***Tina Minkowitz – Intervention in Panel 1, for both questions combined***

First I must challenge the framing. Mental health itself is a controversial and vague concept, because it is linked with social and interpersonal judgments about desirable and undesirable ways of being in the world, and it is linked with brutal human rights-violating regimes of arbitrary detention and torture that are embedded in national law and social practice. These regimes come from the global north and are exported through colonialism and imperialism to the global south; they violate human rights everywhere. It is not possible to separate the concept of mental health from the practices and attitudes and personnel associated with these human rights violations.

Indeed, psychiatrists and other mental health practitioners are considered a key constituency to be consulted and satisfied when standards are being promoted on such a right. They are viewed as the experts despite being as professional communities the perpetrators of serious violations characterized as arbitrary detention and torture. These violations must be stopped and repaired through a process led by survivors and directed by organs of the state related to human rights and justice, not by the health sector, before those professions can play a useful social role. (I recognize individuals who can dissent from their professions by becoming allies to survivors; becoming an ally depends on action and how that action is received by the community that has been harmed.)

The concept of mental health is problematic beyond its linkage with human rights violations. As a field, it depends on the assignment to certain professions (psychology and medicine) of expertise on how to live with our humanness, as individuals in relationship with others and in community. However, ordinary people, as well as other disciplines (philosophy, religion, spiritual practices, natural medicine, traditional healing practices, etc.) have equally valid outlooks on their own way of living with humanness and seeking well-being. Reclaiming our own powers in this regard is not the same as incorporating these other practices and disciplines into a right to mental health – incorporation leaves the psychological and medical professions in charge and fails to challenge the hegemony of concepts of good and bad ways of being human that can be labelled as health, illness, health condition. Uncovering one’s own pain and need for healing, one’s own patterns that cause distress and destruction, is a painstaking process and a private one, that does not depend on any particular expertise rather on what works for an individual. There is a need therefore, to break up the hegemony of mental health professions, democratizing the concepts we use and the policy that we make about how we want to foster a sense of well-being in individuals, communities and societies. Fulfilling human rights – eliminating all the human-caused sources of pain and suffering, including arbitrary detention and torture, as well as the poverty caused by exploitation and massive inequality, wars, climate disasters, and more – by logic and common sense is necessary for our individual and collective well-being. That does not mean it can be subsumed under a right to mental health in the name of ‘social determinants’ – to do so puts those professional communities in the drivers’ seat of all social policy, which is manifestly absurd. It also ends up privileging mental health professions and services as a substitute for eliminating human rights violations and exempting their own violations from outside scrutiny.

The CRPD creates binding obligations in international law for states parties, which are nearly all UN member states. These include: the reform of legal capacity to eliminate guardianship and substitute decision-making for adults, the repeal of involuntary treatment and hospitalization laws and immediate release of everyone subjected to those regimes, and the enactment of positive laws and policies to eliminate discrimination in all areas of life and to ensure an adequate standard of living and full enjoyment of civil, political, economic, social and cultural rights to persons with disabilities on an equal basis as others. The Guidelines on Deinstitutionalization represent the most important comprehensive approach to date to full enjoyment of rights for people with psychosocial disabilities and survivors of psychiatry, because they take account of the forms of discrimination facing people who have left institutions and now not only have to face the losses from traumatic abuse and a period of segregation from the community, with all their economic, social, civil and political implications (losing jobs, housing, educational opportunities, custody of children, identity documents, etc.), but also confront direct and indirect discrimination in seeking housing, jobs, education, and establishing new ties or re-establishing old ones. The DI Guidelines take an explicitly reparative approach, responding to the call for reparations for forced psychiatry that is a long-standing theme of the survivor community. A reparations approach permeates the Guidelines, not only through a formal state-led process of truth-telling, individual justice and perpetrator accountability, but also through an approach to deinstitutionalization as a set of actions to reverse the unjust practice of institutionalization, paying attention to the core principles of the Convention such as respect for legal capacity and centering the rights-holders as protagonists of change systemically as well as in their personal lives.

When our issues are addressed under the CRPD, we are within the bounds established by that treaty – which we contributed to creating, and which are there to prevent free-standing opinions on psychosocial disability, including stereotypes from the mental health field and mental health-related public policy, from interfering with the needed changes. For example, the scope for use of the best interpretation standard relating to legal capacity, if addressed under a mental health and human rights framework (as in the OHCHR-WHO Guidance), will treat survivors’ and people with psychosocial disabilities’ views opposing the use of this framework in the context of mental health services as mere opinion to be balanced against other views that have the privilege of remaining unidentified. In the CRPD context, our human rights are not negotiable – the DI Guidelines require \*affirmative expression\* of free and informed consent in the mental health context to prevent forced treatment, which precludes the use of best interpretation.

Issues such as criminal justice reform for an inclusive standard of criminal responsibility, while needing development and refinement in practice, cannot properly be addressed under a human rights and mental health framework for similar reasons.

Finally, I will mention the obligation under the DI Guidelines to reject not only a forced intervention response to individual crisis but also any approach to crisis as a medical problem requiring treatment. Instead, the support needs of people experiencing crisis or psychosocial disability are described without mental health jargon, referring to people experiencing distress or unusual perceptions, and needs for ‘crisis support, decision-making support …, support to heal from trauma, and other support needed to live in the community and to enjoy solidarity and companionship.’ States must provide support options for these needs as primary services, outside the health system and without a mental health diagnosis. In addition, states must ensure health care services do not embed a medical model of disability: in my view this implies to not use psychiatric diagnosis or an illness approach to any mental health services offered. The DI Guidelines also severely limit the scope of the mental health sector’s influence on decision-making regarding DI plans and strategies, including the design of reparations processes, and elevate that of survivors instead.

None of this means that there is never anything of value done in the name of human rights and mental health. When survivors co-create standards, even if in a compromised context, there are worthy nuggets. But we deserve better and more; under the CRPD we are entitled to have it all.