



General Assembly

Distr.: General
2 February 2022

Original: English

Human Rights Council

Forty-ninth session
28 February–1 April 2022
Agenda items 2 and 3

Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General

**Promotion and protection of all human rights, civil,
political, economic, social and cultural rights,
including the right to development**

Summary of the outcome of the consultation on ways to harmonize laws, policies and practices relating to mental health with the norms of the Convention on the Rights of Persons with Disabilities and on how to implement them

Report of the United Nations High Commissioner for Human Rights*

Summary

The present report, submitted pursuant to Human Rights Council resolution 43/13, contains a summary of the discussions at the consultation, held on 15 November 2021, on the best ways to harmonize national laws, policies and practices relating to mental health with the norms of the Convention on the Rights of Persons with Disabilities. The consultation was focused on: (a) exploring and sharing promising experiences of reform of laws, policies and practices guided by a human rights-based approach in the field of mental health; and (b) highlighting key aspects of legal reform based on the Convention. Recommendations were formulated for States and all other relevant stakeholders, including health professionals, with a view to designing and implementing legal and policy reforms, as well as other measures, with a human rights-based approach in all sectors relevant to mental health in line with the Convention.

* Agreement was reached to publish the present report after the standard publication date owing to circumstances beyond the submitter's control.



I. Introduction

1. The Human Rights Council, in its resolution 43/13, requested the United Nations High Commissioner for Human Rights to organize a consultation to discuss the best ways to harmonize national laws, policies and practices relating to mental health with the norms of the Convention on the Rights of Persons with Disabilities. The consultation was held on 15 November 2021. In the same resolution, the Council requested the High Commissioner to prepare a report on the outcome of the consultation, to be submitted at its forty-ninth session. The present report was prepared pursuant to that request.

2. The Permanent Representatives of Brazil and Portugal to the United Nations Office and other international organizations in Geneva, Tovar Da Silva Nunes and Rui Macieira, respectively, chaired the consultation. The consultation was divided into two panels. The objective of the first panel was to explore and share promising experiences of the adoption, implementation, updating, strengthening or monitoring of laws, policies and practices guided by a human rights-based approach in the field of mental health. The objective of the second panel was to highlight key aspects of legal reform based on the Convention.

3. The panellists were: the Director of Mental Health, Ministry of Health, Peru, Yuri Cutipé; the Director of the Wildflower Alliance (formerly the Western Massachusetts Recovery Learning Community), Sera Davidow; the Unit Head of the Policy, Law and Human Rights Unit, Department of Mental Health and Substance Use, World Health Organization (WHO), Michelle Funk; the Assistant Director and focal point on disability of the Kenya National Commission on Human Rights, Elizabeth Kamundia; the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng; the Regional Mental Health Adviser for Africa, CBM Global Disability Inclusion, Michael Njenga; the Special Rapporteur on the rights of persons with disabilities, Gerard Quinn; and Professor at RMIT University, Melbourne, Australia, Penelope Weller. The following panellists submitted pre-recorded video statements: the Vice-President for Health Programmes of the Carter Center, Kashef Ijaz; the Chair of the Committee on the Rights of Persons with Disabilities, Rosemary Kayess; and the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Nils Melzer.

4. All other stakeholders, comprising Member States, national human rights institutions and civil society, including organizations of persons with mental health conditions or psychosocial disabilities, were invited and encouraged to participate. Written submissions received by the Secretariat are considered in the present report.

II. Summary of the consultation

A. High-level opening

5. In her opening remarks, the United Nations High Commissioner for Human Rights, Michelle Bachelet, emphasized that the moment to make mental health a global priority had been long overdue. She declared that the coronavirus disease (COVID-19) pandemic had had a disproportionate impact on the health and well-being of persons with mental health conditions or psychosocial disabilities and other groups in vulnerable situations. It had widened gaps in access to health services, mental health services and psychosocial support and had exposed that many persons with mental health conditions or psychosocial disabilities either lacked access to recovery-based support services or were caught in a vicious cycle of violence in their interaction with them.

6. She underscored the urgent need for the global community to implement the Convention, which constituted the international legal framework under which mental health systems could be respectful of the dignity and rights of both users and professionals. Countries needed to move away from institutionalization and towards inclusion and the right to independent living in the community. She welcomed the collective recognition, expressed in May 2021 at the World Health Assembly, of the importance of scaling up access to high-

quality and rights-based mental health services. She commended WHO on its QualityRights initiative and called for greater investment in community-based support services that responded to people's needs and rights, as well as greater investment in the social determinants of health. Such investment could empower and restore individual dignity and contribute to more tolerant, peaceful and just societies.

