



## **Transforming Communities for Inclusion (TCI Global)**

### **Response to the four questions raised by the UN Secretary-General (OHCHR) in the letter to the UK Permanent Representative in Geneva, dated 23 June 2025**

#### **Introduction and Statement of Support**

Transforming Communities for Inclusion (TCI Global) is a post CRPD movement, and a membership based global organization of persons with psychosocial disabilities with members in 18 countries.<sup>1</sup> The identity of persons with psychosocial disabilities is derived from the Convention on the Rights of Persons with Disabilities (CRPD) description of disability and is inclusive of persons who identify as ‘users and survivors of psychiatry, ‘mad’ persons’, persons who have been targeted as ‘of unsound mind’, autistic persons, persons with intersectional and neurodiverse identities, including persons with psychosocial disabilities. Empowered by the extraordinary vision and guidance of the Convention, TCI’s purpose is to situate them at the centre of the cross-disability movements at the national, regional, and global levels, to reclaim their dignity and autonomy and experience independence to realize their right to live in the community.

This submission is made in full support of, and as a complement to, the detailed shadow report submitted by Liberation, which is a full member of TCI from the UK. Through this submission, we aim to reinforce our member OPD’s concerns by contributing an international perspective grounded in the experiences and positions of the global movement. The submission highlights how the UK’s proposed Mental Health Bill reflects the same patterns we see across contexts in terms of coercion, institutional control, denial of legal capacity and the continued dominance of the medical model undermining the legal obligations as set forth in the CRPD.

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<sup>1</sup> <https://tci-global.org/>

## TCI's responses to questions posed by the Secretary-General (OHCHR)

**Question One: the measures adopted to ensure the removal from the text of the proposed “Mental Health Bill” (Bill 225) of provisions allowing for the deprivation of liberty of persons with disabilities on the basis of actual or perceived impairment, in conjunction with any other criteria, such as posing a danger to oneself or others.**

In line with the concerns raised by Liberation, the Mental Health Bill seeks to redefine grounds for disability specific deprivation of liberty. From the CRPD and global movement of persons with psychosocial disabilities perspective, we confirm that these provisions that continue to allow detention based on disability combined with a risk assessment are in direct contravention to the Convention. Article 14 explicitly provides that *“the existence of a disability shall in no case justify a deprivation of liberty,”* meaning that any law allowing institutionalization or forced detention, linked to mental disorder whether for risk prevention or treatment, is inherently discriminatory. Adding criteria such as “risk to self or others” does not address the discrimination, because the threshold criterion remains the disability label, amounting to discriminatory profiling.<sup>2</sup>

Any grounds or reasoning justifying forced detention and deprivation of liberty based on disability is not aligned with the CRPD principles. We can affirm through our experience as persons with psychosocial disabilities that the moment we are ‘diagnosed’ or given a label of being a patient or a person with mental illness or mental disorder, we can be put away in an institution (of any form or shape), without our consent or choice, and more often, on the recommendation of a healthcare provider, family members or community persons. Historically, and unfortunately even today, this forced detention has been justified citing as ‘being done in our best interest’ and we have vehemently rejected this paternalistic thinking and emphasized that coercion can never be care for us. These paternalistic justifications or inadequate community services cannot legitimize such coercion, which is inherently discriminatory and incompatible with the CRPD’s human rights model.<sup>3</sup>

Risk approach has always projected persons with psychosocial disabilities as violent, dangerous and a threat to themselves and society, and it is deeply rooted in negative stereotypes, historical misrepresentation and ‘othering’ of any experience that deviates from the norm. Terms such as ‘persons with unsound mind’ ‘lunatics’ ‘persons with mental illness’ etc. are still present as legal identities in laws and policies across

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<sup>2</sup> Minkowitz, T. (2011). *Prohibition of Compulsory Mental Health Treatment and Detention Under the CRPD* (SSRN Scholarly Paper 1876132). Social Science Research Network. <https://doi.org/10.2139/ssrn.1876132>

