all about expanding choice and control. The best method is that with which the person feels more comfortable with, that which nourishes the person.

E. PACIFIC TIME

Facilitator: Jillian Ferguson

Speakers: Silvia Soares, Sidney Lord, Angeline Chand

Through this session, the aim was to share experiences, as persons with disabilities and with psychosocial disabilities, in the context of different countries in the Pacific region. Fiji Islands, Tonga and Timor Leste, were represented in the presentation. Several Pacific Island countries were British protectorates, some with very recent experience of Independence. Timor Leste, for example, has strong conflicted experiences of becoming independent, and trauma is intensely felt by communities. Due to colonial perceptions, OPDs are often not aware to be inclusive of persons with psychosocial disabilities at the national level.

The Experience of Timor Leste

In Timor Leste, there is discrimination at the family, community and government level towards persons with psychosocial disabilities. The health sector discriminates against persons with psychosocial disabilities. Timor Leste, like many other Pacific Island countries, has signed but not ratified the CRPD. Their Constitution also says that persons with disabilities have a right to live in the community. However, there is an increasing value placed on institutionalization and psychiatric care for persons with psychosocial disabilities. In fact, overcrowding in mental institutions has resulted in many deaths inside
them. There is very limited chances for persons with psychosocial disabilities to participate in communities. They are also barred from voting and only those who have a licence from the Government can vote.

With the formation of a new OPD, a lot of advocacy took place with educational institutions around reasonable accommodation for persons with psychosocial disabilities. Dropping out of school and not being able to complete their education is a big concern for persons with psychosocial disabilities in East Timor. The newly formed OPD also works with the health sector to eliminate discrimination. Defensoria Pública de Timor -Leste (DPTL) works together with Ministry of Social Justice, in close co-operation with RHTO, to get the Government to ratify the UNCRPD.

**The Experience of Tonga**

The Tonga understanding of persons with disabilities is very different from New Zealand and many other countries. In Tonga, the perception of persons with disabilities is that they are people suffering from a curse from the cradle, or being afflicted by a spirit. Tonga views disability from a religious, spiritual perspective and there is some difference with the health care system. The general attitude towards persons with psychosocial disabilities is that it is a personal choice; and people choose to be like that. While in some ways they are prioritized, for example in terms of assistance after the cyclone, challenges continue in terms of ensuring CRPD compliant systems.

**The experience of Fiji**

The Psychiatric Survivors Association (FPSA) is led by people with psychosocial disabilities. It works through the modality of peer to peer support. It is associated with national OPDs and works with people with a wide range of mental health issues and disabilities. The FPSA seeks to improve the lives of psychiatric survivors in Fiji through the following ways:

1) Visits to psychiatric hospitals.
2) Organizing workshops for members to develop coping skills and increase understanding of mental health issues.
3) Organizing community awareness campaigns to promote awareness and knowledge on overcoming mental health issues; and supporting family members.
4) Organizing workshops for members to develop income generating skills and support for finding livelihood options.
5) Organizing social gatherings.
6) Assisting members in securing housing.
7) Advocating for the rights of persons with mental health issues.
8) Creating linkages with other mental health stakeholders in Fiji.

The Association provides counselling for members and non-members and their family; organizes monthly meeting of the members and raising community awareness on mental health and the role of PSA.

**Pacific Disability Form**

The Pacific Disability Forum (PDF) is a regional disability rights organisation focussing on improving the lives of persons with disabilities, to ensure that their human rights are respected. PDF works across 21 countries in the Pacific region. The PDF primarily has three primary areas of work:
1) Capacity Building of OPDs in the 21 countries.

2) Partnership building, such as with IDA, TCI and CBM.

3) Ensuring that persons with disabilities are included in all initiatives and that marginalized groups within the disability movement are recognized.

They conduct their advocacy as a two pronged approach, one to educate persons with psychosocial disabilities and the other, to fight stigma and create inclusion.

Their message is to understand how different OPDs and people with different disabilities can work together; learn from each other’s experience and support other persons with psychosocial disabilities in the Pacific, since presently there is just Psychiatry Survivors Association in Fiji.

Other new member countries had a chance to also present their issues in this plenary session.

**Status of persons with psychosocial disabilities in Maldives**

Maldives, an island nation, is primarily a Muslim country, where the family is the primary social institution. Around the 1970s, it was found that the community was not able to accommodate persons with psychosocial disabilities; and therefore the Government started an institution, which was on a separate island. However, even though institutionalisation is considered a last resort based on psychiatric evaluation of the person, visits to the institutions show that they are like jails, involving compulsory detention. Advocacy has been around ensuring that people come out of these government institutions; and live safely in their own natural communities.

The Government of Maldives has signed the CRPD. There are 10 NGOs (Non-Government Organizations) working on advocating for the rights of persons with psychosocial disabilities. Medical perspective and experts in psychiatry are still very much insistent on pills and institutionalization. However, the Government is taking a moderate ground and focuses more on the rehabilitation process. The advocacy focus of OPD of Persons with psychosocial disabilities is on deinstitutionalizing and ensuring that persons with psychosocial disabilities are not restricted.

Maldives has a National Disability Council, which was established under the Disabilities Act. It is a monitoring body for ensuring the rights of persons with disabilities, including both mental and intellectual disability. The Council makes visits, tries to understand the challenges faced by persons with psychosocial disabilities and has also set up projects for their greater inclusion in communities.

**Status of civil and political rights of persons with psychosocial disabilities**

Colonial practices prevail all over the region on access to civil political rights for persons with psychosocial disabilities. In Nepal, employers can terminate the employment if the disability status of persons with psychosocial disabilities is made known to them. No legal rights for employment of persons with psychosocial disabilities in Timor Leste. Bangladesh follows the colonial Lunacy Act that prohibits political participation of persons with psychosocial disabilities. In Timor, persons with psychosocial disabilities are barred from voting, unless they have a certificate from the hospital. In Fiji, when the election rules came out, it was declared that persons with psychosocial disabilities cannot vote. The Psychiatric Association protested against it and the rule was amended to state that those who are registered and have an ID (Identity Document) can vote, but those who are institutionalized in homes still cannot vote.
Prevalence of cultural notions around persons with psychosocial disabilities

In Fiji, disability is closely associated with being possessed: People using marijuana are also seen as having a mental health issue. There are drives against marijuana in the country. There is a strong belief in spiritual and religious healing. This feature is common across the Asia Pacific region.

F. SOCIAL PROTECTION

Facilitation: Alexandre Cote

i. Reframing social protection

Social protection offers a promise of opening the doors to mainstreaming and full inclusion of persons with psychosocial disabilities. There could be different aspects of social protection that support inclusion; as well as issues undermining access to social protection and inclusion. The session provided space for members to share concerns, experiences and recommendations to make social protection more inclusive in the regions.

Social protection often gets equated to disability benefit/pension; however, social protection is about a broad range of services entailed for persons with disabilities.

Historically, social protection has been considered as a form of safety net, when you age or become incapacitated to work or as a social insurance mechanism against the risk of accident, hazard and disability for workers. Therefore, the idea of social protection evolved in the context of labour law and workers’ security and not for the benefit of persons with disabilities.
However, social protection is particularly important for persons with disabilities, because there are extra costs of having a disability. For example, as a person with psychosocial disability, you lose income as a result of discrimination. There are heightened opportunity costs, requirements of extra insurance or additional guarantee to rent a house; affording support systems of care; covering for being excommunicated from the family or being institutionalized, in social seclusion; extra costs for tuition when you are not able to complete a semester, etc. Instead, the whole argument for social protection is based on a limited understanding of incapacity to work and earn wages. It is generally understood that the moment one is able to take up paying work, the disability benefit ends. These additional costs required for reasonable accommodation are not accounted for.

From the side of governments, social protection is usually in the form of money and benefits provided to people, health care costs, support services for persons with psychosocial disabilities, insurance and through institutionalisation. However, it is important to note that although the Government covers health costs, these costs are very narrow and cover very limited services. Often persons with psychosocial disabilities are not included in general insurance. One of the social benefits and protection is also for institutionalization, which is contra CRPD.

Therefore, this raises some critical questions: Where is the money being allocated for social protection? Who is deciding what services are to be covered? In the context of health care, it is seen that often there are higher allowances for western medicine/hospital bed admission, but lesser or no allowance for an individual to make choices of different health care options.

The following are key issues around social protection, which calls for a paradigm shift:

- Moving away from the incapacity to work approach. It is not a question of whether you cannot work, but a question of discrimination preventing you from working, even when you are willing to work.
- Social Protection should further the outcome of inclusion. In many countries, it is seen that the disability benefit is utilized by the family for covering other costs and persons with psychosocial disabilities are prevented from taking up jobs to ensure that the family continues to get an income. This does not enable the participation of the person.
- Social protection should ensure that there is a move from institutionalized care to support for independent living in open communities.
- There cannot be a flat minimum for all, as different persons have different needs.

The experience of persons with psychosocial disabilities is that because psychosocial disability is assumed to cost a lot of money, governments are reluctant to provide protection to persons with psychosocial disabilities.

ii. Assessment to access social benefits

Countries have a criteria for providing social protection. For most countries, persons with psychosocial disabilities need a psychiatric evaluation to access social protection.