7. The Deputy Director-General of WHO, Zsuzsanna Jakab, stated that, despite the growing awareness among countries in the last two decades, most countries still had outdated legal, policy and service frameworks that were not aligned with human rights standards. The COVID-19 pandemic had compounded the inadequate, fragmented and outdated nature of mental health systems worldwide and had highlighted the damaging effects of mental health institutions, the lack of cohesive social networks and the insufficient holistic, community mental health services. She highlighted the call for reform in the Convention, echoed also in the 2030 Agenda for Sustainable Development through its promotion of mental health and well-being with human rights at its core, and in the political Declaration of the high-level meeting on universal health coverage.¹

8. She highlighted the recognition by States of the importance of scaling up access to high-quality and rights-based services, expressed at the World Health Assembly, and expanded options for the implementation of the WHO comprehensive mental health action plan. She referred to the WHO comprehensive guidance on establishing and scaling up rights-based mental health services, launched in June 2021 as part of the QualityRights initiative. She announced that WHO and the Office of the United Nations High Commissioner for Human Rights (OHCHR) were drafting new guidance on human rights, legislation and mental health, aimed at supporting reform.

9. The Deputy Board Member of the European Network of (Ex-)Users and Survivors of Psychiatry, Stéphanie Wooley, expressed concern about the draft additional protocol concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment, developed by the Committee on Bioethics of the Council of Europe, to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (the Oviedo Convention), which would legitimize the involuntary treatment of persons with psychosocial disabilities in violation of the Convention on the Rights of Persons with Disabilities. She highlighted laws and practices that discriminated against and violated the rights of persons with mental health conditions or psychosocial disabilities in some European countries, which had increased during the pandemic. She gave examples of countries and regions that were moving towards ensuring respect for human rights in mental health, including through efforts to recognize legal capacity, supported decision-making and the right to vote. Such promising practices, which required the meaningful and systematic involvement of persons with mental health conditions or psychosocial disabilities from the bottom up, cost much less than forced hospitalization and had much greater benefits. Referring to the challenges involved in replicating such practices, she pointed to the need to increase the resources available to and the authority of monitoring mechanisms and ombudspersons, including a mandate to monitor all closed regimes and facilities.

10. The Minister for Health of Brazil, Marcelo Queiroga, in a pre-recorded video statement, reiterated his country's commitment to the right to health, recalling that, alongside Portugal, it had sponsored Human Rights Council resolutions on human rights and mental health. He highlighted Law 10.216 as the basis for psychiatric reform over the past 20 years and the Brazilian Law for the Inclusion of Persons with Disabilities. He stressed the need to consider mental health as an integral and inseparable part of the human right to health, as well as the social determinants of mental health. Measures had been taken by his Government to promote community-based mental health care and to expand psychosocial support throughout the country. Public health care was provided through the Brazilian Unified Health System, including all services in the mental health network. The achievements made as a result of the Brazilian Mental Health Policy included strengthened facilities, services and awareness-raising activities among health workers to reduce stigma and prejudice. He

¹ General Assembly resolution 74/2.

announced that there were plans to reinforce urgent and emergency care, telemedicine and mental health care in primary health care.

11. The Minister for Health of Portugal, Marta Temido, in a pre-recorded video statement, said that, despite mental health conditions being common, mental health remained a neglected area worldwide. Collective action was needed to ensure that mental health enjoyed parity with physical health. She highlighted the multiple violations against persons with mental health conditions or psychosocial disabilities, which often occurred behind closed doors. Stigma was still a major barrier to the quality of care and access to the full range of services. She underscored the commitment of her country, together with Brazil, since 2016, to addressing the issue of mental health in the Human Rights Council. She highlighted the support and commitment of OHCHR and WHO, in particular the latter's QualityRights initiative. The Convention laid the foundation for mental health reform that was respectful of the rights of persons with mental health conditions or psychosocial disabilities, however, States faced major challenges and needed guidance to trigger that paradigm shift. She listed the main efforts being made by Portugal to align laws, policies and practice with human rights, including ongoing legal reform, improving access to outreach care, carrying out independent monitoring of mental health facilities and involving users of mental health services and families in matters affecting them, including in the National Mental Health Programme team in the revisions to the mental health law.

B. Overview of presentations: public policy reform

12. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health said that the legacy of colonialism had shaped current mental health systems, leading to differences within and between countries and contributing to adverse health outcomes. Any commitment to supporting good mental health must coincide with a commitment to eradicating systems of inequality that had an impact on people's overall health. Indigenous and traditional knowledge had to be recognized and integrated into public health systems. Poverty, social injustice, inequality, discrimination and violence produced mental distress, particularly when people were persecuted on grounds of their race, gender, sexuality, religious affiliation, social class or disability. Reforms required recognizing users as individuals with equal rights and recognition before the law. It entailed ensuring the participation of persons with mental health conditions or psychosocial disabilities in the planning, monitoring and evaluation of services, in system strengthening and in research.

13. She emphasized that coercion, involuntary treatment and forced placement were outdated, ineffective and incompatible with human rights. She highlighted the duties and guidance in the Convention, commended WHO on its QualityRights initiative and provided examples of alternative models of mental health services, including peer-respite centres, medication-free wards and recovery communities. She reiterated that the overreliance on medications in mental health treatments was a significant obstacle to the realization of the right to health, as had been expressed by her predecessor. She renewed his request that WHO develop a new, holistic list of essential psychosocial and population-based interventions, informed by evidence and supported and developed in accordance with human rights principles, and to review the WHO essential medicines list with a view to removing the mental health medications for which there was no evidence of an adequate risk-benefit ratio. She encouraged the participants to work together to take into account intersectional vulnerabilities and develop holistic programmes that would help to achieve better health and well-being.