<sup>3</sup> Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/22/53). Geneva: United Nations Office of the High Commissioner for Human Rights. [https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53\\_English.pdf](https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf)

the globe.<sup>4</sup> This stereotyping translates into denial of autonomy and enforcement of substituted decision-making regimes, practiced informally within homes and institutions and formally through guardianship and conservatorship.<sup>5</sup> This is as good as ‘legal shackling’, over and above the physical shackling that persons with psychosocial disabilities are subjected to’.<sup>6</sup>

Drawing from the evolving CRPD jurisprudence and a high level of participation by the cross disability movement, some United Nations bodies through their offices have called disability based detention/forced detention as deprivation of liberty, unlawful and arbitrary<sup>7</sup>; form of violence<sup>8</sup>; de facto denial of capacity<sup>9</sup>; and called for facilitating an immediate move towards ending all forced psychiatric treatments and confinements.<sup>10</sup> Activists and senior leaders of the movement have demonstrated and explained in nuanced details as to how forced institutionalization (and forced psychiatry) amounts to torture. The four main elements (severe pain or suffering, intent, purpose and State involvement) defining torture fits the description of forced institutionalization.<sup>11,12,13</sup> Forced institutionalization, seclusion, and non-consensual interventions deny bodily integrity, and freedom from torture or ill-treatment and they re-traumatize rather than support recovery.<sup>14</sup>

Our constituency has long documented how forced detention also leads to worst forms of abuse, violence and violations within these settings.<sup>15,16,17,18</sup> The UK has also

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<sup>4</sup> TCI. (2025). *Submission to the Committee on the Rights of Persons with Disabilities on the Day of General Discussion (DGD) on Article 29 of CRPD*. <https://tci-global.org/wp-content/uploads/2025/02/TCI-Global-Submission-for-General-Comment-on-Article-29-CRPD.pdf>

<sup>5</sup> TCI. (2025). *Submission for the Half-day of general discussion on gender stereotypes to CEDAW Committee*. <https://tci-global.org/wp-content/uploads/2025/02/Submission-for-Half-Day-Discussion-on-Gender-Stereotypes-by-TCI-WEI-and-II.pdf>

<sup>6</sup> *Statement of Expert Testimony on the topic of Legal Capacity and Guardianship of persons with disabilities, before the Hon. Constitutional Court of Indonesia.*, Hon. Constitutional Court of Indonesia (2023). <https://tci-global.org/wp-content/uploads/2024/02/Submission-Indonesia-Constitutional-Court-Expert-Testimony-TCI.pdf>

<sup>7</sup> A/HRC/40/54

<sup>8</sup> Accelerating efforts to eliminate all forms of violence against women and girls: preventing and responding to all forms of violence against women and girls with disabilities. (A/HRC/47/L.18/Rev.1). United Nations. Available: <https://documents.un.org/doc/undoc/tld/q21/176/46/pdf/q2117646.pdf>

<sup>9</sup> CRPD/C/5

<sup>10</sup> A/HRC/35/21

<sup>11</sup> *Concept note: International Seminar Commemorating the Day of Support for Victims of Torture ‘Hidden Torture: Institutionalization of Persons with Disabilities in Indonesia’*. (2023). <https://tci-global.org/wp-content/uploads/2023/08/Hidden-Torture-Concept-Note-Updated.pdf>

<sup>12</sup> Esq, T. M. (2015, April 30). Forced Psychiatry is Torture. *Mad In America*. <https://www.madinamerica.com/2015/04/forced-psychiatry-torture/>

<sup>13</sup> Halmi, A. (2004). *COERCIVE PSYCHIATRY A TORTURE SYSTEM*. 2. [https://www.iaapa.de/zwang/zwang2/halmi\\_english/](https://www.iaapa.de/zwang/zwang2/halmi_english/)

<sup>14</sup> TCI Global. (2025). Restoring dignity and autonomy: Global best practices as alternatives to involuntary hospitalization and treatment and pathways for reform in Armenia. Prepared for the Helsinki Citizens' Assembly Vanadzor Office (HCAV). Available: <https://tci-global.org/wp-content/uploads/2025/08/Global-Best-Practices-for-Reform-in-Mental-Health-Landscape-in-Armenia.pdf>