There are different approaches to disability assessment:
While in Bangladesh, Timor Leste and sometimes in Philippines, this evaluation has to be done by a doctor, Sri Lanka allows the evaluation to be made by a social worker. In Indonesia, the disability benefit can be accessed through OPDs; but the quota is decided by the Government, thereby sometimes forcing OPDs to pay it out of their budgets to cover for a shortfall. For accessing travel benefits, it is enough to get a recommendation from an OPD. In Singapore, the government does not give the benefit directly to people. It regulates the usage of the benefit they give, as well as gate keep on age factor for accessing the benefit.

In some countries, it is based on membership of OPD. In very few countries, it is the community that decides. However, the problem with psychosocial disability is that it is an invisible disability. When the person assessing the disability cannot ‘see the disability’, evaluations and assessments become very difficult and discriminatory.

In many countries, the amount of benefit is linked to the severity of the condition. However, it is important to ask as to who gets to decide what severity is. Often, it is seen that it falls in the hands of psychiatrists. No doubt the person can get the benefit, but it also brands the person and creates more stigma and discrimination. In many countries, the disability is mentioned in the disability card mandated by governments, increasing the discrimination and gate keeping. Many other countries have fought to ensure that it is not mentioned.

G. WORKSHOP ON SELF-PRESERVATION

Facilitators: Kavita Pillai and Shreshtha Das

The session outlined the need for self-preservation by activists and equipped them with some practical methods of healthy breathing that they can incorporate into everyday lives. In TCI, there has been an
expressed need and interest in the area of self-preservation and caring for the self. This session was offered in response to that need.

Whether one is asserting their own rights or rights of others, they have survived different kinds of experiences and fought many small battles, sometimes internally and sometimes with others. Over days, weeks, months and years, this could lead to brain fog, fatigue and exhaustion, self-doubt and having days of not wanting to be seen and/or heard. It could also lead to a sense of emptiness and vacuum, hopelessness and experiencing a loss of purpose.

The instinct for individual preservation comes from the need to keep oneself safe, out of harm, and alive. Self-care is care provided 'for you, by you, to you.' It’s about identifying one’s own needs and taking steps to meet them. It is taking the time to do some of the activities that nurture you.'

Through breathing and body exercises developed by AniLa Pema\textsuperscript{25}, especially in the context of Anxiety, Yoga and Trauma, the session provided activists with some simple breathing techniques that can be used towards healing. The session also highlighted the prevalence of many traditional forms of healing that are practiced in the contexts of the different countries and can be used for self-care\textsuperscript{26}.

**H. REGIONAL FOCUS AND COMMITMENTS**

Through this session, the participants were invited into different regional groupings to discuss the focus for their regions, identify opportunities of the cross-disability movement’s work and advocacy spaces, going over and beyond just mental health. The following points of actions emerged region-wise:

**South Asia** (Pakistan, Nepal, India, Maldives, Bangladesh, Sri Lanka)

1) Build the network by increasing the membership. This would involve reaching out to different stakeholders within the respective countries\textsuperscript{27}.

2) The members committed to staying connected with each other, sharing ideas and keeping each other informed of key developments in their country. The members also committed to supporting each other and sharing information on technical support and funding opportunities and other resources.

3) Finalize, translate, circulate the Bali declaration as the key message to other stakeholders in the country, especially people in policy making position and governance.

4) Reach out to key players through the formation of an association/ regional body in the SARRC region as a part of TCI advocacy.

5) Connect with the South Asian Disability Forum (SADF). As a primary step, members would find out the current membership and reach out to them encourage them to join TCI Asia membership.

**South-East Asia** (Philippines, Myanmar, Singapore, Vietnam, Malaysia, Indonesia, Thailand)

\textsuperscript{25} Resource on 'Meditation' by Ven. Ani Pema found at https://www.youtube.com/watch?v=ilocQp8nJWE

\textsuperscript{26} Bapu Trust in association with a number of international partners hosted the INTAR India 2016, in Pune. The conference presented a host of alternatives, bringing the practices within CRPD framework, and policy expressions. INTAR (International Network for Treatment Alternatives & Recovery) INDIA interviews from world leaders on alternatives and the CRPD, and all sessions videos, find at: https://www.youtube.com/channel/UCP6i6bEhryHaRuonVu-OFSLA/videos

\textsuperscript{27} A new strategic instrument of 'Sub regional meetings' has been started by TCI Asia Pacific, with a view to enhance participation and to grow the movement at the sub regional level.
1) 3 member countries (Singapore, Vietnam, Myanmar) did not have any OPDs for Persons with psychosocial disabilities led by Persons with psychosocial disabilities. Each country representative committed to setting up or supporting the setting up of OPDs led by Persons with psychosocial disabilities.

2) ASEAN Disability Forum (ADF) is working in the region, but only Myanmar and Indonesia representatives had contacts in the ADF. The members committed to having themselves included in the ADF, through either attending their next meeting as a whole group or appointing a representative to attend the meeting.

3) Appointing a secretariat for the ASEAN (Association of Southeast Asian Nations) region, or a sub-regional office, to have easier communication between the members.

**East Asia** (South Korea, China, Taiwan, Hong Kong, Japan)

3 key issues were found to be common to the region:

1) Involuntary hospitalization. While forced hospitalization has come down after Mental Health Care Act, it has become increasingly difficult for people to come out of the institutions. There are good support services in institutions but none for independent community living.

2) Prevalence of Guardianship.

3) Severe stigma within the community, whereby residents oppose co-living with Persons with psychosocial disabilities.

**Commitments:**

1) Enhance mutual visits and exchange experience around strategic litigation.

2) Access foreign funds that can allow projects to take place in communities that are not limited by local authorities.

3) Research and evidence building around the common issues in the region. Some NGOS were identified that can support organisations with legal research and can therefore help with the language.

4) Get in touch with East Asia offices of the International Organisations

**Pacific** (Timor, Tonga, Fiji)

1) The members committed to making a representation at the 3rd Pacific CBR Seminar in November to include Persons with psychosocial disabilities and to also provide capacity building on inclusion of Persons with psychosocial disabilities and how rights based services can be provided.

2) Ensure that half way homes are not getting linked up to the institutions and are instead linked back to the community.

TCI Asia and the Steering Committee committed to providing technical support wherever support is required by each group.
PARALLEL SESSIONS

A. ADVOCACY FOR CHANGE

Speakers: Emmy Charissa\textsuperscript{28}, Linus Yang\textsuperscript{29}, Yuhei Yamada\textsuperscript{30}

It has been the experience of TCI in the years of its existence, that the Asia Pacific region has diverse legal frameworks, based on their colonial past. Also, typically, high income countries have oppressive institution based systems. This panel was aimed at highlighting experiences of advocacy for change from an East Asian perspective. Advocacy for Change is pertinent for working from the rights perspective, as well as peer led activism. The session involved sharing what peer led activism can do for changing laws and hence rights. The sub region is highly medicalized and uses predominantly psychiatric institutionalization.

Personhood, Capacity and China’s Mental Health Law

The Mental Health Law of China was passed in October 26 and entered into effect on May 1, 2013.

Xu Wei’s case\textsuperscript{31} was the first case under the mental health law. Xu Wei had been incarcerated in psychiatric hospitals and other custodial institutions since 2002, spending around fourteen years in captivity. When China enacted its Mental Health Law in 2013, Xu Wei could finally invoking legal provisions to end his institutionalization. He sued his brother(guardian) and the psychiatric institution.

Since, the mental health law was largely initiated by psychiatrists it suffers from severe defects. One of the key shortcomings is that it uses the ‘insight’ language used by psychiatrists and widely criticized by many is used as a basis for understanding legal capacity. The other obstacles is a mistaken understanding that a persons who has been diagnosed can never fully 'recover' and therefore whether they can enjoy full personhood.

Further, a person’s determination of (in)capacity is determined by forensic psychiatric expert service providers, which are neither professional nor independent. Due to previous history, this system continued to determine Mr. Xu as being incapacitated. This is a discriminatory practice.

While Mr. Xu’s appeal failed the first two times, he drew on civil law principles to get another evaluation done from a different forensic expert service, which identified him as having full capacity. With that, he was able to get out of institution.

Dishearteningly, in China, the ordinary course of action is to directly put a person under guardianship. However, in Hong Kong, it is not that easy to be determined as incapacitated. However, the time spent in retrieving personhood and liberty can be quite lengthy, cutting into a life time with heavy cost.

\textsuperscript{28} Independent activist, Singapore
\textsuperscript{29} Independent activist, China
\textsuperscript{30} Japan National Group of Mentally Disabled People, Japan
Experiences of other countries with mental health laws

India is a post-colonial nation, with its coercive lunacy laws intact, albeit in changed language. There is also a legal activism of taking a piecemeal approach to challenging the mental health legislation. Not only does this make the whole process very protracted, keeping the lawyers in the limelight and seeming busy; it also results in very mixed judgments. Some that are favourable and some that are not. Therefore, there is need for strategy to mount an overall strategic legal challenge against the mental health law per se, rather than this piecemeal approach. Recent laws in the country have provided for Article 19 of the CRPD. That could be one line of litigation to pursue.

In Hong Kong, there is no disability law and different definitions of disability exist among government departments. There are organisations that help NGOs to do research on laws, which can then form the basis for advocacy by the community.

Philippines never had a mental health law and hence there were no case law. However, Philippines now has a new mental health law. Advocates tried to do their best to humanize that law, but the coercive core remains in the Philippines as well.

