Living in the community, support services and mental health

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CRPD course sp 2017

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Introduction

- Beyond abolition of coercion: framing a positive right to diverse communities and to user-designed supports
- Articles 19, 25, 26, 28
- Article 19 *living indepedently, and *being included in community

Models for support in community

- Independent living model
- Personal assistance ; service animals; self-support; general community services like yoga, athletics, community centers, pubs, places of worship
- Survivor community models: peer support theory and basic principles: doing it for ourselves
- Alternative mental health crisis support – e.g. Open Dialogue, Soteria, peer-run respite and drop-ins, Alternatives to Suicide, Hearing Voices, etc.
- Advocacy support – peer advocacy, PO-Skåne, legal and paralegal access to justice programs
- Community and family involvement in supports – e.g. M.O.M.S.

Questions

- What is the difference between ‘community-based mental health services’ and realization of the right to live independently and be included in the community?
- Does the independent living/peer support model of needs-based user-designed support exclude or include:
  - Services provided by or under supervision of mental health professionals?
  - Conventional mental health services (medications, therapy)?
  - Mental health residential facilities (including group homes, supportive housing)?
  - Alternative mental health practices like Soteria?
- Is peer support itself an alternative mental health practice or something different? How do we make the distinctions?

Models for social inclusion

- Peerly human – ‘What can we learn about the nature and challenges of being human?’
- The Red Door – safe space for creativity, everybody/nobody is mad
- TCI Asia – transforming communities as overall frame for CRPD advocacy
  - Eliminating barriers to inclusion such as mental health commitment/forced treatment laws

Transforming mental health services

- End to all coercion and restriction, respect legal capacity at all times including crisis
- Free and informed consent as affirmative obligation − not gatekeeping; accurate information, no incentive/ disincentive etc.
- Removing medical model features that are harmful, e.g.
  - Diagnosis (no scientific basis): instead personal narrative of challenges, desired goal, needs
  - Chemical imbalance stereotype/falsehood: instead drug-based / not diagnosis-based prescribing (Joanna Moncrieff)
  - Professional mystique of esoteric knowledge or divination: instead trained/skilled support for common exploration of life challenges

Example of legislation

- Disability Integration Act (proposed legislation) − enforceable right to receive long term support services in the community instead of institutionalization
  - Autonomy and user control, freedom from coercion and restriction part of definition of community-based service
  - Descriptive needs and tasks, including areas of life and assistance relevant to people with psychosocial disabilities
  - Includes 'emergent and intermittent needs'
  - Public entities obligated to make available affordable housing separate from services
- Limitations
  - Funding streams covered not necessarily universal (in US, need single payer health care besides)
  - No explicit ban on legislated mental health commitment and compulsory treatment
  - Some language more medical-model than we would wish
  - Requires administrative agency regulation, 'devil is in the details'
- Bottom line: strong policy departure from segregated mh law and policy, mainstreams pwpsd in social model, choice-based affirmative right to services and avoidance of institutionalization
- Transitional step in a country that has not ratified CRPD and where medical model and coercive mh laws are highly entrenched