TCI RESPONSE & STATEMENT

WITHDRAW the Proposed WHO & OHCHR Guidance on MH, Human Rights and Legislation

We, in TCI, a global OPD of persons with psychosocial disabilities, warmly welcomes the adoption of the Guidelines on De-Institutionalization [DI] including during emergencies by the CRPD committee at the 27th Session.[1] We express gratitude to the Working Group (WG) on DI, the CRPD Committee and their Secretariat team for the tireless work and guidance in bringing out this all-important resource on realizing the right to live independently and be included in the community. We are honoured to be a member of the Global Coalition on De-institutionalization (GC-DI), in supporting this initiative. The Committee ensured the widest possible participation of and leadership by persons with disabilities and their organizations.

At the same time, the WHO along with the OHCHR published a draft Guidance on Mental Health, Human Rights and Legislation, soliciting feedback from stakeholders.[2] The guidance takes the place of earlier WHO resources on mental health legislations[3]. We appreciate the purpose of this guidance: to evolve a CRPD compliant mental health law against a background of a continuing trail of efforts by various UN human rights mechanisms to address the gap in human rights standards of this particular piece of legislation, worldwide, through guidelines, resolutions, general comments, concluding observations, etc. We also further anticipate the forthcoming resources on community support systems and services from the Office of the High Commissioner of Human Rights and the Special Rapporteur (Disabilities).

The failure of earlier guidance's on improving these laws and their institutions, the harms caused, the lives lost and damaged, and the many decades of tireless struggles by survivors of institutions, persons with 'mad' or 'unsound' identities, with psychosocial disabilities to simply establish their experience that these laws perpetrate violence and torture, need no further evidence[4,5,6,7]. After the advent of the CRPD, the Global South experienced the hugely negative impact of new legal harmonization efforts by health systems, leading to unimaginable increase in the number and diversity of institutions practising disability-based incarceration. Reservations on

[1] https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpdc273-guidelines-deinstitutionalization-including

[2] The consultation, where participation by OPDs was limited, ended in August. See https://www.ohchr.org/en/calls-for-input/calls-input/draft-guidance-mental-health-human-rights-legislation-who-ohchr

[3] WHO. (2005). WHO Resource Book on Mental Health, Human Rights and Legislation. Geneva. This resource influenced many global south countries which did not have mental health laws, to adopt one.

[4] A/HRC/43/49

[5] A/HRC/47/L.18/Rev.1

[6] A/HRC/40/54

[7] A/HRC/44/48

Article 12, the legacy of 'incapacity' laws entrenched within legal systems, the policy stranglehold of colonial ways of treating 'lunatics' and 'idiots', remained through the legal harmonization efforts, subverting the jurisprudence of the CRPD. The number of institutions increased, both public and private; as did the human rights violations.

These laws, which purportedly support community mental health, incite interest politics within families, pushing some persons to be the commodity piece in the 'trade on lunacy'[8] between different stakeholder groups. Through accusations of 'insanity' evoking competent authorities designated by the State, these laws make the person with psychosocial disability a subject of family contest and conflict, the usual consequences being the deprivation of capacity and liberty. **This has nothing to do with care**: Persons with psychosocial disabilities not only have to ensure their own safety from these laws, they also have to fill the care gap by inventing and innovating choice of peer led practices in their own healing and recovery. It's a terrible burden to carry. Health systems need to revert back to their chief role of care and not custody. The DI guidelines is a fitting response to this law, and its consequences on us, offering a new worldview to realize the right to community inclusion.

We, along with Validity Foundation, ENIL and DRI, raised serious concerns regarding this draft guidance[9], which gives guidance on new content for another version of mental health law. In particular, there are concerns that the extensive text falls beneath the purpose and objects of the Convention (art. 1), the general principles and obligations of States parties (arts. 2 and 3), the right to equality and non-discrimination (art. 5), the rights to equal recognition before the law and access to justice (arts. 12 and 13), liberty and security, protections again torture, ill-treatment, exploitation, violence and abuse (arts. 14-16), the integrity of the person (art. 17), and undermining the right to independent living and inclusion in the community (art. 19). There are also concerns that the proposed guidance adopts approaches that undermine respect for privacy (art. 22), do not sufficiently promote a human rights-based approach to the right to health (art. 25), nor the rights to an adequate standard of living and social protection (art. 28) and the centrally important right to participation in political and public life (art. 29).

[8] https://warwick.ac.uk/fac/arts/history/chm/outreach/trade_in_lunacy/research/introduction/
[9] https://www.ohchr.org/en/calls-for-input/calls-input/draft-guidance-mental-health-human-rights-legislation-who-ohchr

Of concern to us, is that this guidance embeds the usual legal algorithms found in earlier mental health laws of disqualifying us of our human rights, providing for substituted decision making and creating legal 'loop holes' for custody and coercion to overshadow care. The concept of 'free and informed consent' is predominant in the text, presiding over choosing 'inpatient service', ECT, psychosurgery, etc. As an example, we share this piece where there is threat of coercion in the guidance given: '*A lot of work, time and flexibility may be needed, so the person understands the nature and need for the procedure. Also, adjustments may be required to ensure the person is comfortable with some procedures*…' (2.3.4). With such guidance, health care professionals can prolong their negotiations with people, who are basically persons with disabilities, to persuade, encourage, pressure and ensure treatment and have recourse to a law that guarantees that this procedure is not torture, but is still within the scope of 'free and informed consent'.

Various other service descriptions invoke the institutional imagination: e.g., the detailed attention paid to the environment inside the services, hygiene and sanitation, not using the patients as unpaid labour, references, in the context of accountability and M&E mechanisms, to 'inspections', 'untoward incidents', maintaining 'death records', and 'permitting reviews of institutional practices'. Further, there are formulations suggested, of 'withdrawal of accreditation and closure' and impunity measures for not being culpable for actions done with good intention, other than dozens of references to 'inpatient services'.

Nowhere does the guidance say that the violence against persons with psychosocial disabilities within institutions must immediately, absolutely stop. The guidance does not prohibit ECT and psychosurgery. If adopted, there would be the perpetration of violence, abuse and exploitation, and the application of inhuman, cruel, degrading torturous treatments against persons with psychosocial disabilities for the next decades, going against the very grain of the CRPD.

The guidance itself endorses, in its best parts (Chapter I) that there is no need for a stand-alone mental health law. There is no need for this guidance, which will fuel countries to once again amend or create mental health laws, without removing the coercive elements therein. Any future efforts in addressing mental health legislation should start afresh, with full and effective participation of representative OPDs of persons with psychosocial disabilities, eliminating and immediately stopping the

torture and violence perpetrated by the system; harmonizing with the recently adopted DI guidelines; providing guidance on the retreat of mental health law; dismantling institutions in all its variety; addressing serious concerns around the role of law and order machinery and forensics entrenched in the MH system; ensuring their retreat; and addressing the diversity of psychosocial needs of persons with disabilities and populations in a humane, CRPD compliant way.

For more information regarding this, please follow @TCI_Global and follow the hashtags **#WithdrawWHOGuidance #AbolishMHlaws**

You can also write to us at secretariat@tci-global.org