Advocacy for change in a soft authoritarian state, Singapore

Singapore is a soft authoritarian state with a one party system and state controlled media. The civil society is not developed and there is successful de-politicization of the people by the State. The State has previously arrested human rights activists using false pretext.

The state of Persons with psychosocial disabilities in Singapore is quite poor and persons with psychosocial disabilities are referred to as customers and arbitrary detention is normalised. Advocacy for change, in the Singapore context is centred on awareness raising rather than challenging structural change, where people are indoctrinated into how advocacy can be carried out. Despite the prevalent culture of not questioning the government, there is an urgent need for structural changes through law and policy.

However, the process of challenging laws and policies is not easy. The prevalent practice also ensures that statements for determination of capacity and institutionalisation are taken during periods of crisis and therefore there is a high rate of institutionalisation.

For strategies for advocacy to be effective there is a need to lobby the local and international press to issue statements to counter the state narrative. It would also be important to use the lobbying space provided by the UN and to ensure that the state’s actions are recognized as cruel and inhumane treatment.

The Experience from Japan TCI Asia Pacific has had a long engagement with the Japan National Group of Mentally Disabled People (JNGMDP). A TCI Action in Japan was hugely successful, with the leadership of JNGMDP and discussed in detail the theme of 'peer support'.

---

Japan has 20 percent of beds of psychiatric hospitals around the world. Psychiatric systems have not only enforced a bio-medical model but also allow structural discrimination system, so as to exclude people who are seen as not being suitable for economic growth or to protect society from 'dangerous' people.

Changing laws or regulations is key to advocacy. One of the primary focus of the movement has been to abolish the Mental Health Act. The Mental Health Act which undergoes regular revision was set to worsen the situation. The Persons with psychosocial disabilities movement played a big role in preventing the amendment bill from passing.

In addition, there is a need to have recognition of people with Persons with psychosocial disabilities and to demand for reasonable accommodation to ensure better inclusion within communities.

**B. COMMUNITY SUPPORT SYSTEMS**

**Speakers: Matrika Devkota, Tien Hao Tsing, Kavita Pillai, Zhuang Chao**

The session explored different approaches and strategies that have been employed in different countries to enable and activate community support systems.

**Community Support System for Persons with Psychosocial Disabilities in Nepal**

Nepal does not have a mental health law, so startup of mental institutions is not a policy trend. Advocacy by Koshis has been against a (draft) mental health law and full integration within disability law and policies. Koshis works from the center of the disability movement.

Koshis creates 'talk spaces' in communities to enable overall support. The community support programs of Koshish, works with most marginalized women and girls with disabilities, to promote wellbeing, while making them economically independent. The idea is to normalize and mainstream psychosocial disability. It uses a peer support model, to impart listening skills so that people have a space to talk when they need to. Mother groups and youth group teams work together to provide support and relieve stress.

There are different stakeholders to provide support to persons with psychosocial disabilities. Diverse groups of stakeholders are mobilized, so that people do not feel isolated and people have spaces to share and talk.

Families provide the maximum care, without any recognition or supports from the government. Advocacy has been around support to families. Female community health volunteers help to mobilize communities and they follow up with individuals and families. 'Mother Groups', with a big role in maternal and child health, are active in community awareness and linked with most of women and girls in community. With some training, they help in stigma reduction. Traditional healers and religious heads are important social influencers, and need to be integrated into the practice of inclusion. Social, cultural festivals, rituals, times when families and communities come together in celebration- these have been occasions to promote news about wellbeing and inclusion.

Self-advocates, peer groups form the bulk of the program. They help in creating a sense of belonging, boosting self-esteem and confidence and provide a space for social contact and friendships. They also link up with various other groups working on human rights, and who can potentially represent their issues in
policy forums. Koshis offered emotion sharing clubs, as a platform for children and adolescents to allow the venting of emotions and also support in stress management.

**Taiwan Peer Support System: We Encounter Similar Social Oppression, We tell stories, We try not to be alone**

Peer support for persons with psychosocial disabilities in Taiwan is a nascent movement. They encounter social barriers and through sharing personal stories, they are able to come together and support each other. Peer support is not centred around diagnosis or disease, but is around self-experience, of having a shared idea and experience of distress. It is, therefore, open to those frequently feeling mentally distressed and oppressed by dominant sex/gender discourses as well. The peer support system provides a space for collective negotiation with different stakeholders, around housing, with medical professionals, etc.

The peer support system operates in the following ways:

1. **Collecting life stories, narratives of LGBTQIA+ with mental health issues**
   Stories told and written by LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Agender, Asexual and Ally) with mental illness are collected through an online space. These stories address issues like peer supports, the boundaries between normal and abnormal and the negotiations of identities in everyday life.

2. **Peer support line: to find peers**
   This involves:
   - a) Providing emotional support.
   - b) Assistance in completing schooling, employment, access to social services.
   - c) Providing information about our peer support meetings if needed.

3. **Peer support meeting held once a month**
   Face to face peer support meeting provides safe space to share life experiences and to establish social connections with each other. Members are encouraged to give recognition to each other's identities, to discuss about their situations and social conditions, to design activities for the meeting and to brainstorm the future services that might be needed.

4. **Enhancing everyday life interactions, connecting**
   This involves a) connecting in near neighborhood, online group and b) building safety nets for each other and preparing for crisis.

Taiwan’s Alliance for Mental Illness has developed many alternative strategies, such as singing, dancing etc. that can be helpful for people experiencing distress. The strategy is to explore the strength of person rather than telling them what to do.

**Running as a way of Recovery in China**

Frank shared his own personal journey with being in a crisis and using running as a way of recovery. Frank started running as a way of healing depression. He found that it gave him purpose and sense of healing. However, given the huge impact it had on his mental health he soon developed it from a personal hobby to creating a group around running.
**Seher Program, Bapu Trust**

The government so far has not taken much initiative excepting allowing the start-up of more mental institutions. Community mental health programs, not controlled by the medical system, is negligible in India. The Seher program works with both the person and the environment as it is based on the recognition that the person in interaction with the environment is facing distress, due to obstacles. The Seher program operates on the recognition that a number of factors in the person’s environment pose barriers for the person's growth and development. The aim is to work with these different factors, so that barriers can be reduced or removed altogether. This involves identifying the person’s ecosystem and building partnerships with them to address the person’s growth and development needs holistically.

The social environment in conjunction with the psychological condition indicates what sort of intervention is required. Based on the distress across a spectrum at varied points of time, different strategies are employed. There are three types of actions:

1) Actions for recovery  
2) Actions for prevention  
3) Actions for promotion

It is also important to simultaneously work with journalists and media to ensure that they do not write harmful things about the psychosocial community. This requires awareness building and capacity building of journalists before they go and speak with the community. In the Sri Lankan context they had also ensured that there was a team to observe and intervene where necessary.

It is important that communities take the ownership of the programs rather than organisations. Even though the project may end, the provision of support continues to be provided by the community.

Religious bodies can sometimes have a role to play in supporting people who are found wandering. They ensure that people have a place to stay and are stabilized before going back. There could also be community volunteers who befriend people who are wandering and also try to gauge their ability and support needed for them to take up professional work.

**C. WORK AND EMPLOYMENT**

**Facilitation: Alex Cote**

There are varied and inconsistent government, private sector responses to the issue of inclusion of persons with psychosocial disabilities in the area of work and employment, in the Asia Pacific regions. Policy responses within national government may be tokenistic and enforcement in general is poor. Program inclusiveness needs to be also analysed, whether programs and schemes are inclusive of all persons with disabilities, or are preferential. The role of the medical professionals in certification and other gate keeping, in this area, also came up as significant.

In high income countries, the domain of work is centred around issues of discrimination in employment, jobs and starting companies. However, in middle and low income countries, it also pertains to the question of livelihood and opportunity, besides discrimination.
The session used a discussion based model to focus on challenges in terms of work and employment for Persons with psychosocial disabilities, the current status of employment in different countries and enquire about the reasonable accommodation required by persons with psychosocial disabilities.

**Discrimination**

In Malaysia, there is a lot of discrimination in employment, as a result of which diagnosis status is not revealed to employers. Disclosure automatically results in the reduction of responsibilities. It can also lead to unnecessary and heightened questioning in case of leave of absence etc. Persons with psychosocial disabilities in some countries take psychiatric tests and may eventually end up leaving the work place. Although this is not prescribed by law, it is quite common in practice. In Taiwan, the Government allows persons to take up work on ground of mental illness.

In Sri Lanka, the labour law is quite strong and there are provisions to accommodate a crisis situation and leave is granted to employees. In Myanmar, disability rights law does not include persons with psychosocial disabilities. Under Corporate Social Responsibility Initiatives many companies hire people with disabilities, but this has never included persons with psychosocial disabilities anywhere in the regions.

Different countries have taken up advocacy against this discrimination in employment in different ways. In Malaysia, there is advocacy being done with the Ministry to raise awareness and create jobs. In India, there is an effort to reframe language through a more trauma informed approach. In Indonesia, the cross disability movement is supportive and advocacy is done in collaboration with them. In Philippines, the groups work closely with the disability department to conduct awareness workshops regularly.