<sup>15</sup> Lewis, J. (2019, November 8). On Admission To Wrekin. Recovery in the Bin. Available: <https://recoveryinthebin.org/2019/11/08/on-admission-to-wrekin/>

<sup>16</sup> Reygan, J. (2022). Personal experiences of the psychiatric treatments in hospitals and community mental health services. *#WhatWENeed*. <https://whatweneed.tci-global.org/wp-content/uploads/2023/02/Personal-Experiences-of-Psychiatric-Treatments-in-Hospitals-Community-Mental-Health-Services.pdf>

<sup>17</sup> Wield, C. (2022). Extract from: ‘Change of Mind; escaping the shackles of the psychiatric system’. *#WhatWENeed*. <https://whatweneed.tci-global.org/wp-content/uploads/2023/01/Cathy-Wield-December-2022.pdf>

<sup>18</sup> Prax, C. (2025). Ending institutionalization (including involuntary detention in psychiatric hospitals and forced treatment). *#WhatWENeed*. <https://whatweneed.in/wp-content/uploads/2025/01/Blog-from-Cheryl-Prax.pdf>

witnessed repeated public exposures of abuse and violence in mental health settings, underscoring the systemic harm inherent in institutional models of care.<sup>19,20,21</sup>

While the movement is using the language of reparations and redress for a historically oppressed and marginalized group, the UK Mental Health Bill cannot continue to recommend forced detention as a solution to issues related to mental health, treatment, or care.<sup>22,23</sup> There are examples from countries such as Japan and Guatemala, where discussions have started on reparations and acknowledging centuries of harms towards our constituency.<sup>24,25</sup>

The CRPD reinforces the human rights model of disability and encourages all stakeholders to imagine and implement a practical world where supports and solutions are located within communities, rather than hospitals or institutions. Deinstitutionalization and community inclusion have been taken up strongly in high-level policy spaces. In 2022, the CRPD Committee adopted the UN Guidelines on Deinstitutionalization, which provide State Parties with a clear, step-by-step framework to implement deinstitutionalization and enable community-based support models.<sup>26</sup> OPDs across the world are already leading the way by implementing community-based, rights-based, non-coercive, and CRPD-compliant models of support, including during crisis or high-risk situations.<sup>27</sup>

If passed, the current provisions of the Bill would reinforce the medical model of disability, which is highly incongruent with the CRPD and undermines this global movement toward dignity, autonomy, and community living.

**Question Two: the measures adopted to ensure the removal from the text of the proposed “Mental Health Bill” references portraying persons with disabilities as “patients”, and measures to ensure that the “mental health bill” is consistent with the standards and principles of the Convention on the Rights of Persons with Disabilities.**

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<sup>19</sup> TCI. (2023). *House of Horrors, Tale of terror: Sadly, nothing new here An opinion piece on the BBC Panorama undercover investigation of the Edenfield Mental Health Care unit, UK.* [https://whatweneed.tci-global.org/wp-content/uploads/2023/01/WhatWENeed-submission\\_TCI\\_Final.pdf](https://whatweneed.tci-global.org/wp-content/uploads/2023/01/WhatWENeed-submission_TCI_Final.pdf)

<sup>20</sup> Care firm's leadership criticised by Care Quality Commission. (2020, January 14). *BBC News.* <https://www.bbc.com/news/health-51092495>

<sup>21</sup> West Lane Hospital: Mental health care 'chaotic and unsafe'. (2023, March 21). *BBC News.* <https://www.bbc.com/news/uk-england-tees-65013550>

<sup>22</sup> *COSP15 Side Event on Remedy and Reparation for Institutionalization.* (2022). [Video recording]. <https://www.youtube.com/watch?v=UOSp7I9z0Nk>

<sup>23</sup> Minkowitz, T. (2024). Deinstitutionalization as Reparative Justice: A Commentary on the Guidelines on Deinstitutionalization, including in Emergencies. *Laws*, 13(2), Article 2. <https://doi.org/10.3390/laws13020014>

