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

**UN Human Rights Office of the High Commissioner**

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**Presentation by Stephanie Wooley**

**on behalf of ENUSP (European Network of (Ex-)Users and Survivors of Psychiatry)**

I am honored to participate in this introduction to this latest consultation on mental health and human rights on behalf of ENUSP, the European Network of Users, Ex-Users and Survivors of Psychiatry. ENUSP is the only independent representative organization of mental health service users, ex-users and survivors of psychiatry at European level with 34 member organizations. I would like to thank and remember at this forum all of the people from ENUSP who have gotten us here today – so that our voice and experiences can be taken into account at this level.

The UN Convention on the Rights of Persons with Disabilities itself and the work, writings, reports and jurisprudence of the CRPD Committee and the UN Special Rapporteurs have been of great promise for our community. After personally being involved in the first review of France by the Committee - which ended up lasting over two years with the pandemic – it was truly an experience of my lifetime to be respected, listened to, believed and in most cases understood by the CRPD Committee members.

This is far from our reception at the Council of Europe today with the on-going battle against the draft protocol to the Oviedo Convention, where hard-to-identify experts want to decide on our fate. With the mobilization against this discriminatory draft protocol by the entire community of persons representing those who would be subject to it, UN bodies we thank here, and even within the Council of Europe itself with our allies such as the Parliamentary Assembly or the Commissioner for Human Rights - it is impossible to believe that we could end up with a two-track human rights system where our rights in Europe would be inferior to those enshrined in the UN CRPD internationally. Europe should be leading the way in human rights in favor of the change of paradigm called for under the CRPD.

But our States lag seriously behind the standards of the UN CRPD even in the most so-called developed countries.

ENUSP is very concerned about reports from the CRPD Committee and the CPT –

from Spain with reported cases of fatal violence against women with psychosocial disabilities or death by restraint and improper medical treatment in psychiatric hospitals,

or Ireland: where patients hospitalized on a voluntary basis are restrained or placed in seclusion, or where patients are secluded for hundreds of consecutive hours without sufficient heat or bathroom facilities and are traumatized by security guards,

or Sweden with restraint ordered by telephone by doctors, young patients in particular are subject to invasive and degrading strip searches, and there are reports of physical violence by staff members

Or finally, in Bulgaria, where patients continue to be physically ill-treated by staff - slapped, pushed, punched, kicked, and hit with sticks and in 2020, the CPT documented the use of chains and padlocks for restraint often for days on end. Although seclusion and restraint are illegal in social care institutions under national law, these practices are also occurring.

This is exactly why the draft protocol to the Oviedo Convention is not a solution.

We do see some signs of progress under our first theme of “positive experiences in reforming services guided by a rights-based approach” and as recognized here from the ground up – “from practice to policy” rather than the other way around.

The Wildflower Alliance started in Massachusetts to be presented has been a great inspiration for us for many years. There have been a few attempts in Europe to found human-rights based and peer-led sanctuaries or respites for persons in crisis, such as in Berlin, Leeds, London… or even Marseille, but they lack sufficient and sustainable financing and access is often dependent on having the status of a homeless person and very limited geographically. And this remains the case although the cost of this type of service has been determined to be much lower and the benefits higher than what is often the only alternative - forced hospitalization.

Slowly, but we cannot say surely yet, certain “practices” such as physical restraint have been abolished, in Iceland for example, or in regions of Germany and more recently in Madrid for psychiatric emergency situations. Certain psychiatrists and practitioners understand coercion is not care and call for an open-door policy, with no restraint or seclusion – and find better results on all sides.

Yet many of these professional allies are pushed aside in favor of a security-oriented, biomedical approach to persons with psychosocial disabilities. These professionals may be considered whistleblowers or lose their position when they speak out as we have seen particularly in connection with increased seclusion, restraint and even abandonment of persons that have occurred throughout this Covid 19 pandemic.

One of the greatest obstacles remains the power imbalance and how often good ideas and practices are coopted and distorted by the mental health system, rather than supporting persons with lived experience to establish the practices that meet their criteria, will and preferences and which can work for them. Meaningful involvement or “co-production” is very rare.

To be in a position to be involved, users and survivors of psychiatry need trust and they need training. Being able to complete an education, practice law or research is in most cases unattainable for the reasons we are familiar with. It is rare, yet so important, for our direct representation. More Schools of law specialized in disability rights and policy such as at Galway, Oxford or Harvard, more university departments such as recently at the Ilia State University in Tbilisi, Georgia and the Jaume I University in Valencia, Spain, must be founded and our community involved. The same is true for continuous education programs for professionals in the legal, medical, mental health, social services and emergency fields.

Legal reform based on the CRPD will depend on the legal community and policymakers and should depend on us! The recent declaration of the Japanese Bar Association along these lines, the organizations of lawyers starting up specialized in defending the rights of persons with psychosocial disabilities are also good signs and help us rethink the issues of health care, liability under criminal law, and ways to ensure the rights of persons with psychosocial disabilities or mental health problems. They are in many cases still prohibited to attend trial or de facto absent in court proceedings concerning their own lives.

This is particularly true with guardianship measures and here, there are budding signs of advances to recognize legal capacity of all persons with disabilities and supported decision-making in Peru, Costa Rica, Spain and Georgia, with other countries lagging further behind, but which have finally recognized the right to vote of persons placed under guardianship or are considering reforming their laws.

Monitoring mechanisms and Ombudspersons deserve greater resources and support and need to be helped to take a CRPD rights-based approach – they should have a mandate to monitor all “closed regimes and facilities” as broadly understood, whether in law or de facto in practice, such as institutions and services for persons with disabilities, migrant reception centers, elderly and dependent care homes or inclusive education and employment programs. External experts in different areas including persons with lived experience must be involved in monitoring which is not often the case.

WHO’s Quality Rights program and WHO’s guidance recently published and to come in the future are precious tools for these purposes we fully support.

When looking at the past and the current results of psychiatry, we can see that it involves practices that are not working very well, to say the least if people must be forced to receive treatment. Psychiatry and mental health services need to be much more humble in their approach and work with us, listen to us and above all adopt a human rights based approach.

Persons with lived experience must be trusted, recognized - including financially for their expertise - and supported to engage on an equal basis in order to deal with these issues of mental health and human rights, based on a belief in our common humanity that the United Nations represents to us.