**Experience with Quotas**

China, Indonesia and India have quotas for persons with psychosocial disabilities, but implementation is poor. Myanmar does not have a quota. In Sri Lanka, government rules dictate that there is 25% reservation for persons with disabilities, inclusive of persons with psychosocial disabilities. There is also a tax incentive that is provided for employing persons with disabilities. In Fiji there is 2% quota and there also tax benefits. However, the enforcement is very poor in these countries. In Taiwan, people who are employed under quotas are often people with other disabilities and seldom Persons with psychosocial disabilities. In Maldives, there is no legislation yet for a quota. However, the draft legislation contains 2-5% quota all persons with disabilities.

In high-income countries such as France, the government ensures that persons with disabilities are not terminated from their jobs, as otherwise the state would have to pay a disability allowance to them. Persons with psychosocial disabilities are allowed to take off and once they have recovered they can take up a part time therapeutic job. The government compensated the payment for the individual to the company. There is also a concept of a job coach which is paid for by the company.

**Status of informal sector jobs**

In Indonesia, it is difficult to find a job in the formal sector. Even if a person with psychosocial disability decides to work in the informal sector, it is difficult to get loans from banks for capital. There are also problems associated with marketing the product. In Sri Lanka, through advocacy, the government has funded a scheme for livelihood development. There are three such programs. The OPDs there handhold individuals in setting up projects and facilitate the marketing of products. There are also OPD-led self-
employment workshops focussing on micro-financing. Group ventures is another form of livelihood, where groups of persons with psychosocial disabilities come together to start and run a venture.

Support from Governments

In Malaysia, the Government encourages entrepreneurs who want to offer jobs to persons with psychosocial disabilities. There is also a Community Based Rehabilitation (CBR) Program in Malaysia. This is mainly for persons diagnosed with schizophrenia. In Maldives, there are 50 CBR programs that are government funded. In Timor Leste, the government gives a subsidy of only $30 for 6 months. The legislation is also discriminatory, as it requires a physical and/or mental capacity certificate to be produced for this. In Taiwan although the policy states that support will be provided to persons with disabilities, in practice, it has been seen that no support was received from the government when persons with psychosocial disabilities started their individual mentors. In Indonesia, while there are government programs to support women, this has not been extended to women with disabilities.

D. HEALTH

Facilitation: Bhargavi Davar

When health is discussed in the context of persons with psychosocial disabilities, the automatic assumption is that it merely concerns psychiatric medicine and psychiatric doctors, whereas there are a range of ailments that persons with psychosocial disabilities can have, like everybody else. If there is a history of psychiatric treatment, the general assumption is to connect every ailment to psychiatry and comprehensive health care is highly neglected. This is similar for people with intellectual disabilities, where any health care problem is addressed as a dental problem or advice for a haircut or tips on personal hygiene.

In this session, members shared personal experiences where the doctors on knowing history of depression and anxiety forced them into shock therapy, even when they have complained of headaches or a sensation of numbness in their hands. In Philippines, when persons with psychosocial disabilities go to general hospital for common ailments, on knowing of their mental health history, they are automatically sent to the ward for mentally ill patients.

There should not be an assumption that when we go to doctors or health care service providers, the reference is always to psychiatric treatment. There are many ailments that persons with psychosocial disabilities can have and they have a right to be treated for that, without psychiatric intervention.

Through the use of a case study, the session discussed the situation of a 37 year old woman living with a diagnosis of schizophrenia over a decade. When she had approached health care providers with complaints of dizziness, buzz in the ears, spells of forgetfulness, wandering and feeling lost and headaches. Her appearance stood out in contrast to the mainstream clothing and hair colour of Indians.

The doctors continues to treat this as a schizophrenic episode and refused to treat her, calling this whole thing a figment of her imagination. She also had to field questions such as ‘are you a lesbian?’ ‘Do you have too many sexual partners?’ ‘Are you a drug user?’ It eventually turned out to be brain tumour. The session called upon the audience to gauge, based on the case study, about what could have been the alternate health care provider responses.
In the discussions that followed a number of reasons were identified for the symptoms that were listed. This ranged from deficiency of vitamins and minerals, where the history of diet/nutrition of a person needs to be considered; neurological disorder - brain damage; non- medical routes - drinking more water, steam inhalation, rest (full range of well-being services are never recommended); side effects of the psychotic drugs prescription which is not recognized by medical health practitioners, for example ‘zombiem’, caused by over use of anti-psychotic medication.

The experiences of people in the room showed that all health related complaints are lumped together as related to a history of mental health issues. Tests are denied, assumptions and generalizations abound; the continuity of care necessitated by the illness is overlooked, often landing the person in an emergency situation. Stigma and cultural bias continue when persons with psychosocial disabilities try to avail treatment from simple to grave symptoms entirely unconnected with their diagnosis. Moreover, for people locked up in psychiatric hospitals, there is no attention paid to the health of the inmates. Often, there is refusal to provide treatment because it is assumed that as a person with a psychosocial disability you would not want to extend your life!

Compounding this is the problem of discrimination from insurance providers. Not only is mental health not covered by the insurance, but if a person has a history of psychosocial disability then it is assumed that the person will not take care of themselves and are therefore more susceptible to diseases. As a result they are hesitant to cover persons with psychosocial disabilities under health insurance.

Even when mental health care is available under insurance, it raises question of what type of health care is provided. If only psychiatric care is covered and no other form of healing, this could be another way of ensuring over diagnosis and making sure that the person is ensnared in the psychiatric system. Every person, including those with high support needs, have a right to feel good about their bodies and wellbeing whether it be a good bath or a good massage, as well a range of services such as yoga and other alternate forms of healing. To deny people a path to wellbeing on the basis of psychiatric disorder is discriminatory.

E. WOMEN WITH DISABILITIES

Susmeera Arayal, Jillian Ferguson, Tien Hao Tsing

Women with disabilities do not just face violence as a person with disability and on account of having psychosocial disability, but as a woman and sometimes on account of other intersectional identities such as identifying as LGBT. Women with psychosocial or intellectual disabilities are perhaps amongst the most stigmatized and marginalized, enduring stigma and discrimination in every sphere of life—personal, professional and public.

It is seen that women or girls with a disability face multiple and compounding forms of discrimination and violence based on their gender, age, marital status, caste, ethnicity, sexual identity and disability. A research by Human Rights Watch on women and girls with disability in India and Australia revealed as follows:

- For most women and girls with disability, stigma and denial of basic human rights are associated with starting menstruation. On attaining menstruation age, many are confined to homes and are isolated from the community. Many others are forced to drop out of schools as the toilets are not accessible and safe and they do not find any support services to manage menstruation.
For many others, the beginning of menstruation could also imply the horror of a forced sterilization, where the ovaries of the girl is removed without their consent and knowledge.

- In India\(^3\), women and girls with psychosocial or intellectual disabilities are abandoned by their families and locked up in institutions for unique gender-specific reasons. In one of the case studies it was seen that a woman was picked up from her home at the middle of the night and forcibly institutionalized. While being institutionalized she was forcibly given electroconvulsive therapy against her will and was not allowed any contact with her family and friends. It was later discovered that this was orchestrated by her husband who wanted her to be declared 'insane' so that he could get a divorce without having to pay alimony. There are many examples where laws have been found to allow for easy divorce based on psychosocial disability and false diagnoses is used to deny rights, even access to kids. Once institutionalised it is difficult to get out and women are subjected to electroconvulsive therapy, physical and sexual abuse.

In Australia, studies show that women with physical, sensory, intellectual, or psychosocial disabilities (mental health conditions) experience higher rates of domestic and sexual violence and abuse than other women. More than 70 percent of women with disabilities in Australia have experienced sexual violence and they are 40 percent more likely to face domestic violence than other women.

The Australian case study also looked at a different dimension of the issue, namely indigenous identity-Aboriginal and Torres Strait islanders who are women. Indigenous women who have a disability face intersecting forms of discrimination because of their gender, disability and ethnicity that leave them at even greater risk of experiencing violence Some of the findings were as follows:

- Indigenous women are 35 times more likely to be hospitalized as a result of domestic violence than non-indigenous women.
- Aboriginal and Torres Strait Islander women are 21 times more likely to be incarcerated than non-indigenous peers. According to a study by the University of New South Wales, aboriginal women with psychosocial or cognitive disabilities also have contact with police at a younger age and have a considerably more encounters with them throughout their lives than non-aboriginal women.

In one of the cases it was seen that when a woman called police as she was facing domestic violence, they came to her house and realised she had unpaid fines. Instead of helping her, they arrested and detained her. As she had wounds from domestic violence she had asked for medical care. However, merely by looking at her the nurse disbelieved her claim and denied her care. She ended up dying in custody.

- Research in Australia shows that women with disabilities, particularly Aboriginal and Torres Strait Islander women with disabilities, experience higher rates of poverty, homelessness, domestic and sexual violence and abuse than non-indigenous peers and peers without disabilities.

The Experience of Discrimination in Taiwan, specifically as a LGBT person and as a question of body size

It is fundamental to understand that 'mental illness' is the social oppression that we embody, the social conditions and structures lead to trauma; therefore, it is not a personal issue. Social barriers and oppression are often seen as a ‘triggers’, but not as a ‘cause’ for distress. This makes psychosocial disability

\(^3\) Human Rights Watch (2014). 'Treated worse than animals. Abuses against women and girls with psychosocial or intellectual disabilities in Institutions in India'. [https://www.hrw.org/report/2014/12/03/treated-worse-animals/abuses-against-women-and-girls-psychosocial-or-intellectual](https://www.hrw.org/report/2014/12/03/treated-worse-animals/abuses-against-women-and-girls-psychosocial-or-intellectual)
a personal issue. However, as a woman, as a sexual minority, the trauma one encounters can be a very important context for understanding distress.