14. Dr. Funk said that, in the current global context, violations of human rights of persons with mental health conditions or psychosocial disabilities were common and legitimized in policy and law. To counter that, countries needed to scale up investment in rights-based mental health services, including services that were free from coercion, including forced admission and treatment. The focus on a biomedical approach often limited treatment to diagnosis and medications and failed to address important areas of people's lives at the root cause of mental health conditions and essential for recovery. Those areas included community inclusion, relationships, a sense of belonging, opportunities for employment and

education, housing, social protection and access to good-quality health care more broadly. WHO had launched the *Guidance on Community Mental Health Services: Promoting Person-centred and Rights-based Approaches* and seven technical support packages in June 2021. In the guidance, WHO had demonstrated that developing rights-based services and achieving good health and social outcomes was possible, often at a cost that was comparable to or lower than the cost of existing mainstream services. It further sought to inspire countries to develop and scale up these services and guide them in doing so. All the services showcased in the guidance had common specific criteria, including being respectful of people's legal capacity and their decisions regarding their recovery, including when in crisis; having a strategy to end coercion; and promoting the meaningful participation of people with lived experience.

15. She listed some of the key recommendations that WHO was making to countries, which included increasing funding for rights-based mental health and social care services; aligning legal and policy frameworks with international human rights standards, including the Convention; building capacity on mental health, human rights and disability for all stakeholder groups; and strengthening data collection. While she regretted that rights-based services were not accessible to all who required them, she was hopeful that a better way forward could be forged in the light of existing services dotted around the world that were aligned with the Convention and which could be scaled up to become the basis of the mental health system. She reiterated the importance of putting in place systems and frameworks that reflected a commitment to leaving coercion behind, while leaving no person behind.

16. Mr. Njenga said that most mental health policy frameworks and systems stemmed from general health laws, which often included an exception to the principle of informed consent and separate, lower standards of protection for the rights of persons with disabilities, resulting in forced admission and treatment only for persons with psychosocial disabilities. He asserted that developing a legal capacity framework based on the Convention was a precondition for any fundamental shift in mental health policy and systems, which should include reframing legal capacity and incorporating supported decision-making. He shared experiences from Kenya and Zimbabwe and highlighted the role and advantages of peer support groups among persons with lived experience in decision-making and the exercise of legal capacity. The WHO QualityRights resources helped policymakers and implementers to advance the rights of persons with psychosocial disabilities, promote recovery and community inclusion, and monitor services using human rights-based indicators. CBM Global had used the tools to organize sessions with families and traditional and religious leaders on providing support in a rights-compliant manner when people were in distress. He emphasized the need to understand mental health from a development lens, addressing the intersections between mental health and the social determinants of health. He recalled general comment No. 7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention of the Committee on the Rights of Persons with Disabilities and the need to ensure the meaningful participation of persons with psychosocial disabilities through their representative organizations.

17. Dr. Ijaz said that, with a global mental health crisis unfolding, a focus on rights-based support was crucial. The Carter Center, bilateral donors and multilateral organizations had the opportunity to leverage resources and partnerships to advance human rights, democracy and health for the world's most vulnerable populations. He noted the alarming disconnect between available mental health services and demand, which had worsened during the COVID-19 pandemic. He welcomed the WHO guidance on and recommendations for ending human rights violations in mental health care as a blueprint that emphasized the role of communities and recovery in country and global policy planning. He described the support provided by the Carter Center since 2010 to reform mental health systems, guided by a human rights-based approach, in Liberia, which had included training health-care workers and journalists and assisting in drafting the first law to improve health care for persons with mental health conditions and to prevent discrimination against them. He underscored that organizations of persons with lived experience were instrumental in advocating for human rights, government accountability and budgets and resources for good-quality mental health services. Currently, funds from mental health budgets tended to be allocated to psychiatric hospitals and institutions, and a human rights shift meant increasing allocations to

community-based services. He highlighted that countries must commit to making mental health a health and development priority.

18. Ms. Davidow shared her own personal and professional experience to highlight the importance of peer support. She said that she had been part of establishing the declaration of peer roles under the Western Massachusetts Peer Network in 2013, which echoed principles and rights contained in the Convention, such as a focus on respect for the dignity of the person, prioritization of self-determination to make one's choices, and the importance of community inclusion and meaningful involvement. She shared information about her organization's work, which sought to support people to take control, including retaining their rights to liberty and choice. She presented the peer-respite support provided at Afiya House, which had been showcased in the new WHO guidance on community mental health services as one of a handful of exemplary rights-based approaches. Peer respite offered an alternative to psychiatric facilities through a stay in a non-clinical setting, which supported people in exploring what was working and what might need to change to enable them to live life to the fullest. The service did not seek to change people but supported their gaining life tools and a sense of control over the distress that might sometimes get in their way, while still ultimately being themselves, even if that meant living in a way that did not match societal expectations. Peer respite offered support while people continued to go to work or school and to access their mail so that they could pay their bills and thereby avoid long-term devastating effects on their lives. Support also included advocating on behalf of individuals to avoid their having to go before the courts for commitment hearings. That element of the service was particularly important as many persons routinely faced inequitable representation and had negative experiences in the justice system, for example, court-ordered forced treatment in a hospital or institution, or the loss of parental rights and responsibilities. The service also supported people who were seeking to avoid or shorten forced commitments. The challenges that the service faced included needing to increase its capacity in order to support more people in avoiding inpatient facilities and other human rights violations. Another challenge was the recruitment and retention of highly skilled peer supporters because there was a discriminatory misconception that peer support required fewer skills than clinical work. The alternative approach of peer respite for individuals considering suicide or hearing voices also had the potential to be cost-effective, including by empowering people to break the harmful cycle of repeated hospital admissions.