<sup>24</sup> *IACHR files application before Inter-American Court in case concerning violations of the human rights of patients at Federico Mora Hospital in Guatemala.* (2025). [https://www.oas.org/en/iachr/jsForm/?File=/en/iachr/media\\_center/preleases/2025/119.asp&utm\\_content=country-gtm&utm\\_term=class-corteidh](https://www.oas.org/en/iachr/jsForm/?File=/en/iachr/media_center/preleases/2025/119.asp&utm_content=country-gtm&utm_term=class-corteidh)

<sup>25</sup> Japan top court says forced sterilisation unconstitutional. (n.d.). *BBC UK.* <https://www.bbc.co.uk/news/articles/c0krnjy72j0o>

<sup>26</sup> CRPD/C/5

<sup>27</sup> TCI Global. (2025). Restoring dignity and autonomy: Global best practices as alternatives to involuntary hospitalization and treatment and pathways for reform in Armenia. Prepared for the Helsinki Citizens' Assembly Vanadzor Office (HCAV). Available: <https://tci-global.org/wp-content/uploads/2025/08/Global-Best-Practices-for-Reform-in-Mental-Health-Landscape-in-Armenia.pdf>

Identifying persons with psychosocial disabilities solely as “patients” is disempowering because it reduces us to passive clinical subjects whose lives are framed through treatment, compliance and medical control. This patient-only identity erases autonomy, makes dissent or emotional expression appear pathological, and often leads to legal and social disempowerment, including forced treatment and institutionalization.<sup>28</sup>

OPD movements have long advocated for a more empowering identity of being persons with psychosocial disabilities, introduced to us after the adoption of the CRPD.<sup>29,30</sup> Being identified solely as patients inadvertently ties us to the medical model of disability, where our support needs are framed entirely within the discourse of medical solutions and institutions.<sup>31</sup> When we are seen only as patients, one aspect of our life overshadows everything else. We cease to be full persons. It is a peculiar characteristic of these systems that any diagnosis or label of mental disorder, mental illness or identification as psychiatric patients turns us into medico legal subjects and strips us of our legal capacity and we become non-persons in the eyes of law.<sup>32,33,34</sup> We can be detained or forcefully uprooted from our homes because we become patients who need to be managed rather than right holders, with full rights on an equal basis with others.

In line with the points noted by Liberation, being called a ‘patient’ also reinforces harmful stereotypes. We are assumed to be incapable of making decisions, in need of treatment to ‘get better,’ and often medicated to the point of emotional suppression, often against our will and consent. Because the medical model only sees medical solutions, we are rendered as subjects of psychiatric systems where forced detention and treatment become default responses. This patient-only identity underpins key powers in the Bill such as forced detention, involuntary treatment, and recall under Community Treatment Orders (CTO) and places people within a framework of clinical management and risk control, rather than autonomy and legal capacity.

Identifying as a person with psychosocial disability or a user/survivor is empowering and rights-based as it recognizes lived experience as a source of knowledge, resilience, and political identity, aligns with the CRPD’s human rights model, and

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<sup>28</sup> Davar, B. V. (2008). From Mental Illness to Disability: Choices for Women Users/ Survivors of Psychiatry in Self and Identity Constructions. *Indian Journal of Gender Studies*, 15(2), 261–290. <https://doi.org/10.1177/097152150801500204>

<sup>29</sup> TCI Global. (2018). Bali Declaration 2018. Available: <https://whatweneed.tci-global.org/bali-declaration-2018/>

<sup>30</sup> Transforming Communities for Inclusion – Global. (2022). Addis Declaration. Available: <https://tciglobal.org/wp-content/uploads/2023/11/Addis-Declaration-2023.pdf>

<sup>31</sup> TCI Asia Pacific (2020). ‘Reframing the momentum: From “mental health” to “inclusion” of persons with psychosocial disabilities’. Report of the Classic Edition Plenary of Transforming Communities for Inclusion (TCI) Asia Pacific, Pune. [Plenary report]. Available: <https://tci-global.org/wp-content/uploads/2022/05/TCI-Asia-pacific-classic-edition-plenary-report.pdf>

<sup>32</sup> TCI. (2023). *Legal Capacity Laws, Policies and Practices, and Women with Intellectual and Psychosocial Disabilities*. <https://tci-global.org/wp-content/uploads/2023/02/Background-Reading-Legal-Capacity-Round-Table.pdf>

<sup>33</sup> Davar, B. (2012). *Legal Frameworks for and against People with Psychosocial Disabilities*. 47(52).

