



Center for the Human Rights of  
Users and Survivors of Psychiatry

## **Submission to the Committee on the Rights of Persons with Disabilities, for Consultation on Potential Content of a General Comment on CRPD Article 19**

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This submission views Article 19 as embodying the paradigm shift from a medical-segregative-coercive model of practices towards persons with disabilities, to a social model of equal membership in communities and availability of practical supports meeting individuals' expressed needs irrespective of diagnosis or particular actual or perceived impairment. Bullet points address obligations under Article 19 towards people with psychosocial disabilities, older persons, and the need for a gender perspective on support.

### **1. General points on Article 19**

- Guarantees under Article 19 extend to all persons with disabilities – including people with psychosocial disabilities – under the same model, which focuses on practical needs of the person and is not diagnosis- or impairment-based.
- Linkage with Articles 12 and 14 should be stressed, as well as linkage with Articles 24, 26, 27 and 28.

### **2. Under paragraph (a) of Article 19**

- Address situations faced by people with psychosocial disabilities, e.g.:
  - Indispensable to abolish and eradicate coercive mental health system practices including commitment and forced or non-consensual treatment, and other practices of disability-based confinement and forced interventions including in prayer camps or by police/prisons.
    - Contrary to Article 19 as well as 12, 14 and 15.<sup>1</sup>

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Thanks to María Teresa Fernández, Activist, Mexico; Ohyong Kweon, Korea; and Mari Yamamoto, Member of Japan National Group of Mentally Disabled People; for valuable additions.

<sup>1</sup> Articles 16, 17 and 25(d) also clearly apply.

- Contrary to Article 5.
  - Short- and long-term impacts include segregation, exclusion, impoverishment, isolation, which further violate Article 19.
  - Contrary to Article 16 protection against all forms of violence. It is structural violence to impose a particular, and harmful, way of life based on disability.
- Needs cannot be defined in terms of shift from institutionalization to “community-based mental health” services. That keeps us within a medical model and segregated from the liberatory potential of Article 19.
  - Difference between shifting location of services and shifting the relations of power between service users and service providers.
  - Deinstitutionalization needs to be accompanied by shift in paradigm, see also below under heading related to paragraph (b) of Article 19.
- Violative practices include:
  - Outpatient commitment (community treatment orders).
  - Failure to make available ordinary housing affordable to people receiving disability pensions, so that only option is mental health system-run housing.
  - Requiring a person to accept unwanted services or allow mental health staff to enter their apartment as a condition of obtaining or maintaining their housing.
- Address situations faced by older people, e.g.:
  - Institutionalization of older people is never based on age alone, in reality it is both age and disability, therefore Article 19 protects against institutionalization in situations such as nursing homes and assisted living environments.
  - Carers and facilities must not have discretion to decide on a person’s level of care or to place the person in a locked unit.

- People may want benefits of chosen congregate living (such as community meals and activities, housework/laundry services, etc.) – provide this while ensuring the person control over personal living space and services.
- No surcharge for support services in congregate facilities.

### **3. Under paragraph (b) of Article 19:**

- Wide range of supports and services – should be designed based on social model of disability, not medical model.<sup>2</sup>
- For people with psychosocial disabilities this includes:
  - Ensuring supports and services relevant to emergent and intermittent needs:<sup>3</sup>
    - E.g. crisis respite houses that fully respect the person’s autonomy, will and preferences in line with Articles 12 and 14.
    - This is a systemic measure to replace coercive mental health interventions, not to be provided alongside coercive measures.
    - Should be available based on declared need, and not rely on diagnostic classifications or duration or extent of actual or perceived impairment.
  - Personal assistance, service animals, other types of support models from independent living movement made available and responsive to needs expressed by people with psychosocial disabilities.
  - Alternatives to medical model within mental health services, and also alternatives to mental health services.
  - Practical supports identified by the person as needed and desirable.