C. Overview of presentations: key aspects of legal reform based on the Convention on the Rights of Persons with Disabilities

19. Dr. Cutipé described the process of legal reforms that Peru had undertaken as a State party to the Convention since 2007, including the General Law on Persons with Disabilities and the development of the Mental Health Law adopted in 2019. He underscored the role of civil society and supranational organizations in advocating for legal reforms and designing and implementing the first community-based mental health services with a human rights perspective. Under the Mental Health Law, the social determinants of health were considered to be critical elements for protecting rights, regarding both the promotion of mental health and the prevention of distress and recovery from it. A programme of results-based financing of mental health services involving coordination among national, regional and local governments had been introduced in 2015, with the aim that it would be scaled up and available throughout the national territory by 2026. In his view, the greatest achievement of the legal reforms that were under way was the momentum to change the paradigm of mental health care from one that equated care with psychiatric hospitals and was characterized by the invisibility of diversity and the containment of symptoms to one that was based on human rights and participation and centred on individuals and their needs for a dignified life. Among the remaining challenges in implementing legal reforms, he noted, were the inherent tensions from the legacy of colonization and old ideas, including about "irregular conduct" and "madness" and their containment and control, which permeated new laws and norms. He noted with hope, however, that other social movements demanding justice and reparation, including associations of victims of political violence from the 1980s to 2000 and, more recently, organizations of survivors of gender-based violence, had succeeded in balancing similar tensions and advancing legal reform. He underscored that organizations of users of

mental health services and of those who could not access health and social protection needed to participate in reforms. Although initial steps towards legal and policy reform were still insufficient to meet needs, new possibilities for a paradigm shift were being created. It was necessary to make the implementation of the Convention tangible for citizens and civil society in order to generate support for a second generation of legal reforms that would advance the purpose of the Convention.

20. Ms. Weller described the law reform recommendations arising from the recent final report of the Royal Commission into the mental health system in the state of Victoria, Australia. The Royal Commission had been established in 2019 in response to growing awareness that the mental health system was crisis-driven, inequitable, unsafe and overreliant on coercive treatment and that the Mental Health Act of 2014 had not achieved its purpose. In its proceedings, the Royal Commission had conducted system-wide, evidence-based analysis and sought guidance and input from those with lived experience. The final report transmitted in 2021 provided a comprehensive road map for system transformation based on human rights, with an aim to ensure that mental health and well-being services, care and support were of high quality: appropriate, effective, integrated, affordable and safe. The Royal Commission recognized restrictive practices as violations of human rights and required immediate action to ensure the elimination of seclusion and restraint within 10 years. The elimination of those practices would be achieved through clear targets, the use of alternative approaches and comprehensive reporting on and oversight of the use of seclusion and mechanical and chemical restraint. Users and clinicians would co-design and implement reduction initiatives in each service or unit. The Royal Commission recommended replacing the Mental Health Act of 2014 with a new mental health and well-being act, which was already being drafted, as the essential foundation of a transformed system. She explained that there had been a significant shift in the way compulsory treatment powers had been designed to support the transition to a system that no longer relied on coercion. The Royal Commission had recognized that the success of mental health legislation lay in broad community understanding and acceptance. The example given showed that mental health systems reform must be built on respect for human rights, consensus, collaboration and compassion.

21. Ms. Kamundia highlighted the role of the Kenya National Commission on Human Rights in the various attempts to amend the Mental Health Act of 1989, including through the current Mental Health (Amendment) Bill 2020. The Bill, following its first reading, had been committed to the National Assembly Departmental Committee on Health for consideration in November 2021. The Commission had made submissions jointly with organizations of persons with disabilities to the Parliament on the Bill. Some of their recommendations had been included in the Bill, in line with the Convention and general comment No. 1 (2014) on equal recognition before the law of the Committee on the Rights of Persons with Disabilities. The Bill had a strong focus on the provision of community-based mental health services. She regretted that other recommendations had not been incorporated and that the Bill still allowed for the appointment of a representative against a person's will, involuntary admissions and the use of seclusion and restraints. The Commission had proposed that the Bill should have an appendix clarifying supported decision-making to ensure that it was not misunderstood as a form of guardianship, but that proposal had been rejected. She noted that key challenges had been how ingrained the biomedical model of disability was in the mental health sphere and the prejudice of some parliamentarians regarding mental health conditions and decision-making. She underscored opportunities for the Commission, including supporting and scaling up user-led initiatives, which provided evidence for policymakers that alternatives to the medical model of mental health care worked. Kenya was the second country in Africa, after Ghana, to take up the QualityRights initiative and a multi-stakeholder committee under the Ministry of Health, including non-governmental actors, had joined in implementing it. She highlighted that, in 2019, the mental health taskforce set up to investigate the mental health situation of Kenyans had recommended the reform of the Mental Health Act, as well as enhanced budgetary allocations to mental health. There were other ongoing law reform processes relating to laws that impacted on people with mental health conditions that could result in opportunities for positive change, including laws that criminalized suicide or behaviour associated with mental health crises. She reflected that specific technical guidance to develop the law in line with the Convention would have been extremely useful. She underscored the importance of

participation, emphasizing that the Commission worked closely with organizations of persons with psychosocial disabilities in all decision-making processes, including reforming the law on mental health, in the spirit of article 4 (3) of the Convention.

