Human Rights Watch has investigated human rights violations against persons with psychosocial disabilities in over 25 countries across North America, Europe, Africa and Asia. The violence and coercion people with psychosocial disabilities routinely experience is deeply rooted in stigma and discrimination. In a number of countries around the world, people with psychosocial disabilities do not have the most basic rights – to get married, to vote, to open a bank account, or make their own medical decisions. If you are a woman or from an indigenous community then you face additional forms of discrimination.

In India, women with psychosocial disabilities are abandoned in mental hospitals. In Ghana, people with psychosocial disabilities are chained because of widespread superstition and beliefs that they are possessed by evil spirits. In Croatia, they are stripped of their legal capacity because they are not seen as being capable of making their own decisions. In Peru, we met a woman who was told at the polling station, “schizophrenics can’t vote.”

Our research across many countries shows that people with psychosocial disabilities experience a range of violence and abuse in mental health settings, including physical and sexual violence, involuntary treatment, electroshock therapy without anesthesia or consent, and being locked up in isolation rooms or restraints. As you heard yesterday, the current mental health system is failing but there are evidence-based examples of good practice in Trieste, France, Kenya to cite but a few that are working and need to be scaled up.

Over 10 years ago, the CRPD embodied a paradigm shift but this rights-based approach is yet to translate into services on the ground that put the person and their will and preferences at the centre.

In order to address violence and coercion in the mental health system, we need a comprehensive approach that:

1) Repeals or amends laws and policies that normalize coercion and discriminate against people with psychosocial disabilities. Instead of creating parallel rights which evidence shows leads to a discriminatory system, we need to ensure the rights of persons with psychosocial disabilities are protected under the same health, education, employment, or social protection legislation as everybody else

2) Ensure that people with psychosocial disabilities are involved in the design, implementation, delivery and evaluation of mental health services, systems and policies. This is the key to success.

3) Moves away from a mental health system focused on hospitals and towards community-based services that include support for education, housing, employment

4) Ensures regular monitoring of mental health settings and services so there is accountability for abuses when they occur. It is the collective responsibility of independent monitoring mechanisms to investigate abuses against persons with psychosocial disabilities – whether it is the national human rights or women’s commissions at the country-level or mainstream UN mandates.

5) Provides training to health professionals, law enforcements, and the judiciary on how to practically engage with people with psychosocial disabilities in a manner that respects their rights

I have visited countless institutions, mental hospitals, and prisons over the years. Most recently, I did research across 14 prisons in Australia where over 50% of people in prison had psychosocial disabilities. The prison staff had received training on rights and mental health and yet we found that the default response of staff was to send people with psychosocial disabilities to solitary confinement because they didn’t understand their cries for help or their support needs. In order for trainings to be effective, they need to be practical with examples from the everyday reality of law enforcement and be conducted in consultation with people with lived experience.

I was in Indonesia two weeks ago and I accompanied the ombudsman on a monitoring visit to an overcrowded private institution, little better than a prison, where people with psychosocial disabilities are locked up indefinitely. It was the first time he had ever been to such an institution and he couldn’t believe the appalling conditions. He kept asking me, “Why are they locked up, they can talk.” In the meantime, his office colleague kept sending him text messages to ask if he was alive. Even the very officials charged with protecting the rights of persons with psychosocial disabilities aren’t immune from stigma.

In order to change mindsets, government officials, policy makers, and law enforcement professionals need to witness first-hand not only the failings of the current system but also see for themselves what good practice in Trieste, France, Kenya or other countries looks like. We urge donor countries to support these efforts.

Real inclusion means that services for people with disabilities should no longer be an afterthought as is so often the case particularly in humanitarian contexts. The Charter on Inclusion of Persons with Disabilities in Humanitarian Action, adopted in Istanbul in 2016, was an important moment and while we are encouraged by steps taken by some humanitarian actors, we are yet to see systematic inclusion across countries and aid organizations. Inclusion doesn’t have to be expensive or difficult, but you need political will. We need countries to lead the charge and this consultation is a great example of how Portugal and Brazil have done just that.

Finally, to tackle the multiple and intersecting forms of stigma and discrimination against persons with psychosocial disabilities, we need not just organizations of persons with disabilities but civil society as a whole, including mainstream human rights groups, women and child rights organizations, and anti-torture coalitions, to join the movement. Whether we like it or not, in order to achieve real change, we also need to work with allies to influence national and international psychiatric associations.

The paradigm shift may not occur overnight, but I am optimistic that together we can turn the tide.