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**Further Comments on draft General Comment No. 5 on Article 19**

The Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP) submits the following thematic comments to complement its paragraph-by-paragraph comments submitted earlier in this consultation.

The Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP) is a DPO and human rights organization that aims to provide strategic leadership in human rights advocacy, implementation and monitoring relevant to people experiencing or labeled with madness, mental health problems or trauma. In particular, CHRUSP works for full legal capacity for all, an end to forced drugging, forced electroshock and psychiatric incarceration, and for support that respects individual integrity and free will.  CHRUSP has been granted Special Consultative Status with ECOSOC and has engaged actively with the CRPD Committee and other mechanisms in the field of human rights and disability. See [www.chrusp.org](http://www.chrusp.org).

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1. Immediate obligation to allow people to leave institutions where they are held against their will

This relates to paragraphs 26, 45, and 94(a) of the draft General Comment. Please see also CHRUSP Comments paragraph-by-paragraph submitted earlier in this consultation.

I would like to see in General Comment No. 5 a complete understanding of the immediate obligation contained in Article 19(a) as it impacts on countries where people are being held in a psychiatric institution or anywhere else against their will, not just as a ‘place of residence’ but as a form of social control.

Reluctance to allow individuals to leave institutions until service providers are satisfied they can be discharged is not a valid reason to hold a person against his or her will, once the person has declared a wish to leave. Article 19(a) incorporates the prohibition of arbitrary detention contained in Article 14, which as the CRPD Committee has held repeatedly, prohibits any detention based on actual or perceived impairment, including when the detention is based on a prediction that the person will harm him/herself or others.[[1]](#footnote-1) Non-disabled people are not pre-emptively incarcerated based on such criteria, and it is nothing more than a biased stereotype, based in a medical model of psychosocial disability, that has perpetuated this practice.

Standards for implementation of Article 19 must be consistent with Articles 12 and 14 as already interpreted by the Committee. It is contrary to Article 12 as well as Article 14 to prevent a person from leaving an institution on the basis of concern that the person may be in need of care or treatment, housing, or social services. The proper course of action is to offer all relevant services, including access to mainstream social protection programs such as public housing and income assistance, food assistance, etc., and to provide access to accommodations and support for the person to understand these options and make informed choices. All these services, and all accommodations and support, are subject to the person’s will and preferences, which cannot be overruled. While it will naturally take some time in many cases where people are struggling to understand their situation after long-term institutionalization, any individual who chooses to exercise their legal capacity to decide on leaving the institution immediately with or without any auxiliary services to support their living in the community, has a right to do so under Articles 12, 14 and 19. This right is of immediate application as an exercise of core civil rights: the right to recognition as a person before the law, the right to liberty and security of the person, and the right to liberty of movement and choice of residence. All people with disabilities, including people with psychosocial disabilities, are entitled to enjoy these rights without any discrimination, on an equal basis with other persons (CRPD Article 1).

The draft General Comment refers to the liberty component of Article 19 as part of the ‘core minimum requirements’. In my view this incorrect, as core minimum is a concept applied in the context of economic, social and cultural rights, and the Committee expresses its view elsewhere in the draft that Article 19 is a hybrid; clearly 19(a) is in the nature of a civil right. The Committee should make entirely clear the immediate character of obligations under Article 19(a) and should explicitly state that this includes the obligation to allow all individuals who are currently institutionalized and wish to leave, to do so in their exercise of legal capacity, the right to be free from arbitrary detention, and the right to liberty of movement and freedom to choose one’s own residence.

It is also incorrect in my view to frame the civil right component of Article 19 as being of immediate application due to its linkage with non-discrimination. It is true that 19(a) is based in non-discrimination, as is the entire Convention, but similarly to the concept of core minimum, non-discrimination is part of the analysis of which elements of economic, social and cultural rights are of immediate application. It would make sense in the context of General Comment No. 5 to address non-discrimination and core minimum with reference to a linkage with Article 28 and equal access to social protection programs available to the general community, and to similarly develop an analysis of disability-specific supports and accessibility of mainstream services in 19(b) and (c) following from the approach already taken in General Comments No. 1 and No. 2. To the extent that such measures are required in order to ensure non-discrimination in the enjoyment of economic, social and cultural rights by persons with disabilities, they are of immediate obligation and not progressive.