Sexual minorities and gender identities that do not conform to the norm were for the longest time seen as 'mental illness'. It was only in 1973 that the American Psychiatric Association (APA) members voted and removed homosexuality as a mental disorder. It was only in February 2018 that the Ministry of Health and Welfare of Taiwan banned 'conversion therapy' (or 'reparative therapy'). In June, 2018, World Health Organization removed 'transsexualism' from the International Classification of Diseases (ICD-11), which was renamed 'gender incongruence' and moved from the 'Mental and Behavioural Disorders' chapter to the 'Conditions Related to Sexual Health' chapter.

It is also seen that suicide rates are higher among LGBT community because of the discrimination and stigma they face. The stigma they face can also trigger Obsessive Compulsive Disorder, where they keep cleaning themselves out of guilt and shame.

Stigma associated with body image is another distress inducing factor, especially among young women and gay men in Taiwan. To counter this, the Alliance started a photo series of taking photos of different body types, celebrating diversity in body sizes and created a public display of it.

- Post marital pressure (mistreatment in the marital homes; overworked, not taken care of and then women are disowned) can also act as a trigger for psychosocial disability. The women are left to fend for themselves and the children, after having developed a psychosocial disability.
- Pregnancy can also trigger depression, which can lead to a psychosocial health issue or a disability, going into a severe state, where they are not able to take care of themselves or the child; and yet do not receive any support.
- In Philippines as well, the issues faced by indigenous women and deaf women are completely sidelined. For example, a lot of people who are deaf also develop psychosocial disability and suicides; and depression is quite common. However, because of the language barrier, this has not been accommodated in the disability movement. It also becomes difficult for them to report sexual violence. They are also more susceptible to HIV (Human Immunodeficiency Virus) because there is very little information that reaches the community. This is given the fact that sexual engagement in the community is very high since it is a tight community. To provide support to this group of women who are deaf and have a psychosocial disability, there is a need to bridge the communication barrier with the deaf community.
- Nepal’s experience is that it is a cycle of violence. It is very difficult for women to report violence since they are often not believed. There is a lot of suicides among women as a result. Suicidal tendencies amongst children who have been raped or faced child sexual abuse is increasing, owing to the distress arising from encountering violence and abuse. Therefore, there is a need to move to a trauma informed approach so that the focus is on the person/social oppressive factors that are causing distress instead of the person.

Persons with psychosocial disabilities have to move into the middle of the women’s rights movement and claim space as women too. It is important to work with the women’s rights organisation, ministries and commissions of women.
• Trainings for persons with psychosocial disabilities must include training on gender and sexuality and not just disability. Women with disabilities are often perceived as asexual or hypersexual, whereas a healthy sexual life is important for their wellbeing.

• It is important to look at the side effects of psychiatric medicine on the libido.

• It is important to talk about domestic violence that women with disabilities encounter at the hands of men with disabilities. It is important to talk about gender inequality within the disability movement. There is also a lot of resistance to partner with LGBT groups.

Some strategies that emerged from the discussions around greater visibility to the heightened marginalisation by women with disability were as follows:

1. Focussing on SDGs that deal with gender inequality.
2. Providing financial assistance to women with disabilities through UN mechanisms.
3. Incorporating disability inclusion in NGOs that work on disability and gender.
4. Connecting with women’s right organisations, governments and commissions.
5. Ensuring that disability rights activist receive gender training.
6. Speaking out against perpetrators from within the movement itself.

F. HEARING UNHEARD VOICES

Speakers: Hing Hee Cheung, Anita Abu Bakr, Vincent Cheng, Susmeera Aryal

This session focussed on different strategies that different individuals/groups have used as a way of coping.

Art Practice as Self-Advocacy

Cheung was diagnosed with Schizophrenia at the age of 13, as she often found herself having visions and illusions. This made it difficult for her to recognize words or vocalize what she was feeling. Through ‘training’ on hearing voices, however, she has developed the ability to hold on to the pictorial vocabularies in her mind and transform them into lots of delicate visual language in her work. Cheung has actively been involved in advocacy with UN, community organizing, as a creative writing tutor and as editor of different magazines. Through writing for magazines she has found fiction as a tool of communication.

She is also the chief editor and author of 'Disabilities CV: The Stories of the persons with psychosocial Disabilities in Hong Kong', published in 2015, which is commended as an effective approach to promote social inclusion. The book also brings up the issues of transitional justice in the process of life experiences and their transformation.

The session highlighted the negative experiences of young persons who hear voices within the educational system. Until 2017, there was not enough support or resources available for students. In 2010, this led a high school student, committing suicide on the first day of being forced to take medicines by the teacher.

Cheung started a series called 'Soft Stones' that was inspired by erasers she had collected from primary schools and tuition centres. It was based on the idea that while the erasers were shaped like stones, they were still soft inside. In one of the pieces, the erasers were then arranged in the form of a tombstone, representing the suicides by high school students.
Hearing Unheard Voices, A Spiritual Solution

Anita Abu Bakr shared her experience of receiving a diagnosis and the debilitating impact that it had on her and the support she found in her family and in other people to recover. This experience also made her turn to God. Post her recovery she set up the “Mental Illness Awareness and Support Association” (MIASA).

MIASA is a consumer led advocacy group that fills in the crucial gap of a missing voice in the mental health movement. MIASA uses the bio-psycho-social spiritual model since they believe that the spiritual aspect is one of the core elements of successful recovery. MIASA receives strong support and endorsement from medical doctors, spiritual healers and the Malaysian government.

MIASA uses a spiritual solution because they have found that the role of spirituality is under-recognized and is highly stigmatized. This is due to the fact that it lacks scientific research and also due to other factors, such as the occurrence of fake spiritual healers and conmen who call themselves as spiritual healers but use deviant or false methods to trick communities. However, they have found that many people have benefitted from spiritual treatments and activities, like Quran recitation, remembrance of God, acts of worships, spiritual gatherings, etc. MIASA ensures that various religious scholars are consulted to identify the criteria of true spiritual healers who use correct methods of traditional healing.

Better ‘Alternative’ And Human Response to ‘Unusual’ Experiences, Vincent Cheng

Vincent shared his journey with mental health issues leading up to hearing voices, seeing visions and having unusual beliefs at the age of 19. Vincent found that his earlier voice were bad for him, he would hear someone claiming to kill and prosecute him. He would find a response deep within to deal with these situations positively. Psychiatrists had put him on medication, which they kept changing time and again. Although it helped him with sleeping and to desensitize the distressing voices, he experienced severe side effects as a result. Vincent established the first registered self-help group run by persons with lived experiences in 1995. Since then he has been working on CRPD compliance and on promoting the recovery movement and personal agency and transformation.
The Hearing Voices Movement began in 1987. Currently, 27 countries are a part of the Hearing Voices Network. The hearing voices movement is open to all kinds of explanations for violence and is an empowering movement. In his experience, Vincent has found that voices are often related to spirituality or trauma. It is against the mainstream psychiatric perspective which constructs hearing voices as schizophrenia, a mental illness to be remedied by medications. The Hearing Voices Movement believes that it is not a question of whether the voices are real or not; it is a real experience for a person and cannot be viewed as an illness. The movement sees hearing voices as diverse and a common human experience and helps members to find self-help strategies.

Vincent set up the first group in Hong Kong for persons who are hearing voices in 2014. A Hearing Voices Group (HVG) is a self-help, support group, that provides peer support through sharing experiences, exploring thoughts, feeling and coping strategies and helps to build more effective relationships with the voices, visions and thoughts. The group is planned and led by voices hearers. HVG meetings may include the following components:

1. Affiliation and warm-up activities, sharing ethos and group norms.
2. Check-in: sharing one’s recent experiences.
3. Sharing on hearing voices, may include the following themes:
   - Recent experiences of hearing or seeing voices, and the feelings involved
   - Occurrence patterns (i.e.: timing, place, circumstances, content, frequency, strengths)
   - Explanatory framework
   - Coping strategy
4. Activities conducive to voices-integration:
   - Voices-profiling questions / worksheet
   - Painting or acting out the voices
   - Dialogue with the voices
5. Check-out: Sharing feelings or blessings evolved in the meeting

HVG helps people hearing voices to rebuild their lives in the following ways:

![Figure 8: How HGV helps people who hear voices to rebuild their lives](image)
HVG has also offered **immense benefits** to those who hear voices:

1. Benefit of peer support:
   - Normalizing experiences
   - Exploring coping strategies
   - Safe and non-judgmental: neither being prescribed greater dosage nor being labelled

2. Building relationship with voices:
   - Uncovering more possibilities of relating to voices
   - Learning to live with the voices and change the power relationship with voices

3. Building lives: having more confidences and capabilities to live better.

**Women’s Group For Disability Rights, Susmeera Arayal**

Susmeera started with her journey of being diagnosed with schizophrenia while in college. This was also the period when Nepal was undergoing a prolonged period of conflict. Her diagnosis led to being isolated for 7 years. During this time, she developed the habit of writing. Having experienced the beneficial change the recreational activity of writing brought to her, she started helping people around her. This was when she started the Women’s Group For Disability Rights.