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<sup>2</sup> A bill introduced in the US Senate is a good example of a rights-based guarantee of social model services that is inclusively designed and responsive to the needs of diverse sectors of people with disabilities, including people with psychosocial disabilities. S.2427, 114<sup>th</sup> Congress, 1<sup>st</sup> session, see in particular Sections 3 and 4. Caveat, the bill has flaws elsewhere that I hope can be remedied.  
<https://www.congress.gov/bill/114th-congress/senate-bill/2427/text>.

<sup>3</sup> See e.g. *ibid*, sec. 4(b)(7).

- Use of medication should be provided based on drug-based rather than illness-based approach (i.e. matching the action of a drug to a person's expressed needs, rather than protocols based on diagnostic labels),<sup>4</sup> and with fully free and informed consent.<sup>5</sup>
- Address gender-related aspects of support, including:
  - Women are worldwide the majority of informal support providers, including disabled women.
  - Need to transform social attitudes and patterns that rely heavily on women's unpaid work and can result in women not getting their own support needs met (linkage with CEDAW Article 5a).
  - Provide support to supporters while also providing resources to those receiving support to challenge power imbalances (disability, sex, age).

#### **4. Under paragraph (c) of Article 19:**

- Ensure access by people with psychosocial disabilities to work, school, health services, licenses or registrations that are available to the public, on an equal basis with others.
  - Ensure people with psychosocial disabilities can obtain licenses (such as driver's licenses and licenses to practice any type of occupation) on an equal basis with others (abolish laws or regulations to the contrary).
  - Ensure that people with psychosocial disabilities are eligible for work in all fields on an equal basis with others (abolish laws or regulations to the contrary).

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<sup>4</sup> As discussed by Dr Joanna Moncrieff, practicing psychiatrist and academic, in her work linked on this page of her website: <http://joannamoncrieff.com/about/>.

<sup>5</sup> A model consent form for psychiatric drugs developed by researchers David Cohen and David Jacobs reflects the comprehensive scope of information that would shift the requirement of informed consent from a standard designed to protect practitioners against lawsuits, to one in keeping with informed consent as a human right, a component of the right to health (good quality health care and right to control one's own body and health) as well as the right to be free from torture and other ill-treatment. <https://kellybroganmd.com/consent-form-for-psychiatric-drug-treatment/>.

- Ensure that people with psychosocial disabilities are not denied desired health care and services based on a belief that they will not adhere to the treatment regimen, or are incapable of doing so, or because the person refuses psychiatric treatment.
- Ensure that people with psychosocial disabilities receive health care for their physical needs on an equal basis with others, that is properly responsive to their complaints of ill-health and does not mis-characterize such complaints as psychiatric in nature.
- Combat stereotypes and prejudices that lead to exclusion from services and facilities open to the community at large, including:
  - Fear that people with psychosocial disabilities will endanger ourselves or others.
  - Belief that people with psychosocial disabilities are particularly fragile.
  - Belief that people with psychosocial disabilities cannot negotiate mutuality in relationships.<sup>6</sup>
- Ensure reasonable accommodation and elimination of barriers such as:
  - Social expectations of behavior that fail to take account of diverse responses to trauma, oppression, everyday emotional ups and downs, major life events.
    - Including sex, race/ethnicity, age and similar stereotypes.
  - Negotiation of mutuality in relationships and avoidance of scapegoating in situations where needs conflict.

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<sup>6</sup> On mutuality, see the work of Shery Mead and others on Intentional Peer Support, <http://www.intentionalpeersupport.org>. This article Crisis and Connection is a good example of the significance of mutuality in contexts where it is often denied, <http://www.intentionalpeersupport.org/wp-content/uploads/2014/04/CrisisAndConnection.pdf>. See also the first chapter of the IPS workbook and curriculum, <http://www.intentionalpeersupport.org/wp-content/uploads/2014/12/IPS-An-Alternative-Approach-2014-First-Chapter.pdf>.