Check against delivery



**Statement by MR. GERARD QUINN,**

**UNITED NATIONS Special Rapporteur**

**on THE RIGHTS OF PERSONS WITH DISABILITIES**

**Human Rights Council**

**Intersessional one-day consultation on mental health and human rights**

***(Human Rights Council Resolution 43/13)***

*Segment II: Highlighting key aspects of legal reform based on the Convention on the Rights of Persons with Disabilities (15pm – 17pm CEST)*

GENEVA (ONLINE)

15 November 2021, 3 – 5 p.m.



Excellencies,

Distinguished delegates and participants,

My name is Gerard Quinn and I am the Special Rapporteur on the rights of persons with disabilities. I want to thank you at the outset for this important consultation on mental health and human rights.

The topic has both personal and professional significance to me.

I started my professional career as a legal intern in the Council of Europe in the early 1980s, working on the landmark *Recommendation (83) 2*, “concerning the legal protection of persons with mental disorder placed as involuntary patients.” That personal experience started a lifelong interest in the field and especially in comparative law.

What struck me even then was how the mental health field was considered wholly distinct from other fields like accessibility, employment and even health law itself. There was, yet, no field of disability law, much less international disability law.

Looking back, I would have to say that this disconnectedness had allowed the mental health field to continue to exist along separate lines, resting on a completely separate set of premises and with its own peculiar shape and content. There was as yet no unifying field theory to align mental health law with, say, international human rights law.

Also looking back, I like to think that there were two distinct waves of a human rights response to the mental health field.

The first one – one that powerfully influenced *Recommendation (83) 2* - was not really founded on a radical re-think of the field. It was a response to the well-known abuses of psychiatry especially emanating from authoritarian States.

Not being able to imprison political dissidents through the ‘ordinary’ criminal justice system, authoritarian regimes simply branded dissidents as mentally ill and civilly committed them. This had many ‘advantages’ over criminal due process. They could be detained not for any specific event or infraction of the law but for their condition (or alleged condition). They could be detained indefinitely (and not for, say, 6 years for theft). And the process was reflexive and not reflective in that there was no need for their case to be processed in an open court with due process protections. Interestingly, the mental health field was not even conceived of as problematic until the 1980s. One is tempted to say where were human rights until then?

In any event, the first wave of a human rights response at least problematised loss of liberty and the loss of ancillary rights. But it simply regularized the same by telescoping down the grounds upon which one might be civilly detained and it super-added more due process guarantees of procedural fairness. Emblematic of these changes was the evolving jurisprudence of the European Court of Human Rights. Remember, the ECHR (and civil rights treaties like it) is all about controlling the loss of rights with objective safeguards. It is not primarily about the material conditions needed to give reality to rights. It was never intended to be that. Nevertheless, this jurisprudence went a long way toward taming the mental health field, placing metes and bounds on its reach.

It was obvious even to me back then that this was not enough. Even when the field was tamed, even when reduced to the core, it still nevertheless had massive implications for those caught up in its coercive embrace. It seems that taming the field did not fundamentally mean challenging it.

The second wave of a human rights response only began with the adoption of the Convention on the Rights of Persons with Disabilities (CRPD). For the first time a lot of outlying fields of disability law and policy were brought together and unified under one roof. No longer was mental health to be kept apart and subject to *sui generis* rules. It could no longer rest on its own separate foundations - it now shared new foundations in common with other areas of disability.

And the CRPD was not just another equality or equal treatment thematic treaty. It was even more fundamentally grounded on personhood. You might say the core problematic was invisibility (as a person) and that the various inequalities that resulted were just that – symptoms of invisibility.

Why do I say this? I say this because Article 12 of the convention posits that there I always a person – always a *self* – behind the exterior mask of disability including psychosocial disability.

I say this because, while sickness may cloud this sense of self and make it less accessible to others, it does not destroy it. It is interesting that 20 years ago there was no science of interpreting informal (non-verbal) communication. Now that field is booming party because of the stimulus of Article 12 to find new ‘discovery techniques’ to reach the person.

That being the case, it makes sense to re-ground the field of mental health on human personhood and autonomy.

And, if equal treatment means anything, it must mean a radical roll back of coercive laws and policies that strip persons with disabilities of their liberty and that enforce other coercive measures.

One thing that *Recommendation (83) 2* happened to coincide with in point of time was the massive medicalisation of the mental health field. In the early 1980s there was an optimism (of sorts) that a telescoped down range of coercive measures combined with the adroit use of medicine would produce the right results. So a good faith effort to clean up the field and regularise or legalise it was combined with an almost exclusively medicalized approach.

The interesting thing to me is the frank admission of many clinicians who participated in drafting the latest edition the Diagnostic Manual that many of the ‘ills’ specified in the manual lack any recognisable organic root. Put another way, the field was and is considerably over medicalized. So, the web of laws and policies we have inherited which rest on coercion lack an evidence base – or at least an evidence base sufficient to warrant the continuation of a coercive approach.

Think about that. If we prize evidence-based policy making – as we should – then it behooves us to make the right inferences from admissions such as the above.

One other point. The old model – the first human rights based approach aimed at taming civil commitment laws – fitted neatly into a civil rights model which its core focus on controlling the loss of rights or liberties. The astute will notice that the CRPD - unlike say the ECHR - is not just about controlling the loss of rights – it is more crucially about breathing life into rights.

Being bottomed on personhood and rejecting unequal treatment (as most assuredly civil commitment is) it starts the policy and law reform debate on profoundly different premises.

And the personhood theory the CRPD embraces is not just the old atomistic conception of the person, it is one of shared personhood – the inter-subjective or relational self. Which is why I think an approach based on peer support even in crisis situations (or perhaps especially in crisis situations) is to be preferred.

In sum, the mental health field is being brought in from the cold – from the edges of disability law and policy to the centre.

Like the rest of the field, it is now anchored on personhood and equality.

In the process, the field is being re-made and the boundaries between it and other fields are being blurred.

The first human rights wave – taming mental health – has run its course.

The next human rights wave of reform is exciting – it invites States to exercise a new kind of policy imagination. The prize is immense. I commend the WHO for its recent efforts to highlight positive steps that States are taking in this new direction. This is of massive assistance to States. It is the WHO at its best.

I have added my voice to that of many others, including the esteemed chair of the CRPD Committee, Rosemary Kayess, in seeking to dissuade the Council of Europe from adopting its proposed draft Protocol to the Oviedo convention which offers only a variation on an old theme of the first wave of human rights – too little and too late. We don’t need the fragmentation of international law as we exercise a new policy imagination.

As States exercise a new policy imagination, they will have persons with disabilities at their side – always eager to innovate and create a much different future in partnership.

The past of mental health law belongs to the past - and that past should not control the boundaries of our new policy imagination.

I thank you and look forward to our interactive dialogue.

//ENDS