22. Ms. Kayess said that ensuring the exercise of rights for persons with psychosocial disabilities was a critical area of law reform that was long overdue. She recalled the outcomes and recommendations of the consultation held by OHCHR in 2018 to identify strategies to promote human rights in mental health² and the opportunity to build on them. She noted that, under the biomedical model of disability, persons with psychosocial disabilities were perceived not as rights holders but as objects of treatment, management and control. Even worse, the denial of rights of persons with disabilities was framed as “safeguarding” of the person experiencing distress or of the community in which that person was perceived as dangerous. The Convention provided the principles and standards that enshrined the recognition of persons with psychosocial disabilities as rights holders, whereby impairments were not a basis for the diminishment or limitation of rights. She insisted that legal reform had to ensure that all rights and fundamental freedoms applied equally to all persons. She clarified key elements of the Convention, including: the recognition of legal capacity for persons with psychosocial disabilities; the meaningful involvement of persons with psychosocial disabilities and their representative organizations as mental health experts and active participants in designing mental health support systems; the prohibition of detention on the basis of impairment and explicit recognition of the principle of free and informed consent for health care; the protection of the security and personal integrity of persons with psychosocial disabilities; community-based alternatives to institutional settings; and reformed access to justice to enable redress and reparation. Countries also needed to enable the participation of organizations of persons with psychosocial disabilities, including through funding and the development of strategies, such as a standing consultative mechanism of people with disabilities. Preventive mechanisms had to be established and have oversight over places of detention where persons with psychosocial disabilities were held. She recalled that, for guidance, States could refer to the Committee’s general comments and its guidelines on the right to liberty and security of persons with disabilities. Without legal reform, a society in which all human rights and fundamental freedoms were realized could not be achieved.

23. Mr. Quinn described how mental health laws began as a separate field characterized by coercion and loss of rights. However, the adoption of the Convention had provided an imperative to ground laws on personhood and rights. There had been two main waves of human rights responses to the well-known abuses of psychiatry and involuntary commitment of persons with mental conditions. The first wave was about controlling the loss of rights with objective safeguards. The second wave began with the adoption of the Convention and was about challenging the core problem of invisibility as a person and the resulting inequalities. Equal treatment as foreseen by the Convention meant radically doing away with coercive laws and policies that stripped persons with disabilities of their liberty and enforced coercive measures. The mental health field was overmedicalized, and he stressed that inherited laws and policies permitting coercion had to be discontinued and replaced by laws guaranteeing personhood and equality. He encouraged countries to be forward-looking in the next wave of human rights reform and commended WHO for highlighting the positive steps that States were taking in that new direction. He reiterated his call, along with that of many others, including the Chair of the Committee on the Rights of Persons with Disabilities, to dissuade the Council of Europe from adopting its proposed draft additional protocol to the Oviedo Convention. He concluded that States should consider persons with disabilities as allies who were eager to innovate and contribute to imagining new policies for a very different future in partnership.

24. The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment stressed the pressing need to abolish legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability and to ensure regular review of any decision involving institutionalization, including independent monitoring by human rights experts, national human rights institutions, national preventive mechanisms, civil society and international mechanisms. States should adopt legislation

² A/HRC/39/36.

recognizing the legal capacity of persons with disabilities and supported decision-making. Legal capacity had to be inherently linked to a community-based approach to living and support, and independent living in the community had to be recognized as a right. States should facilitate deinstitutionalization by introducing social welfare laws and providing a range of support services to persons who required them. He highlighted the crucial need for guidelines on free and informed consent and the impact of institutionalization, on treatment, and on living conditions for persons with psychosocial disabilities. Furthermore, adequate training for and awareness-raising among law enforcement officials and prison staff was necessary. It was imperative to recognize violence and abuse perpetrated against persons with disabilities as a form of torture or other cruel, inhuman or degrading treatment or punishment, in order to afford victims and advocates stronger legal protection for those violations. He concluded by calling for an inclusive society to end marginalization and discrimination.

25. A video of a poem written and read by Erin May Kelly entitled “The power of purpose” was shown, which highlighted many people’s experience of coercion and inhuman treatment in mental health services, particularly in institutional settings. It also highlighted the positive impact that mental health services could have when they were truly responsive to people’s needs and rights.

D. Statements by representatives of Member States and other stakeholders

26. During the ensuing discussion, representatives of Colombia, Costa Rica, Israel, Malaysia, Timor Leste and the United Kingdom of Great Britain and Northern Ireland took the floor.