<https://www.epw.in/journal/2012/52/special-articles/legal-frameworks-and-against-people-psychosocial-disabilities.html>

<sup>34</sup> Davar, B. (2022). The Discriminatory Standards of Constructing ‘Patienthood’ of the ‘Mentally Ill’ within Public Health. *#WhatWENeed*. <https://whatweneed.tci-global.org/wp-content/uploads/2022/11/The-Discriminatory-Standards-of-Constructing-%E2%80%98Patienthood-of-the-%E2%80%98Mentally-Ill-within-Public-Health-for-WhatWENeed.pdf>

connects individuals to peer networks, advocacy movements, and collective empowerment.<sup>35</sup>

The Mental Health Bill must not continue usage of forced measures in spite of decades of advocacy and experience sharing by leaders and peers of this movement, past and present. This approach of framing individuals solely as patients is incompatible with the CRPD's human rights model, which recognises persons with psychosocial disabilities as full rights-holders entitled to liberty (Article 14), equal recognition before the law (Article 12), and community inclusion (Article 19). Reframing identity away from 'patient' toward that of a person with psychosocial disability is critical to uphold dignity, agency, and CRPD-compliant law reform.

**Question Three: The measures adopted to secure that the “Mental Health Bill” ensures that the provision of community-based mental healthcare services is available to everyone, including to persons with disabilities, and that the provision of health services, including mental health services, is based on the free and informed consent with the person with disability concerned, through supported decision-making and not by third party interventions.**

TCI also aligns with Liberation's concern that the proposed Mental Health Bill does not ensure the scale or nature of community-based services required under Article 19 of the CRPD. Expanding services without removing the legal basis for disability-based detention and forced treatment risks replicating institutional harms in the community.

The bill seeks to maintain Community Treatment Orders (CTO), which are coercive mechanisms allowing people with psychosocial disabilities to live in the community under conditions of control and surveillance. They extend the clinical gaze into private and intimate spaces, transforming homes into sites of monitoring. CTOs reinforce the medical model by treating the individual as 'community patient' on conditional release, rather than a rights-holder entitled to autonomy and support. Persons with psychosocial disabilities have described CTOs as a form of 'chemical incarceration'<sup>36</sup> often accompanied by threats of recall, routine check-ups, and conditional access to housing, employment, or services. This amounts to social control rather than support. There have been numerous attempts to demonstrate the efficacy of CTOs but most of have been unsuccessful and have also raised ethical and human rights concerns.<sup>37</sup> Persons with psychosocial disabilities have shared how CTOs identify them as risky, defective, in need of constant surveillance resulting them in feeling criminalized, disconnected, traumatized and gaslit.<sup>38</sup>

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<sup>35</sup> Davar, B. V. (2008). From Mental Illness to Disability: Choices for Women Users/ Survivors of Psychiatry in Self and Identity Constructions. *Indian Journal of Gender Studies*, 15(2), 261–290. <https://doi.org/10.1177/097152150801500204>

<sup>36</sup> Brosnan, L. (2018). Who's Talking About Us Without Us? A Survivor Research Interjection into an Academic Psychiatry Debate on Compulsory Community Treatment Orders in Ireland. *Laws*, 7(4), Article 4. <https://doi.org/10.3390/laws7040033>

<sup>37</sup> Maylea, C., Zirnsak, T.-M., Edan, V., Armitage, P., Robert, H., & Brophy, L. (2025). Ensuring compulsory treatment is used as a last resort: A narrative review of the knowledge about Community Treatment Orders. *Psychiatry, Psychology and Law*, ahead-of-print. <https://doi.org/10.1080/13218719.2024.2421168>

<sup>38</sup> Jager, F. (2021). *The Effect of Community Treatment Orders on Identity* [University of Ottawa]. <https://ruor.uottawa.ca/server/api/core/bitstreams/4bcc3ea4-02f5-4880-9472-5d28a1d01aba/content>

From the CRPD and global OPD perspective, CTOs constitute a form of substitute decision-making, where the person's autonomy and preferences are overridden by clinical authority, violating Article 12. The community becomes an extension of the institution rather than a space of freedom, care, and choice, undermining the right to live independently and be included in the community (Article 19). The UN Guidelines on Deinstitutionalization clearly call for the prevention of coercive practices like CTOs and emphasise the creation of voluntary, rights-based, and peer-led support systems.