Women’s Group For Disability Rights (WGDR) is a non-government, not for profit and non-partisan Organization of Persons with Disabilities (OPD) based in Nepal. Majority of members of the organization are women with psychosocial disability. Their main activity is providing peer support. They also conduct psychosocial intervention training. The group also does advocacy and conducts policy training and capacity building for Persons with Disability in ICT (Information and Communication technologies) issues.

The Plenary highlighted the fact that persons with psychosocial disabilities in the Asia Pacific region choose a myriad ways of addressing their psychosocial health and wellbeing needs. Also, importantly, choice is not limited to making a “wellbeing” choice, but a whole range of choices that will help them attain dignity and respect and be a full member of society.

![Figure 9: Some strategies for inclusion used by the Bapu Trust Pune](image-url)
G. NATIONAL OPD FORMATION

Facilitator: Jenny Rosa Damayanti

The session explored the following questions:

- How do you build your organisation?
- What are the challenges faced by OPDs of Persons with psychosocial disabilities?
- How do you connect to the broader disability movement?
- How can TCI Asia as a regional body support OPDs in their national level endeavours?

‘From being a wallflower in the psychiatric conventions, I wanted to have my own voice’.
- Jenny Rosa Damayanti, on why she wanted to start an OPD.

How to start a OPD?

Case Study: Timor Leste

The case of Timor Leste offers a good case study for OPD formation. It has historically been colonized and is a commonwealth country. There is very high trauma and development services are in shambles. There is also a lot of violence against women arising from conflict. In the backdrop of this, members from TCI Asia were invited by mental health service providers and a consultancy firm that was charged with bringing multi stakeholders on issues face by persons with psychosocial disabilities in Timor Leste. PRADET – Psychosocial Recovery and Development in East Timor has been at the centre of providing support services for people with psychosocial disability in Timor.

At that time of the consultation there were no OPDs, there were a few people from PRADET, who were people with psychosocial disabilities. The first step was to get persons with psychosocial disabilities into the room. In a multi-stakeholder formats there is a division of 'us' (the people who know) and 'them' (the people you tell) where the voices of persons with psychosocial disabilities are not heard.

The next challenge was to ensure that their voices are heard and respected. For this, it was important to have a space where persons with psychosocial disabilities could meet on their own. This encouraged them to share their story.

The next step was to create spaces where people could tell their stories safely- a space to speak for themselves and whenever they want to. Often in the pretext of ‘keeping them safe’ persons with psychosocial disabilities are not even allowed into these spaces. Instead, it should be the onus of the organisers to ensure that the space is safe. Over the days, with insistence, it became a norm that persons with psychosocial disabilities should be in the room, they should be safe and they should participate. One of negotiation with the lead service providers was that the new emerging OPDs will be given an independent space to go to. Slowly, it led to a name being articulated and the OPD coming to life.
Getting Involved

It is important to have a strategy for each stakeholder in the room.

a. With the cross disability movement

Case study: Indonesian Mental Health Foundation (IMHA) and experience sharing. IMHA is in the very epicentre of the cross disability movement in Indonesia.

b. Find a third party who can act as a bridge

Technical and financial support organisations can be a good entry point for accessing the broader disability movement. It is a good strategy to have a third party who can facilitate and act a bridge, especially if the third party is well regarded and respected by the cross disability movement.

In the case of IMHA, the Disability Rights Fund (DRF) was an important facilitator in interacting with the disability movement. DRF organized a space where persons with psychosocial disabilities were brought into the same space with other disability groups. Although there were several confusions around their presence initially, IMHA started being invited to other disability seminars and meetings. People within the disability movement began to understand the problems and challenges that faced persons with psychosocial disabilities. This camaraderie was solidified in the face of a new Disability Act, which required different groups to present a united front. Although the result is not what persons with psychosocial disabilities wanted, the process itself brought them together with the rest of the disability movement. In the process, they became stronger as the Government could no longer isolate them as they were a part of the disability movement. IMHA realised that they were being taken more seriously by governments and psychiatrists as a part of the disability movement, rather than as ‘patients’.

This was the case in the Philippines as well, where a third party helped in reaching out to the cross disability movement and orienting and sensitizing them on psychosocial disability. The cross-disability groups were concerned that we are under-represented and had reached out to the OPD of persons with psychosocial disabilities.

c. Develop a language to articulate the similarity

Sometimes, people in the cross disability movement are not able to support persons with psychosocial disabilities, because they don’t know how to. It is important to point out that the key to extending support is to just ask what support is needed, similar to any other disability. Support is the same, to continuously touch base with the person and ask, how they may be best supported.

d. Strong understanding of CRPD

If OPDs have a full and strong knowledge on CRPD, the cross-disability movement has no choice but to respect them. For this, it is important to have national CRPD trainings to build up the knowledge of those who are a part of the movement. Meeting spaces, such as TCI Asia Pacific, help people to understand what is happening globally; and regionally and to have more knowledge and be confident about their positions.

e. Learning about other disabilities

To be a part of the cross disability movement, OPDs must be open to learn from each other. For Philippines, this involved learning the sign language, learning how to provide support to the blind and knowing the ethics of how to support people with locomotor disability.
f. **Mutual support**

Reaching out to organisations that are already established can also help in running a OPDs. Mutual support can be provided to each other. For example, in the illustration from Philippines, the group had given support on CRPD to a well-established OPD in turn and they became the Secretariat for persons with psychosocial disabilities since the OPD of Persons with psychosocial disabilities did not have too much human resource.

Some of the other strategies which members had tried were as follows:

1. Know the founders and networks of online support groups and try to influence them.
2. Insisting that instead of OPDs being created for Persons with psychosocial disabilities, they would be created by Persons with psychosocial disabilities.
3. Having a CRPD Compliant Day- having a specific day dedicated to psychosocial disability.
4. Changing the stigma around psychosocial disability by identifying key people who may have a personal story to share or may have a good understanding of disability.
5. Finding small funds for new OPDs.

**Challenges faced by OPDs**

- In Nepal, the OPD, Koshis, articulated that for them there are serious questions in terms of their financial strengths; second-line leadership; administration and management structures. Moreover, because of the stigma, many people are scared to come out and publicly claim that identity.
- Exclusion from the disability movement because psychosocial disability is not seen as a disability.
- In the Malaysian context, the following challenges have emerged:
  a. Awareness is very low on psychosocial disability.
  b. People were very scared to have persons with psychosocial disabilities in public spaces, because nobody wanted to hear the truth, especially mental health professionals.
  c. The biggest challenge is that people are scared to talk. The only safe spaces are peer support groups or talk spaces.
  d. The same group of people speak publicly. How does one empower others to speak?
  e. The challenge of sustaining volunteers.
  f. Lack of training for OPD staff
  g. The question of funding

H. **CROSS DISABILITY SUPPORT TO NATIONAL OPDs**

The session focussed on the ways in which persons with psychosocial disabilities have been included within the cross-disability movement and the support they have received. Different countries shared their experience in achieving this.

**Indonesia**

In Indonesia, there was an effort to reach out to the most marginalized among persons with disability which resulted in the formation of the marginalised group of the national coalition of OPDs. Although there were hesitations initially, through good lobbying attention was drawn on the ways that persons with psychosocial disabilities are particularly marginalized.
Members from other countries such as Hong Kong, Maldives, Philippines and Myanmar also reported facing a problem in the inclusion of persons with psychosocial disabilities as there is very limited understanding of psychosocial disability within the broader disability movement or stigma attached to persons with psychosocial disabilities.

However, different countries have taken different steps to ensure greater inclusion,

- Using the CRPD categories of disabilities to ensure different disabilities are represented in their committees.
- Using CRPD monitoring processes to develop a joint parallel report on status of persons with disabilities.
- Identifying barriers faced by different groups and collectively working to remove it.
- Using radio shows to highlight the issues of different groups.
- Reversing the burden and putting the accountability on cross-disability groups to ensure effective organising and inclusion of persons with psychosocial disabilities.
- Stressing on uniformity of barriers experienced, rather than the fact of the specific barrier.
- Creating greater understanding of what reasonable accommodation entails for persons with psychosocial disabilities. This could be developed through some broad guidelines by the movement.

I. LEGAL HARMONIZATION

Speaker: Alberto Vasquez

Legal Harmonization is the process of reviewing the national framework to make it compliant to treaties like the CRPD. It includes:

- Abolishing legislation
- Amending legislation
- Adopting new legislation

In order to ensure there is effective harmonisation between the CRPD and the state laws, it is important to understand the hierarchy that the country follows between the CRPD and its own constitution and the law. In some countries, international law is valued above national legislation and hence if there is a conflict between the two the judge will hold down the legislation to ensure compliance with the treaty. If, for example, if voting is denied under the constitution/national legislation, PERSONS WITH PSYCHOSOCIAL DISABILITIES (PPSD) can challenge the provision in courts as CRPD recognized the right to vote. If a country treats treaties and the constitution at par, the argument could be for applying the Treaty since it is more recent. In yet other countries, treaties are valued below the constitution. OPDs and persons with psychosocial disabilities should advocate with governments to ensure that there are rules in place which ensure compliance with treaties over national constitutions and legislations.
The process of harmonizing the national legal framework with the CRPD would entail the following:

1. **Comprehensive review of the national framework in the light of the CRPD (deliberative process)**

Often the tendency within the disability and mental health movement is to limit to an examination of the mental health and disability law while looking at compliance. However, there are laws on a range of issues such as property laws, marriage laws, adoption laws, criminal codes, electoral laws, taxation laws, education laws, labour codes etc. that need to be examined to ensure all laws affecting various aspects of a life of PPSD is compliant. It is crucial to be very comprehensive when examining.

