**Intersessional Consultation on Mental Health and Human Rights**

**(RES 43/13)**

15 November 2021 | 10 – 12HRS & 15 - 17HRS (CET)

Virtual meeting on Zoom platform and Room XVII Palais des Nations.

Your excellency the permanent representative of Portugal to the United Nation, your excellencies, distinguished guests, ladies and gentlemen its such an honour and privilege to be able to contribute to this session on transforming the generalities of the Convention on the Rights of Persons With Disabilities as we shift towards a human rights based approach in reforming mental health systems by promoting the human rights of persons with psychosocial disabilities and ensuring their full and effective participation in our society on an equal basis with others.

I would like to start by stating that most mental health policy frameworks and systems by essence departs from the general health laws regulating the health system. They introduce an exception to the principle of informed consent and creates a separate and lower standard that allow for forced admission and treatment only for persons with psychosocial disabilities.

A pre-condition for arriving at mental health policies and systems that are in compliant with the CRPD is that a legal capacity framework which draws from the principles of the CRPD is developed. A legal capacity framework would provide the building blocks for decision-making, consent, intervention or non-intervention in one’s decisions, which can then be used and adapted for the area of mental health.

There is no way to reach CRPD-compliant mental health policies without first rethinking the perception of “capacity” and “incapacity” and introducing and incorporating supported decision-making into the equation – in short, drawing a framework for legal capacity and this must be the starting pointing of any fundamental shift from policy to practise.

In the realization of this I would like to share the role of peer support in providing a framework for supported decision making and the exercise of legal capacity from experiences learnt in Kenya.

Firstly, there exists a direct link between peer support and the making of certain decisions that have legal consequences. This is especially the case regarding mental health treatment decision-making where peer support members can get information from each other, for example about the side effects of certain drugs, or of electroconvulsive therapy (ECT). Members also can get information about human rights, including what others can or cannot do to you legally”.

Peer support boosts agency and autonomy, which in turn boosts the exercise of legal capacity. After attending peer support group meetings over a period, members start to ‘reclaim’ their voice and to become more assertive.

Peer support group promotes autonomous decision-making. Where members of the peer support group do not always use peer support to make decisions, and that they often make decisions autonomously/without the input of peers – same as everybody else. This underpins important concepts like allowing them the ‘dignity of risk and the right to make mistakes – just like everyone else and learn from those mistakes.

The WHO Quality Rights Tools Kit provides policy makers as well as implementers with innovative tools for advancing the rights of persons with psychosocial disabilities by adopting models that are recovery oriented and promotes human rights.

Its addresses key concepts that are important towards promoting recovery and community inclusion this includes the right to legal capacity and [strategies to end the use of seclusion, restraint and other coercive practices](http://apps.who.int/iris/bitstream/10665/254809/1/WHO-MSD-MHP-17.9-eng.pdf?ua=1). that contradicts the Convention and international human rights standards.

WHO has also recently launched a new service guide that highlights services that complies with the CRPD however at the core of this and as we aspire to transform community based mental health services and supports, we must have clear human based indicators that are in compliance with the CRPD and provide clear guidance and the technical capacity to ensure all services reflect the letter and spirit of the CRPD to all the state parties to the Convention?

CBM Global worked with a range of different stakeholders through the invitation of WHO in Zimbabwe to discuss the practical implementation of the Quality Rights by delving into difficulty questions that arise in the implementation of the CRPD.

This session was very useful in thinking through different ways of navigating contextual issues that are hindering the move from policy to practice for example the distinction between legal capacity and mental capacity, the role of families, traditional and religious leaders and providing support when people are in crisis or distress in a way that is in compliance with the CRPD.

In conclusion I would like to emphasis that the shift from policy to practise will require us to look at mental health from a development lens and address the intersections between mental health with the social determinants of health. At the core of this must be the meaningful participation of persons with psychosocial disabilities through their representative organizations in line with the General comment NO 7 of the CRPD Committee. We must also address the power imbalance that exists in the context of mental health in order to provide a pathway for meaningful engagement in bringing substantive reforms in the area of mental health. Thank you very much