We are also deeply concerned by the absence of adequate supported decision-making mechanisms in the Bill. These are essential to upholding autonomy and legal capacity under Article 12. Without rights-based and voluntary supports developed in collaboration with OPDs, the proposed reforms remain incompatible with the CRPD. Authority continues to rest with the 'responsible clinician' perpetuating the same power hierarchies that have existed for decades. There are progressive examples from Ireland<sup>39</sup> and British Columbia<sup>40</sup> on enabling supported decision making for persons with disabilities and legal reforms that uphold legal capacity of everyone above the age of 18 years and abolishing substituted decision-making regimes from Spain,<sup>41</sup> Mexico<sup>42</sup> and Colombia<sup>43</sup>. There are also examples from OPDs that have also demonstrated how peer support can be strengthened and utilized to enable supported decision making among peers.<sup>44,45</sup>

Community mental health centres have often been cited as extension of the '*clinical gaze and have tended to colonize the home settings in a 'panoptical' way, since the person's everyday social life, including the family and community become objects to be examined more closely for finer details*'.<sup>46</sup> They broadly function under the umbrella of mental health systems and this paradoxical position undermines their goal to provide non-coercive and user led alternatives.<sup>47</sup> We see reformist approaches that focus on better staff or improved infrastructure within institutions or community mental health centres as attempts to build more humane 'museums of madness'.<sup>48</sup> These efforts fail to address the core problem which is a custodial system empowered by law

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<sup>39</sup> Assisted Decision-Making (Capacity) Act 2015 (2015). <https://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html>

<sup>40</sup> Representation Agreement Act [RSBC 1996] CHAPTER 405 (2001). Available at: [https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96405\\_01#section2](https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96405_01#section2)

<sup>41</sup> Rodríguez, S. D. (2022, November 25). People with disabilities. Spanish legal reform 8/2021: Decision-making rights and assistance | Susana Rodríguez Puente Abogados. <https://srpuenteabogados.com/en/2022/11/25/support-people-with-disabilities/>

<sup>42</sup> LEGISLATIVE ORDER Amending, Adding and Abrogating Various Provisions of the General Health Act on Mental Health and Addictions. (2022). [https://www.ohchr.org/sites/default/files/documents/issues/health/draftguidance/submissions/2022-09-02/Mexico\\_general\\_health\\_act\\_16may2022EN.pdf](https://www.ohchr.org/sites/default/files/documents/issues/health/draftguidance/submissions/2022-09-02/Mexico_general_health_act_16may2022EN.pdf)

<sup>43</sup> UN expert welcomes legal capacity reform in Colombia to end guardianship regime. (2019). <https://www.ohchr.org/en/press-releases/2019/08/un-expert-welcomes-legal-capacity-reform-colombia-endguardianship-regime?LangID=E&NewsID=24926>

<sup>44</sup> Davar, B. V., Pillai, K., & LaCroix, K. (2021). Seher's "Circle of Care" Model in Advancing Supported Decision Making in India. In C. Sunkel, F. Mahomed, M. A. Stein, & V. Patel (Eds.), *Mental Health, Legal Capacity, and Human Rights* (pp. 213–229). Cambridge University Press. <https://doi.org/10.1017/9781108979016.017>

<sup>45</sup> USP-K. (n.d.). THE ROLE OF PEER SUPPORT IN EXERCISING LEGAL CAPACITY.