2. **Drafting law reform proposals (citizen initiatives)**

After a deliberate process, a law reform proposal can be arrived at. In most countries, it is elected representatives who are the only ones that can present bills in Parliament. However, there are many countries which allow for citizen initiatives, whereby people can propose laws. 

For example, in Peru, the disability movement were able to gather 55,000 signatures for the proposed Bill and could get the Bill to pass. Similarly, in Bangladesh, citizens can put forward proposals and petitions for reforms.

3. **Debate at the parliament or congress**

This method calls for an obligation of active involvement and consultation on the part of persons with psychosocial disabilities. This may require the civil society to work with political parties. It is essential to lobby with different parties to ensure that there is discussion in the Parliaments. Pressure can be exercised on governments by calling upon them to honour their obligation to actively involve and consult PwDs (Persons with Disabilities) in the application of CRPD, which can cover a broad range of laws.

4. **Adopting new legislation**

There are different strategies available. One of the key areas is constitutional law, which if not in compliance, will require to be amended.

Another area to consider is whether to advocate for a new disability legislation or amend existing legislation to ensure greater compliance. It is often seen that disability laws are limited to providing entitlements to PwDs, but do not recognise the rights as granted under the CRPD. Countries may sometime also have anti-discrimination law, but the scope of such laws continues to remain narrow, providing for accessibility and reasonable accommodation but keeping structures of inequality and discrimination intact.

The other question is around having a separate mental health law. The experience of a separate mental health legislations in most countries has shown that mental health legislations are often limited to regulating seclusion, restraint and has coercion at its core. Involuntary treatment and the targeting of minority groups for involuntary treatment continue to be perpetuated by mental health legislations. Since, the aim is to ensure equal treatment at par with other disabilities, it is better to advocate for inclusion within a disability law instead of having a separate mental health law. If a separate mental health law cannot be avoided, it is critical to ensure that checks provided by CRPD are incorporated into the law.
It is important to remember that CRPD is transformative and therefore one needs to be smart when proposing, advocating, drafting a new legislation.

1) Monitoring new legislation is an important way of ensuring the implementation of the CRPD. It is critical to ensure that the provisions are merely lifted from other laws which often ends up excluding the concerns of Persons with psychosocial disabilities. Best practices from other countries can be drawn on from other countries. Reports of the Special Rapporteur always have a section on law and can provide a good start. But, it is important that each law responds to local realities and situations; and therefore what works in one context may not work in others.

2) Mental Health Legislations: Professional organizations are the main drivers behind pushing for a mental health legislation. It is important to do advocacy with professionals to restrain them from passing a legislation. For this, a good aid would be the opinions by international bodies (Special Rapporteur, OHCHR) that advises against the Mental Health Care Act. Persons with psychosocial disabilities/OPDs could also aim to find people within WHO and other UN mechanisms who are wary of passing a new mental health legislation and use that to do advocacy at the country level.

Instead of falling back on a mental health law to address different concerns such as the issue of health etc., it is important to address those issues through national legislations/ international bodies addressing them. Working within WHO- find people within these bodies who are wary of passing a new mental health legislation and use that to do advocacy at the country level. Find the recommendations from within the UN systems to do advocacy.
ORGANISATIONAL MATTERS

In the Bali Plenary, TCI Asia membership (Core members of TCI[^4]) voted on key organisational matters. Voting took place on three key issues:

1) **Adopting the Bali Declaration**

   The draft text of the Bali Declaration was presented before the membership and there was a clause by clause analysis and discussion of the text and suggestions were taken from members to arrive at the final content of the Declaration.

   The text of the Bali Declaration is attached as **Annexure A**.

2) **Re-naming TCI as TCI Asia Pacific**.

   The members voted unanimously to change the name.

3) **Adopting new member** countries from South Asia, South East Asia, West Asia, Pacific Region, Central Asia etc.

   The members voted unanimously to adopt the members.

[^4]: Are those who self-identify as a person with a psychosocial disability
ANNEXURE A: BALI DECLARATION

We, persons with psychosocial disabilities and cross disability supporters from 21 countries of the Asia Pacific region, in Bali, on August 29th 2018, and at the Plenary meeting of Transforming Communities for Inclusion – Asia Pacific [TCI Asia Pacific],35

Hereby confirming

- The systematic and pervasive violation of all our human rights; including all forms of discrimination, exclusion, violence, inhuman, degrading and torturous treatments taking place, in higher and lower income countries; in cities and rural areas; in outer islands; in institutions and communities; in schools, universities, health care centers, and in social services.
- The failure of the most current, and new policy responses framed by the medical model which are restricting freedom, choice and opportunities; the gatekeeping by the mental health system, by assessing, conditioning, controlling and restricting our exercise of our rights; often ignoring resources for inclusion within communities, cultures, belief systems that may increase our choices and chances of full inclusion.
- Those policy responses often centered on mental health do not comply with international human rights standards and, frameworks provided by various international Conventions and treatises, most importantly, the UN Convention on the Rights of Persons with Disabilities [CRPD].

Encouraged by the progress made by some countries in the region ensuring the inclusion of persons with psychosocial disabilities within policies and legislation for the inclusion of all persons with disabilities, in accordance with the CRPD; confirming the absolute relevance of the paradigm shift towards 'inclusion' and away from medical model or a sole focus on 'mental health';

Alarmed by the extent to which even the most progressive mental health environment still control and deny our rights to education, work, have a family, access to social protection, food, basic needs and an adequate standard of living; rights to vote, life and liberty, equal recognition before the law, among all other rights guaranteed by the human rights framework;

Among the issues of sustained discrimination, and exclusion of persons with psychosocial disabilities, we highlight as grave:

- The growth of new mental health laws in the Asia Pacific region with core provisions of involuntary admission and treatment; often leading to highest rates of stay in psychiatric hospitals 36; the terrible conditions in mental institutions, including physical and sexual abuse of people with psychosocial disabilities of the region 37; risk of life due to infections, starvation,

35 TCI Asia Pacific is an Asia Pacific alliance of persons with psychosocial disabilities from the Asia and Pacific regions, and their cross disability supporters, from 21 countries. The vision of TCI Asia Pacific is the implementation of CRPD for all persons with psychosocial disabilities. TCI Asia Pacific is focussed on expanding the pedagogy and practice, of the inclusion of persons with psychosocial disabilities (Article 19 of the UNCRPD).
36 Korean OPD and NGO Coalition for parallel report on CRPD (2014). INT_CRPD_CSS_KOR_18207_E. After the new mental health was implemented, over 90% admissions are involuntary. Average stay in mental hospitals is 247 days; 3693 days for those living in psychiatric sanatoriums. See CRPD Monitoring Committee List of Issues in relation to the initial report of the Republic of Korea. CRPD/C/KOR/Q/1 of 12th May, 2014.
37 Human Rights Watch, (2014). 'Treated worse than animals. Abuses against women and girls with psychosocial and intellectual disabilities in India'. https://www.hrw.org/report/2014/12/03/treated-worse-animals/abuses-against-women-and-girls-psychosocial-or-intellectual
malnutrition, direct shock treatment (Shock treatment without the use of anesthesia)\textsuperscript{38}, unregulated use of restraints and solitary confinement, and other inhuman, degrading, and torturous treatments;

- Violations in the families and communities- including pasung, (shackling) a practice commonly found; being cast out and deprived of all access to any kind of family, or community engagement; seclusion in inhuman, degrading, cruel and torturous conditions within social care institutions, unregulated houses, shanties and animal coups;

- The complete silencing of voices of persons with psychosocial disabilities through State sanctioned discrimination using incapacity laws more frequently practiced in the Commonwealth; the systemic discrimination against our inclusion within development especially of women, children, LGBTI, indigenous and other groups otherwise facing multiple discriminations in our societies.

That, such concerns are not being a sporadic occurrence but confirmed as frequent occurrences, in all parts of Asia Pacific; deeply embedded within legal, normative, and social structures; being reinforced by colonial, historical traditions set within national laws;

That, such violations in law and practice cannot be addressed by marginally improving mental health systems that perpetuate the denial of human rights in the name of 'our best interest', but by adopting the full shift of paradigm of the CRPD towards inclusion in accordance with our choice, will and preference.

