"Stronger Together" Disabled Feminist Leaders and Movements

*Wednesday, **June 14, 2023***
4:45pm to 6:00 PM
Conference Room C, United Nations Headquarters, New York

Bhargavi Davar, Transforming Communities for Inclusion, India (10 mins):

Building a supportive and sustainable community of and for people with disabilities is central to collectivization and strengthening movements. Bhargavi's intervention highlights what it means to build a community for people with mental and psychosocial disabilities and those who have neurodiverse identities. Some of the questions her intervention aims to answer are - what does inclusion mean in practice? How does inclusion for people with disabilities cross intersecting identities, including gender? What tools for advocacy have been most successful in this work? Where do you see opportunities for further collaborative work across movements to ensure rights and well-being for all?

I would like to start with the question of 'representation'. TCI began as an idea 10 years ago, with the entry of the CRPD. Before that, there were individual leaders but no movement as such, in the global south for persons with psychosocial disabilities.

We started out with the identity question, who are we and who shall we include? We were seen as 'patients', subjects of health systems, or as 'accused of unsound mind', subjects of the mental health laws. This is especially the case in Commonwealth nations, where old colonial ways of seeing us as fit for institutions and coercive care still prevails. Once we entered the mental health system, we were denied personhood, through associated legal incapacity laws: Around the world, for millions of persons, past and present, there would have been daily struggles between family, psychiatrists and persons of 'unsound mind' to retrieve any semblance of personhood and decision- making rights. Patriarchial hegemony made it that much worse for women, girls and persons on the gender spectrum, as gender non conformity was often legal grounds for a charge of unsound mind.

The other context was about the difference in identity positions between the global north and south, making global movement building challenging. 'Users and survivors' the preferred identity position in the global North, subverted patient status, but still remained in orbit with psychiatry, occupying the opposite pole. In the global south, there were few services available. So there were very few angry 'users and survivors' of psychiatry. The CRPD gave us the opportunity to start afresh on the identity question.

Here, we remember our erstwhile leaders from the WNUSP and elsewhere, who collectivized to have us included within the CRPD, and struggle for the articulation of some key articles, on Legal capacity, Liberty, right to bodily and mental integrity and the right to live independently in the community. We view the CRPD as a potent decolonizing

instrument for under represented groups, returning our personhood back to us and a potential for a new positive identity.

We started by including persons who self-identified as persons with psychosocial disabilities, irrespective of any medical associations they may have had. Neurodiverse persons, LGBTQI+ persons, indigenous people caught in the nexus of a globalizing mental health industry, autistic persons, those who were disqualified as 'unsound', 'mad' activists', including the traditional 'users and survivors of psychiatry' started joining our movement. In the global North, some U/S organizations were also shifting their own location, joining in the CRPD monitoring process, and building bridges with the national cross disability umbrella.

Therefore, we witnessed transitioning identities and becoming more political with the guidance of the CRPD. To fuel this process, we hold learning sessions, share experiences across different identities globally. People gather together on collective experiences of violence faced in the care system, institutionalization, being denied right to decision making, and an over determined patriarchal, systemic violence and a severe epistemic injustice done to them, obliterating their traditional ways of being, their expressions and their communities.

TCI effected a paradigm shift in our advocacy location- from 'mental health' to 'inclusion'. We side stepped the polemics of engaging with mental health care system, psychiatry versus anti-psychiatry. We do not ask for reforming the mental health care system. The arena of play in this polemic was too small, focused only the right to health and informed consent. As long as those vicious laws exist, we do not expect change from that system of care.

We wanted so much more, guaranteed by the CRPD and the SDGs. To convey the idea, we use a '3 Door metaphor' or talk about 'shifting the entry point'. The Mental Health door is pretty small and obliterates us. A larger SDGs door allows us to raise issues of social justice and opportunity; The human rights door, being the largest, provides us maximum safeguards for ensuring that our community lives are not interrupted. Following our studied advocacy on the 'entry point', several organizations changed their name towards Inclusion and registered as OPDs.

To build individual identity positions, especially of emerging leaders in different countries, has gone hand in hand with developing several program instruments, such as Fellowships, Microgrants, OPD support grants, Country Missions, Multi stakeholder meetings, and so on. By now we have strong OPDs in several countries which did not have them before. Some are engaged in advanced advocacy at the national level, for example, on De-institutionalization, petitioning in courts against legal capacity, guardianship, etc. Some members have evolved community support practices on community inclusion of persons with psychosocial disabilities.

Withdrawing our location within 'mental health', resisting the 'legal shackling' that we are subjected to, we do keep a core interest in developing personalized and specific psychosocial support systems and services in communities. Organizations have been evolving support programs by changing the entry point, not engaging so much with 'treating mental disorders' but with providing housing, employment, social protection,

completing education, creating support groups, offering peer support, trauma informed support, having 'listening or storying hubs' and enabling violence free environments.

For example, Bapu Trust, an organization I have been associated with since the last 20 years, was ambitious to build a CRPD compliant support program, and evolved what they call an Eight Point Recovery Framework, which includes self-care, nutrition and fitness for overall wellbeing, family empowerment, skills and livelihoods, individual and group peer support, and connecting people with a variety of mainstream services in the community. To release people from high restriction to community participation, the program specializes in conflict resolution, setting up community dialogue spaces, prevent institutionalization, deploy bystander ethics, arbitration methods, empowering families and neighbourhood on disability inclusion and changing the overall psychosocial ecosystem of communities.

So, the Bapu Trust, like many of our member organizations, are 'transforming communities for inclusion' using their own culturally relevant ways of organizing for support and community justice. This, and other such programs, show that a solution to a legal problem (denial of capacity) is not always legal. Supported decision making involves deep engagement with communities and mobilizing neighbourhoods and networks in support. Circles of care can be mobilized around persons with psychosocial and other disabilities to lead the way to their inclusion. Building such circles must be an independent funding strategy.

The most important strategy that we have used to build cross movement alliance, is to encourage and plan for engagement of our members with the national cross disability alliance. At the global level, the IDA has been our closest ally and partner, supporting our movement since a decade or more, providing opportunities to engage various stakeholders. The cross-disability values and advocacy agendas helps our members to see that there is a wider world out there, and to stay closed in the 'mental health' agenda clips our wings. It helps to decolonize ourselves, drop the chip off our shoulders, and get into the arena with disability rights arsenal. It has not been easy to build that partnership, but atleast in global and regional spaces, this alliance is being welcomed.

I want to specifically highlight the programs we have been offering to our members, on country missions and multi stakeholder meetings. When we mobilize in a country, at Mission level, we organize around strengthening the capacity of the local OPD, bringing members together, training on CRPD, gathering needs and building an advocacy canvas. Following this, a wide range of stakeholders are invited for a 'dialogue', where the national OPD leaders present their advocacy canvas. The stakeholders range from national UN agencies, HR institutions, women's groups, organizations against institutions, LGBTQI+ groups, human rights groups, justice officers, CSOs, donors, etc. and ofcourse with the partnership of the national cross disability movements. We have seen change in several countries and in sub regions, and interest to build more inclusive disability spaces in policies and programs.

Thank you!