A panelist at the Conference of States Parties put forward a further proposal that I would like to record as objectionable, in particular to do away with the distinction between the two sets of rights and simply adopt a standard of realization ‘to the maximum extent possible.’ Such an approach is detrimental to people with disabilities and to the human rights framework as a whole, as it could justify states in making excuses for serious violations such as arbitrary detention, torture and refusal to recognize an individual’s legal capacity or legal personhood. As we see in the context of Articles 12, 14, 15 and 19, this is not merely speculative, as there is a clear need for instruction to states that the civil rights of persons with disabilities are to be taken seriously and they have an immediate right to be released from institutions or hospitals where they are being held against their will, to have any forced treatment immediately end, and to have their legal capacity restored.

1. Avoid medical-model and provider-focused approach to 19(b) supports and services

This relates to paragraphs 20, 29, 30, 64, 75, and 86. Related concerns arise in paragraphs 14, 15(d), 21, 27-31, 38, 40, 42, 52, 55, 56, 59, and 94(i). Please see also CHRUSP Comments paragraph-by-paragraph submitted earlier in this consultation.

For people with psychosocial disabilities, many actors have wrongly interpreted Article 19 as amounting to a transfer of individuals from institutions to community-based mental health services. This approach maintains segregation, both from the community at large and from programs offered to other people with disabilities that are based in a social model, such as personal assistance and the principle that supports should be user-designed and user-directed. A social model approach to support under Article 19(b) would be user-directed for all people with disabilities, would be equally responsive and relevant to all people with disabilities irrespective of the type of impairment, and would be developed in consultation with representative organizations in a process designed for interaction and synergy among different groups.

Where representative organizations have not been created, consultations should be undertaken to find individuals with disabilities who can come together and work on this particular consultation on an ad hoc basis, rather than look to family members or service provider organizations. Support and accommodations as understood under Articles 9 and 12 should be made available subject to the person’s will and preferences, so that people with disabilities can express their views directly both in collective processes to develop supports in a social model and in processes for individuals to design and direct their own supports, including children with disabilities as required by Articles 4.3 and 7.3.

The concept of user-designed and user-directed supports is clearer than ‘individualized’ supports, as the latter could be supports designed by professionals or carers based on their view of what the person needs. While suggestions from paid or unpaid service providers and supporters may be welcomed, the person concerned needs to be in a position of control and having the final say over what kind of support she/he needs and how it should be provided. A process of working with the person to ascertain and help them to explore their will and preferences can be a form of independent support provided for this purpose, for example the model of the Personal Ombudsperson in PO-Skåne as described by Maths Jesperson.[[2]](#footnote-2)

The role of professional services such as social work, psychological counseling, psychotherapy, and medicalized services like psychiatry, is ambiguous in the context of Article 19. While for people with physical or sensory impairments such services might be seen as valuable services for ensuring their inclusion in the community, which do not define them by their impairment or proceed from a medical model point of view, the opposite is true for people with psychosocial disabilities. People with psychosocial disabilities will be defined by their impairment if we understand the services required under Article 19 as incorporating such professional services. All people with disabilities have a right to professional services that they may need under Articles 25 and 26, and these services may be necessary to support the person to live in the community. There should be a unified approach to the linkage between Articles 25/26 and 19, that is equally relevant and responsive to all persons with disabilities, including people with psychosocial disabilities.

Services created by people with psychosocial disabilities as many forms of peer support have been acknowledged in the text of Article 26 as being an alternative way of enhancing individuals’ potential, outside the framework of habilitation and rehabilitation which are driven by service providers. Peer support has been a site for knowledge creation and politicization, as well as providing support to individuals in an egalitarian setting.