Recalling,

- Commitments of all UN members states to implement the sustainable development goals to leave no one behind reduce inequalities and empower and promote the social, economic and political inclusion of all,

- Obligation of most Asia-Pacific countries that have ratified the CRPD to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity, autonomy and independent decision making, on equal basis with others

- Commitments of all Asia Pacific states to 'Make the right real' for all persons with disabilities throughthe implementation of the Incheon Strategy

- Commitments of Pacific countries to the Pacific Framework on the Rights of Persons with disabilities

Recognising, that an inclusive implementation of Sustainable Development Goals and the full realisation of human rights mutually reinforce each other,

Welcoming,

- The concluding observations and recommendations of the UN CRPD committee to Asia – Pacific countries to date, as well as the General Comments on Equal Recognition before the law (Art 12)\textsuperscript{39},

\textsuperscript{38}Center for Advocacy in Mental Health (2006). 'ECT in India'. http://www.ect.org/?p=551, accessed online on 04-09-2018

\textsuperscript{39}CRPD /C/GC/1, (2014) CRPD General Comment 1 on Right to Equal Recognition before the Law.
Women with Disabilities (Art 6), Living independently and being included in the community (Art 19), Non-discrimination and equality (Art 5) among others,

- The reports of the UN Special Rapporteur on the Rights of Persons with disabilities to the UN Human rights Council on Social protection, Inclusive policy, Legal capacity and participation and rights-based support for persons with disabilities,
- The report from the Special Rapporteur on the Right to highest standards of physical and mental health to the human rights council on Mental Health, statement on the 'corruption' in the mental health systems around the world and the denunciation of the 'global burden of barriers' faced by persons with psychosocial disabilities,
- The 2017 Human Rights Council Resolution on Mental Health and Human Rights, including call to address the underlying social, economic and environmental determinants of health; to abandon all practices that fail to respect the rights, will and preferences of all persons; de-institutionalization; to prevent over medicalisation and to promote and respect the enjoyment of the rights to liberty and security of person and to live independently and be included in the community.

In full realization of all human rights as enshrined in the CRPD, and especially the human right to live independently and be fully included in communities (Article 19, General Comment 5), we want (1) to be able to decide our place of residence and who we want to live with (2) have access to a range of in home, residential and / or community support services nearby our places of residence (3) be included in all services available on equal basis with others and (4) all services should be responsive to our specific needs.

*Call for Actions*

That recognize, inclusion of persons with psychosocial disabilities involves a paradigm shift and reframing of policy environment from medical model to social model; mental disorder to psychosocial disability; public health to inclusive development; institutionalization to inclusion; treatment to support systems, evoking the guidance of CRPD and the SDGs to bridge such reframing;

- That will place Inclusion of persons with psychosocial disabilities as the purpose, process and outcome of all social, legislative, policy, program, service actions, across all sectors, involving all actors including, but not limited to health care, and within all Development agendas, plans, programs, and partnerships for change,
- Going beyond recent harm reduction approaches for example, by the WHO, to revive and reform towards 'humane' mental health care; and also expressing apprehensions about the continuing 'reform' efforts to maintain the systemically flawed, archaic colonial designs of psychiatric.

---

40 CRPD/C/GC/3 (2016) General Comment on Women with disabilities.
41 CRPD/C/GC/5 (2017) General Comment on Right to Living independently and being included in community.
43 A/70/797
44 A/71/314
45 A/HRC/37/56
46 A/HRC/34/55
47 A/72/137
48A/HRC/35/21
49 A/HRC/34/32
detention; and concerned that the WHO Quality Rights\textsuperscript{50} would be wrongly considered as the solution to our problem of inclusion,

- Adopting the movements for non-violent, peer led, trauma informed, community led programs, healing, cultural practices preferred by local groups of persons with psychosocial disabilities; attentive to the movement of non-medical alternatives worldwide, and in the Asia Pacific region; and progressive models for support in the communities,

We submit, the following measures be realized, with the due consideration that persons with psychosocial disabilities be engaged at every step-

- The right to education be realized within all educational systems supported by reforms towards lifelong learning; access to alternative and augmentative means of communication such as non-verbal / arts based expression; reasonable accommodation; access to flexible programs and a range of support services; prohibition of hazardous, forced or over medicalization and institutionalization of children;
- The right to work and employment be realized with the inclusion of persons with psychosocial disabilities in all job markets, employment exchanges, job placements and support for livelihood opportunities; provision of support, flexible hours and reasonable accommodation within work places; disability benefits at work, on equal basis with others; due recognition of contributions; possibilities of professional growth, access to trainings, promotions, etc. on equal basis with others;
- The right to adequate standards of living and social protection be realized for the inclusion of persons with psychosocial disabilities in all social security programs; the right to food ensured; the right to housing being of utmost importance, especially for relieving the persons in detention / shackled in the region, to prevent institutionalization and to live in communities; social protection schemes to help persons to escape poverty and to thrive; such schemes be designed to ensure the dignity, respect, autonomy and independent living of all persons with psychosocial disabilities.
- The right to health care be realized including comprehensive general health care, on equal basis with others; that psychiatric care does not become a barrier to access highest standards of health and wellbeing; that reporting of iatrogenic concerns by persons with disabilities and their families (for example, zombiism, tardive dyskinesia, Parkinson's, psychosis, suicidal ideation and behaviours, in addition to metabolic, cardiovascular and other general health complications) be recognized and addressed; various kinds of culturally sensitive healing and well-being methods, including diet therapy, yoga, tai chi, qi gong, meditation, trauma informed counselling, talk therapies, arts therapies and other, be available within health care coverage;
- Program measures be available for de-institutionalization, ensuring community support systems, such as personal assistance, community circles of care, peer support, formal and informal networks for support, family empowerment, listening spots, refuge / drop in / quiet rooms, spaces for creative expression, personal insight building especially about crisis, support persons trained to dialogue and negotiate the safety on the basis of the will and preference of persons with psychosocial disabilities, support to be available nearby where the person is living, especially concerning the homeless, and environments of peace and safety within communities;

• The **Right to political participation** is ensured in all countries of the region, especially the right to vote, stand in elections, and hold public office;

**We recommend,**

That, our right to full and equal recognition before the law be immediately recognized by all countries in our regions; that laws be so harmonized with the CRPD so that no one with a psychosocial disability shall ever be denied a civil, social, political, economic or cultural rights on the basis of 'incapacity' or 'unsoundness of mind'; that the legal system be cleansed of its colonial legacy, especially in the Commonwealth;

That, the dictum of 'Nothing about us without us' be ensured in all processes including the development of technical, ethical and other guidelines, policies, legislations, and any other efforts towards our inclusion;

That, all United Nations and allied agencies, aid agencies, and global actions of governments towards the development of our regions, including the WHO, to consider our participation and inclusion in all co-operations towards inclusive development; that all such actions be mindful of the paradigm shift from mental health to inclusion;

**We aspire,**

• To the extent that all such progressive actions for our inclusion are in our interest, to contribute to those actions through co-operations on trainings, capacity building, guidance on inclusion, research and any actions thereof, towards re-directing the legislative and policy environment towards inclusion;

• To work with organisations whose goals are aligned with ours, and which respect the principle of leadership and full and effective participation of persons with psychosocial disabilities and our expertise on all matters that concern our lives and our rights, in the drive for social change;

• To have a meaningful place in our societies, be it through paid work, social justice work, creative work, informal care and support work, or so on. We believe that an environment that facilitates the full development of our human potential in all its diversity will also further the social, economic, cultural and political advancement of our societies.

*Declaration adopted by TCI Asia Pacific*

5th ‘Classic Edition’ Plenary of TCI Asia Pacific,

Bali, Indonesia, 29th August 2018.
TCI Asia Plenary in Bali, August 2018

Proposed draft proceedings

Dates: 27-28-29 August 2018. 30th- Steering Committee meeting.

Format of the plenary:

As has become a norm, the plenary format will have the following elements:

- Pre-preparation for new country members (26th mid-afternoon) and 'catching up' sessions in the evenings
- Market Place (Country status reports on status of persons with psychosocial disabilities)
- Capacity building and learning cycles on Inclusion (Presentation of Inclusion synthesis report; Dialogue on WHO Quality Rights; focus on mainstreaming of persons with psychosocial disabilities in different development areas)
- Proceedings of TCI Asia on organizational matters: (AGM simulation and testing format; Refreshing Code of Conduct; Approval of TCI Asia Pacific and decision on logo; Sharing 1 year works and budgets; Memberships status; New members to SC; Way forward); News on registration and issues thereof
- This year, additionally, there will be a steering committee meeting, of country members, and where needed their deputies;
- Platform for dialogue with technical assistance agencies and other stakeholders from the cross-disability movement, if budgets permit
## Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday 27th</th>
<th>Tuesday 28th</th>
<th>Wednesday 29th</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.00-09.50</td>
<td>Introduction and Market place</td>
<td>E. Work and employment</td>
<td>H. Self preservation</td>
</tr>
<tr>
<td>10.05-11.00</td>
<td>A. Reframing the momentum(S)</td>
<td>5. Children with psycho-social</td>
<td>6. Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MH movement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ASEAN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pacific</td>
</tr>
<tr>
<td>11.15-11.55</td>
<td>B. Updates from the Global level</td>
<td>F. Social protection (cash benefit, social housing..)</td>
<td>I. Adoption of the Bali declaration</td>
</tr>
<tr>
<td>12.00-13.00</td>
<td>1. WHO Quality rights</td>
<td>2. Special rapporteur report</td>
<td>7. Women with disabilities</td>
</tr>
<tr>
<td></td>
<td>2. Special rapporteur report</td>
<td></td>
<td>8. Disability determination</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Plenary Decisions</td>
</tr>
<tr>
<td>14.15-15.05</td>
<td>C. The inclusion report(s)</td>
<td>G. Kenya case study</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>STEERING COMMITTEE</td>
</tr>
<tr>
<td>16.30-17.30</td>
<td>3. Advocacy for change</td>
<td>4. Community support system</td>
<td>Feedback groups in plenary on cross cutting issues</td>
</tr>
<tr>
<td></td>
<td>4. Community support system</td>
<td></td>
<td>Preparation planning and decision plenary</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOCIAL EVENT</td>
<td></td>
<td></td>
<td>Preparation of the declaration</td>
</tr>
</tbody>
</table>

56