<https://rodra.co.za/images/countries/kenya/research/Role-of-Peer-Support-in-Exercising-Legal-Capacity.pdf>

<sup>46</sup> Alevanti, E. (2020). *Mental Healthcare Reform in Belgium: A qualitative study with mobile teams* [Doctoral, Birmingham City University]. <https://www.open-access.bcu.ac.uk/12383/>

<sup>47</sup> Ibid

<sup>48</sup> Scull, A (1979). *Museums of Madness: Social Organization of Insanity in 19th Century England*.

to strip individuals of dignity under the guise of 'care'. The issue is not poor staffing, but it is the existence of a system that legitimizes coercion and confinement. Moreover, public health expenditure on mental health services is routinely dedicated to in-patient care, while community based and non-coercive psychosocial services remain severely underfunded.<sup>49</sup>

We urge the State Party to set up community health services that are CRPD compliant, voluntary, non-coercive, rights based, centres the will and preferences of persons with psychosocial disabilities and offers them a range of choice regarding their healing and well-being options. These services must not replicate institutional practices in community settings or operate through surveillance, forced treatment, or conditional compliance. Instead, they should be holistic, culturally appropriate, user-led, and embedded within broader systems of community inclusion ensuring access to housing, education, and social protection.<sup>50</sup> Additionally, State Party should also focus on *'developing and strengthening existing movements for the non-violent, peer-led, trauma-informed, community-led programmes, healing and cultural practices preferred by local groups of persons with psychosocial disabilities, attentive to the movement of non-medical alternatives and progressive community support worldwide.'*<sup>51,52</sup>

**Question Four: The measures adopted to ensure that persons with disabilities and their representative organizations are closely consulted and actively involved in the drafting process of this proposed legislation.**

TCI emphasizes that meaningful consultation and active involvement of persons with disabilities and their representative organizations is a core obligation under Article 4(3) and Article 33(3) of the CRPD. This is not only a procedural requirement but essential to ensuring that laws reflect the lived realities, priorities and rights of those most affected. We support Liberation's detailed submission and the rigorous process they have followed to engage with relevant stakeholders, which centres the voices of persons with psychosocial disabilities in the UK. Their approach exemplifies the standard and methods of engagement all States must uphold when drafting legislation that directly impacts our constituency.

Closely consulting and supporting active participation of OPDs in law making is a mandatory step prior to the approval of laws and policies, as per General Comment 7 of CRPD. It is an *'obligation under international human rights law that requires the recognition of every person's legal capacity to take part in decision-making processes based on their personal autonomy and self-determination.'* When State Parties engage OPDs at the outset of developing laws and policies, they ensure the inclusion of the

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<sup>49</sup> A/73/161

<sup>50</sup> A/HRC/35/21

<sup>51</sup> A/HRC/44/48

<sup>52</sup> TCI (2022). TCI positionality on Community Inclusion. TCI Global, Geneva. Available at: <https://tci-global.org/wp-content/uploads/2024/07/TCI-Positionality-on-Community-Inclusion-2022.pdf>

richness of lived experiences of persons with psychosocial disabilities into legislation. This helps ensure that those most affected by legal frameworks are the ones leading the way, with the support of policymakers.

Close consultation and active participation of OPDs can reduce the risk of needing to revise legislation later due to gaps, unintended consequences, or non-compliance with CRPD making the laws effective, legitimate and sustainable. In this way, meaningful participation also supports legal clarity, strengthens accountability, and helps avoid the financial and administrative costs associated with ineffective policy rollout, stakeholder resistance or legal challenges. By failing to consult with OPDs, the UK risks inefficient and ineffective reform, undermining both CRPD compliance and prudent public administration.

### **To conclude,**

We submit this letter in full support of Liberation's shadow submission. We urge the Committee to hold the State Party accountable to its obligations under the CRPD and to ensure that any mental health reform upholds the rights, dignity and legal capacity of persons with psychosocial disabilities. The Committee has already published concluding observations in 2017 and 2024 and makes multiple recommendations, which if implemented by the State Party can truly realize the rights of persons with psychosocial disabilities, in line with the CRPD. As a global OPD, we remain committed to advancing rights-based, non-coercive reforms that reflect the leadership and strength of our movement.