I am Jolijn Santegoeds, co-chair of the World Network of Users and Survivors of Psychiatry, WNUSP, and I will share a statement on behalf of the World Network of Users and Survivors of Psychiatry.

WNUSP entered into the CRPD negotiations to radically reframe international law with regard to our human rights. As a treaty on the rights of persons with disabilities, the CRPD centers the perspective of persons with disabilities as rights holders. This contrasts sharply with approaches to ‘human rights in mental health’ that often prioritize clinicians’ viewpoints and the preservation of their social and legal power as “those who know best what to do”.

The CRPD prohibits forced institutionalization and forced treatments, such as psychiatric drugging and electroshock, restraint and solitary confinement. These are forms of torture and other ill-treatment, as well as violations of the fundamental right to legal capacity.

Despite the fact that the CRPD prohibits deprivation of liberty in mental health services as a discriminatory regime of arbitrary detention, these practices continue, and we know of no country that has entirely abolished them.

While it is important to reshape mental health services on a basis of respect for human rights, the starting point must be the full and equal rights of persons with psychosocial disabilities in all aspects of life. Our right to work, right to housing, right to an adequate standard of living, right to culture, right to political association and participation, are inseparable from elimination of the violations that target us directly and particularly for acts of disability-based arbitrary detention and torture. All the articles of the UN CRPD are important. The regime of forced psychiatry is a widespread and systematic human rights violation existing throughout the world wherever psychiatry itself has penetrated. Coercive psychiatry reinforces a system of inequality, violence, stigma, exclusion and abuse that legally and socially disempowers persons with psychosocial disabilities within families, communities, countries and the world. Stigmatizing diagnoses and the dehumanizing practices that follow from them do not bring social understanding but actually mystify the issues and create distance.

There is a fundamental difference between coercion and care.

Coercive practices cannot be reformed to comply with human rights standards;

the coercive legal and social power must be abolished and something different created to meet the human needs for connection and support.

WNUSP calls on everyone to oppose and lobby against the Council of Europe’s Draft Additional Protocol to the Oviedo Convention on Human Rights and Biomedicine concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment”.

The adoption of such a Protocol would be absolutely detrimental to the human rights of persons with psychosocial disabilities and persons with intellectual disabilities.

Society needs to accommodate distress and disturbance without scapegoating and without controlling targeted individuals in the name of paternalistic help.

There is the risk with programs which use the title ‘human rights in mental health’ , because this could feed into the status quo, suggesting that the mental health system itself is primarily responsible both for operationalizing the obligation to end forced interventions and detention, and for securing the realization of our positive human rights. This would center the power again in the hands of psychiatry, and enforce the status quo as if “they know best what is good for us, users/survivors”.

We call for an approach to our human rights which is centering our voices, our holistic and comprehensive human rights needs and concerns, beginning with the abolition of arbitrary detention and torture, and the right to legal capacity. Only then we can work to realize all articles of the UN CRPD, and eventually realize full inclusion in all areas of life.

We believe that the UN reparations framework, encompassing both collective and individual measures of satisfaction, guarantees of non-repetition, restitution, compensation and rehabilitation, is the best starting point to make a complete break with the past; overturn centuries of oppression at the hands of states, psychiatry, society and other actors; and begin to repair the damage to individuals, families and communities that has been created through violence and exclusion.

At the same time, community based support must be realized.

Such a process can only succeed if it is fully consultative to include diverse voices of people with psychosocial disabilities and our collective self-representation at every stage including planning, design, implementation and follow-up, to remedy serious human rights violations and build sustainable, inclusive communities.

As a final remark, I would like mention that in Latin America there have been developments and actions to form a regional network of users and survivors of psychiatry. In the past days, there has been a meeting with organizations and people with psychosocial disabilities from Argentina, Chile, Colombia, Costa Rica, Bolivia, Uruguay, Paraguay, Mexico and Peru. This meeting was the first step for the construction of this regional network with a view to having the second meeting at the end of this year. This network will advocate for the rights of persons with psychosocial disabilities in Latin America.

Thank you for the opportunity to bring these points to the consideration.

**Second statement**

RE panel 4

I would like to highlight:

Safeguards to coercive interventions, such as registration and options to file complaints afterwards, do not offer actual protection, since the so-called safeguards still allow the harmful practices to take place, and only AFTER the harm has already been done, the person can appeal to have their rights respected. This is a rather meaningless form of protection.

On top of that, there are barriers to access justice, which cannot be overcome, since the laws allow the harmful coercive practices, making it hard to argue there is a violation. And when there is no technical breach of the law, it is nearly impossible to file complaints effectively.

We also see a misleading human rights rhetoric in law reforms. For example, in western Europe, several laws call to “Respect the will and preferences during coercion”, by offering choice between various forms of coercion. However, coercion implies that the person does not want the intervention in the first place. So to “respect the will and preferences during coercive practices” is in itself totally impossible, because it doesn’t give a real choice.

Under the CRPD, the coercive practices are now illegal, so change is unavoidable. It is important to stress that in the future, the mental health care system will definitely not be the same as it is now.