27. Representatives of the following treaty bodies, intergovernmental bodies, non-governmental organizations, organizations of persons with disabilities and academia also contributed to the discussion: Vice-Chair of the Committee on the Rights of Persons with Disabilities; Citizens Commission on Human Rights Europe; the Center for the Human Rights of Users and Survivors of Psychiatry; the Centre for Mental Health Law and Policy; the European Union; Hope for the Abused and Battered; Human Rights Watch; the Parliamentary Assembly of the Council of Europe; the World Federation for Mental Health; the University of Glasgow; and the University of Nottingham.

28. Written submissions were received from: the American Psychology Association; the Centre for Mental Health Law and Policy; the Indian Law Society; the Ohaha Family Foundation; and Lene Sjøvold, in her capacity as a clinical psychologist and mental health adviser.

29. Many of the representatives of States reiterated that the COVID-19 pandemic had had a disproportionate impact on the mental health of persons with mental health conditions or psychosocial disabilities and other marginalized groups. Marginalization directly translated into limitations in access to education and health services. States expressed their commitment to improving the mental health of their populations and shared information on the measures that they had taken to increase access to mental health services, some of which related specifically to the pandemic period. The pandemic was a reminder of the centrality of health and the interdependency of rights. States also highlighted the legal reviews under way, reforms achieved and efforts to develop community-based mental health services. States acknowledged that mental health was a major public health concern, as was ensuring that persons with mental health conditions or with psychosocial disabilities were able to exercise their rights, and requested guidance in that regard. They requested technical support from WHO and OHCHR on how to better align legislation, policies and services with the Convention. Persons with psychosocial disabilities had to be recognized as having a fundamental role in policy design, and it was critical to address the specific needs of groups who were marginalized or in a vulnerable situation, including women, girls, youth, persons deprived of liberty, migrants, lesbian, gay, bisexual, transgender, queer, intersex and gender-diverse persons and other persons in vulnerable situations. States emphasized that mental health had to be at the centre of COVID-19 recovery plans, which included ensuring the place of mental health in national and international policies and the implementation of existing international standards and conventions.

30. The representative of the Committee of Social Affairs, Health and Sustainable Development of the Parliamentary Assembly of the Council of Europe and Rapporteur of the report on the deinstitutionalization of persons with disabilities, Reina De Bruijn-Wezeman, announced with regret that, 15 years after the adoption of the Convention, discrimination based on impairment, in particular involuntary placement, had not yet been eliminated. States parties must review their legislation in order to respect and uphold all rights of persons with disabilities, including equal recognition before the law. She expressed with concern that the draft additional protocol to the Oviedo Convention would have the effect of legalizing the taking of measures without the informed consent of the person concerned in mental health care, in stark contrast to the provisions of the Convention. She expressed the opposition of the Parliamentary Assembly and the Council of Europe Commissioner for Human Rights to the proposal.

31. Civil society representatives welcomed the increasing focus on rights and emphasized the importance of a human rights-based approach to mental health. They noted that it was time to move forward with the implementation of the Convention, including regarding supported decision-making. Various speakers asked for additional guidance to reorient their work around rights. Others noted that monitoring progress through human rights indicators was crucial and that WHO and OHCHR, the latter of which had developed human rights indicators on the Convention, could support in that regard. Echoing some of the views of the panellists, several participants highlighted that there were still grave violations and abuses being perpetrated in mental health systems, including involuntary treatment. The challenges were greater for those who experienced racial discrimination, political exclusion and marginalization. Some participants highlighted the continuing documented practices of chaining and shackling in various countries around the world, as well as a country case study in which 70 to 90 per cent of persons did not have access to mental health care. They urged States to facilitate the training of service providers to ensure respect for human rights and a full understanding of the scope of the Convention and the rights that it sought to protect. Speakers highlighted that the lack of understanding and knowledge about the human rights model of disability among professionals, practitioners and policymakers was a barrier that needed to be overcome. They also made reference to the criminalization of disabilities and to unjust policing practices that disproportionately targeted persons with mental health conditions on account of their health rather than wrongdoing.

32. Participants from the floor joined the call for States to reject the proposed draft additional protocol to the Oviedo Convention. Recalling the theme for World Mental Health Day, “Mental health in an unequal world”, panellists underscored the importance of addressing human rights and ensuring access to health care for all. They noted that case examples of services that worked also existed, as showcased in the recent guidance on rights-based community mental health services issued by WHO under its QualityRights initiative. They expressed concern that high-income countries seemed to be lagging behind many others in terms of implementing human rights approaches in mental health systems and asked how change could be expedited. Speakers agreed that persons with psychosocial disabilities must participate in policy design and all decisions concerning them as a matter of rights and because they could provide valuable input.