In addition, people with psychosocial disabilities have initiated services open to the general community, such as The Red Door, a project created by Reshma Valliappan, which allows everyone to express themselves artistically and accepts that everyone is equally ‘mad’. Such initiatives by people with disabilities should be acknowledged under 19(c), as inclusion is not one-way but mutual; social and economic entrepreneurship by people with disabilities is not to be patronized as ‘special’ but simply acknowledged for its contribution to society. This approach is in keeping with Article 8 awareness-raising of the contributions and capabilities of persons with disabilities, and with Article 30.4, which entitles people with disabilities on an equal basis with others to recognition and support for their specific cultures. Disability cultures are not limited to Deaf culture and sign language, and encompasses the creation of new social services as well as culture in the more limited sense of artistic productions.

1. Freedom from forced psychiatric interventions as right under Article 19

This relates to paragraphs 40(a), 48, 49, and 94(g). Please see also CHRUSP Comments paragraph-by-paragraph submitted earlier in this consultation.

Forced psychiatric interventions have moved into the community in addition to taking place in institutions. The practice of compulsory treatment in the community, usually consisting of compulsory medication with neuroleptics and other mind-altering drugs, compulsory supervision by service providers, and other restrictions on freedom such as an order directing the person to live in a particular place or to attend a day treatment program, is becoming increasingly widespread in the global South as well as the global North. Some actors have advanced compulsory outpatient treatment as a less restrictive alternative to institutionalization. The Committee must make known that compulsory treatment in the community violates the person’s right to live independently and be included in the community on an equal basis with others, in addition to violating Articles 12, 14 and 15.[[3]](#footnote-3)

In addition, some actors have promoted a view that short-term involuntary hospitalization in mental health settings is a less restrictive alternative compared with long-term institutionalization. The Committee should reaffirm its jurisprudence that any confinement against the person’s will in any kind of mental health facility is incompatible with the Convention, and should state that such practices violate the right to live independently and be included in the community on an equal basis with others. When a person is vulnerable to disruption of their work, family, home, community ties at any time due to the judgment of service providers that they pose a risk to themselves or others, or need care and treatment, they cannot be secure in their relationships and access to community, and are denied the right to live independently and to exercise legal capacity in making their own assessment of their safety and their needs. Supports that comply with Articles 12, 14 and 15 and Article 19 must be made available for emergent and intermittent needs, so that people with psychosocial disabilities can fully enjoy their rights under Article 19 on an equal basis with others. At the same time, it can never be justified to continue a practice of arbitrary detention and forced or coercive interventions, which numerous human rights experts in addition to the Committee have recognized to be severely traumatizing and to amount to acts of ill-treatment and torture.[[4]](#footnote-4)

1. See especially Guidelines on Article 14, paragraphs 6-10, 13-15, 19, 22-23 and 24. See especially quoted paragraph 126(d) and (e) of the document issued by the Working Group on Arbitrary Detention, contained in paragraph 24 of the Guidelines on Article 14. [↑](#footnote-ref-1)
2. Maths Jesperson, PO-Skåne – a concrete example of supported decision-making, Presentation at the OHCHR Symposium on the Human Rights of Persons with Psychosocial Disabilities, Forgotten Europeans Symposium No 5 at Martin’s Brussel EU Hotel 17 October 2014, http://europe.ohchr.org/SiteCollectionImages/Events/Disabilities%20symposium%20October%202014/Maths%20Jesperson.pdf. [↑](#footnote-ref-2)
3. The Committee recognized that compulsory treatment in the community violates Article 14, in its Concluding Observations on Australia (2013), paragraph 34. [↑](#footnote-ref-3)
4. CRPD General Comment No. 1 paragraph 42, Guidelines on Article 14 paragraphs 11, 12, 22, 23, 24 (including paragraph 126(d) and (e) of the quoted material in paragraph 24). [↑](#footnote-ref-4)