E. Closing

33. The Director of Transforming Communities for Inclusion, Bhargavi Davar, welcomed mental health policy reforms but cautioned that they were only one part of the larger reforms needed to ensure rights and inclusion. She described her own personal history to exemplify that a specific disability group had suffered over a century of intergenerational trauma, torture and pain caused by the collective systemic oppression of mental health services. It was not enough to stop the violence and coercion within mental health systems or only to offer good-quality mental health services. To achieve the full inclusion of persons with mental health conditions in the community, it was also necessary to do away with archaic policy designs that inherently eroded quality of life and well-being. She noted that inclusion was impossible if gatekeeping of access to various other services, such as housing and insurance, was done by the mental health system. The past harms endured by persons with psychosocial

disabilities, based on disability status, had to be recognized and redressed, taking a similar approach to that used in the case of the harms caused by racism and those endured by indigenous peoples and other oppressed people. States needed to put in place reparation and accountability mechanisms for the past wrongdoings.

34. The social movement of persons with psychosocial disabilities, in collaboration with the cross-disability movements worldwide, was using the Convention to decolonize and demedicalize their lives by creating opportunities for participation in integrated community engagement and contributing to its development. The movement of persons with psychosocial disabilities supported reforms to mental health care as a harm reduction measure but its real aspiration was to develop a community of practice around inclusion, rather than “good treatment”. That involved families, support groups and services and other circles of care and was one where health care supported inclusion in all areas of life and where there were public inter-agency coordinated actions for support with regard to housing, employment, sport, self-care, relationships, leisure and family.

35. The Director of the Thematic Engagement, Special Procedures and Right to Development Division, OHCHR, Peggy Hicks, thanked Brazil and Portugal for advancing discussions on mental health and human rights at the Human Rights Council. She said that the focus of the global community had inevitably been drawn to the devastating impacts of the COVID-19 pandemic on the physical and mental health on the lives of millions of people. While everyone had been affected by the stress and fear caused by the pandemic, those with pre-existing mental health conditions and psychosocial disabilities had been particularly affected, in terms of both increased inequalities in access to mental health services and long-term implications. She noted the relevance to mental health of the report of the Secretary-General entitled “Our Common Agenda”. In that report, the Secretary-General had called for a new social contract, mending trust and embracing a comprehensive vision of human rights. She highlighted a few key building blocks for strengthening mental health systems anchored in human rights. Among them was ending violence, deprivation of liberty and forced treatment based on disability status, actual or perceived, that currently persisted within systems. She encouraged States to harmonize legal and policy frameworks with the Convention and highlighted that evidence continued to show that there was a need to move away from coercive measures and seek rights-respecting alternatives to involuntary placement and involuntary treatment.

36. She expressed concern about the draft additional protocol to the Oviedo Convention, which would allow for forced treatment and would breach the guarantees under the Convention on the Rights of Persons with Disabilities, which most of the Council of Europe member States had ratified. She reiterated that laws denying equal recognition before the law based on disability status, in particular under guardianship or conservatorship, were discriminatory and thus prohibited. She emphasized the role of persons with psychosocial disabilities or with mental health conditions and their organizations as agents in their own recovery. The pandemic had provided an occasion for governments to start recognizing violations and ensuring effective remedies and reparation for victims and survivors of certain forms of abuse in health-care settings, particularly those that might have crossed a threshold of mistreatment that was tantamount to torture or cruel, inhuman or degrading treatment or punishment. As the COVID-19 pandemic continued, health services needed a more sustainable footing, and the root causes of poor health, including mental health, needed to be addressed in an integrated manner, with a whole-of-government, whole-of-society approach.

III. Conclusions and recommendations

37. The panellists agreed that human rights needed to be the backbone of all discussions and actions around mental health and recalled that there was no health without mental health. Several representatives expressed that the starting point was international human rights law, and specifically the Convention on the Rights of Persons with Disabilities, which framed the legal obligations, policy and practice in all sectors relevant to mental health, serving as an implementation tool and offering a vision and providing a language of change. Political commitment from countries was needed to ensure compliance with the Convention, which would then be reflected in rights-based policies, laws and services. One panellist noted that

a major challenge to implement the Convention was how to provide and create the necessary support services to enable persons with mental health conditions or with psychosocial disabilities to make decisions and access health or social services. It was crucial to fund and promote rights-based approaches and to have the meaningful participation of persons with disabilities and their organizations at all levels of decision-making regarding mental health. Panellists stressed that States had to fulfil their obligations to ensure that every person who required services could have access to them. States also needed to ensure that everyone had access to public health information in accessible formats, as many young persons were being left out.

38. Most speakers mentioned the need to address the social determinants of health and to reach persons who were socially marginalized or who had experienced discrimination, including on the grounds of age, race and disability. Many underscored that progress would be possible only if inequalities in policies, laws and services were addressed and agreed that there was momentum to invest in addressing the social determinants of health to overcome the effects of the pandemic, as well as in community-based services. They welcomed the fact that discussions on mental health from a disability rights perspective had broadened the perspective on the issue, such that it encompassed not only health but the social sector as a whole and included the right to independent living in the community. Speakers agreed on the crucial role of capacity-building and developing skills and understanding on the ground to transform systems, and the need for human rights education of all health professionals and stakeholder groups, including people with lived experience. The material provided by WHO under its QualityRights initiative and its e-training platform to be launched in 2022 would support countries and promote further research to generate evidence-based solutions. Panellists underscored the need to change attitudes and awareness-raising to reduce stigma and overcome the dominance of the medical model to disability, including among legal professionals.

39. Panellists drew attention to the need to strengthen independent monitoring and national institutions, as well as to realize article 32 of the Convention on international cooperation, to better exchange promising practices and knowledge about services in different contexts. They highlighted the importance of educating persons with mental health conditions on issues around loss of power and control. Various panellists reiterated that changing systemic oppression, seeking out the people most at the margins of society and empowering them would lead to social improvements for everyone. The language that framed mental health conditions as “mental illness” had to change as it gave a very narrow idea of people’s needs and reinforced the profound loss of power and control for people using mental health services. Some panellists joined the urgent call made to member States of the Council of Europe to oppose the draft additional protocol to the Oviedo Convention.

40. **In the light of the discussions, the United Nations High Commissioner for Human Rights makes the following observations and recommendations for States and all other relevant stakeholders, including health professionals, on ways to harmonize, as appropriate, laws, policies and practices relating to mental health with the provisions of the Convention on the Rights of Persons with Disabilities and on how to implement them:**

(a) **States should carry out legal reform in line with the Convention in all sectors relevant to mental health, including anti-discrimination, legal capacity and criminal justice, education, health, social protection and family law. Wide legal and policy reforms should be undertaken with a human rights-based approach, ensuring that all persons are guaranteed equal rights and equal recognition before the law. The recommendations and general comments of the Committee on the Rights of Persons with Disabilities provide useful guidance in this endeavour;**

(b) **With regard to mental health systems, States should adopt measures to ensure that everyone who requires mental health support is recognized, first and foremost, as a person, in accordance with the human rights model of disability. Throughout the consultation, participants reiterated the need for guidance on carrying out reforms to mental health-related legislation and practices to ensure their compliance with the Convention. States can avail themselves of technical support from OHCHR and WHO in this regard, including the materials provided through the WHO**

QualityRights initiative and the forthcoming rights-based guidance on mental health-related legislation;

(c) Stemming from their obligations under the Convention, States should repeal provisions on forced institutionalization and substituted decision-making in law and in practice. States' commitment to deinstitutionalization should include ending involuntary treatment practices, promoting supported decision-making and developing rights-based mental health services in the community. Moreover, efforts should be made to provide individualized support services that give people a range of options, including in-home, supported living and personal assistance. These measures should be accompanied by other structural changes to address the barriers to inclusion in the community and to prevent isolation or segregation from the community. Mental health intersects with the underlying social, economic and environmental determinants of health. States should simultaneously carry out efforts to address interconnected rights that contribute to independent living, including housing, inclusive education and employment. The focus of mental health systems and services should be widened beyond the biomedical model to include a holistic approach that considers all aspects of a person's life;

(d) States should ensure that, in all fields, including law and health, the language, especially in connection with disability and mental health conditions, reflects a human rights model that does not reinforce stigma, prejudice or ableism;

(e) States should take measures to ensure that persons with mental health conditions and psychosocial disabilities enjoy access to justice on an equal basis with others and to enable them to access redress and reparation. States should take simultaneous measures to develop and implement innovative justice that is inclusive and person-centred;

(f) In line with the Convention, the 2030 Agenda for Sustainable Development and the political declaration of the high-level meeting on universal health coverage, States should take measures to reduce inequities in access to, and the delivery of, health services and to increase access to high-quality health services, including mental health and psychosocial support services. States should identify and address barriers to accessing high-quality health services. They should scale up training programmes, build capacity in the health workforce to address barriers and improve the quality of services. States should provide a diverse range of comprehensive, safe and high-quality mental health and psychosocial support services that are recovery-oriented;

(g) States should ensure that mental health and human rights are at the centre of COVID-19 recovery plans and that the specific situation of groups who are marginalized or in a vulnerable situation is considered, including women, girls, youth, persons deprived of liberty, migrants and lesbian, gay, bisexual, transgender, queer, intersex and gender-diverse persons;

(h) States should support national human rights institutions, including through adequate resources to monitor and evaluate the quality, effectiveness and inclusiveness of health services for persons with disabilities. States should ensure that their relevant independent mechanism for the prevention of torture has the mandate to monitor all "closed regimes and facilities", as broadly understood, where persons with disabilities may be placed, whether in law or in practice. States should also include external experts with expertise in different areas, including persons with lived experience, in monitoring. They should use human rights indicators to monitor the progress made in implementing the Convention;

(i) States should ensure that persons with psychosocial disabilities and mental health conditions are meaningfully involved in the planning, monitoring and evaluation of mental health services, in mental health system strengthening and policy change, and in relevant research. States should guarantee to persons with psychosocial disabilities and mental health conditions equal opportunities for education and training. States should facilitate and promote the organization and participation of users of mental health services and take efforts to reach out, in particular, to those who are

unable to access health care and social protection. States should promote the development of peer-support services in mental health services and ensure that services take into account the lived experience of persons with disabilities and respond to their requirements;

(j) All States parties to the Convention should undertake a review of their obligations before adopting legislation or instruments that may contradict their obligations to uphold the rights of persons with disabilities, as called for in the Convention. In particular, States are urged to re-examine from this perspective the draft additional protocol to the Oviedo Convention currently under consideration by the Council of Europe and to consider opposing its adoption and requesting its withdrawal.
