

VIRTUAL ROUNDTABLE

Impact of Human Rights Council Reports on Mental Health

CARMEL WILLIAMS AND AUDREY CHAPMAN

Introduction

In June 2017, Dainius Pūras, the former United Nations (UN) Human Rights Council’s Special Rapporteur on the right to physical and mental health, presented a landmark report to the Human Rights Council calling for a paradigm shift in mental health to models centering on rights-based care and support.¹ The report called on states and all stakeholders to move toward “mental health systems that are based on and compliant with human rights.”

It encouraged a move from a biomedical model of mental health care to a human rights-based approach, highlighting the harms associated with disregarding the social determinants of mental health. This was the first report on the global state of mental health and human rights and was the first articulation of the right to mental health since the ratification of the Convention on the Rights of Persons with Disabilities (CRPD) by the UN in 2006.²

The report stressed that greater care is necessary, especially when health systems are under-resourced, to use health funding wisely. It urged states to focus on the social determinants of health and to consider new possibilities for mental health care beyond narrow individualized interventions. Pūras encouraged policy makers to reframe mental health, moving from the traditional “global burden of disease” approach to a “global burden of obstacles.”³ He challenged the assumption that mental health interventions always require pharmacological and psychological treatments. He drew on the lived experience of those left furthest behind due to stigmatization and marginalization. The report challenged the status quo of mental health and endorsed the work of those engaging in rights-based approaches to mental health, encouraging others to embrace this new approach.

In response to the report, the Human Rights Council in September 2017 recognized the importance of integrating mental health services into primary and general health care in a General Assembly resolution, requesting that the High Commissioner develop a report outlining how to promote human rights in mental health.⁴ Subsequent reports on mental health by Pūras during his tenure addressed the social determinants of mental health, and rights-based approaches to mental health.⁵ Additionally, the Human Rights Council called on states in July 2020 in another resolution to promote a paradigm shift in mental health and to implement, update, strengthen, or monitor all existing laws, policies, and practices.⁶ In June 2021, the World Health Organization released its *Guidance on Community Mental Health Services: Promoting Person-Centred and Rights-Based Approaches*, which presents successful examples of best prac-

CARMEL WILLIAMS, PhD, is executive editor of *Health and Human Rights Journal*, Boston, United States.

AUDREY R. CHAPMAN, PhD, is Healey Professor of Medical Ethics and Humanities at the University of Connecticut School of Medicine, and an adjunct professor at the University of Connecticut Law School, United States.

tices in mental health service provision respecting dignity, moving to zero coercion, and eliminating neglect and abuse, and offers insight into the rights-based future of mental health.⁷

To mark the occasion of the five-year anniversary of Pūras's first mental health report during his time as the Special Rapporteur, *Health and Human Rights Journal* is hosting this virtual roundtable with participants from around the world. Below, roundtable participants discuss the impact of the report on local and global policy and activism on mental health.

Participants
METTE ELLINGSDALEN, chair, We Shall Overcome, user/survivor organization for human rights, self-determination, and dignity in mental health, Norway
JAVIERA ERAZO, advisor on service provision, human rights, and the law, Department of Mental Health, Undersecretary of Public Health, Ministry of Health, Chile
MICHELLE FUNK, unit head of policy, law and human rights, Department of Mental Health and Substance Use, World Health Organization, Switzerland
YOSHIKAZU IKEHARA, senior attorney, Tokyo Advocacy Law Office and acting chair of the Headquarters on Abolishment of Involuntary Commitments and Establishment of Dignity of Individuals with Psychosocial Disabilities under the Federation of Bar Associations, Japan
VICTOR LIZAMA, coordinator of the facilitators team of Documenta's Disability and Justice Program and spokesperson for the Red Orgullo Loco México, Mexico
FARAAZ MAHOMED, adolescent mental health technical advisor at UNICEF and visiting research fellow at the Centre for Applied Legal Studies, University of the Witwatersrand, South Africa
CRISTIAN MONTENEGRO, research fellow, Wellcome Centre for Cultures and Environments of Health, University of Exeter, and former advisor in the Department of Mental Health, Undersecretary of Public Health, Ministry of Health, Chile
KERIS MYRICK, lived experience Black and Indigenous mental health advocate and podcast developer and host of "Unapologetically Black Unicorns," United States
PETER STASTNY, consulting psychiatrist at Community Access and the Pratt Institute, United States, and founding member of the International Network towards Alternatives and Rights-Based Supports

Audrey and Carmel: *Thank you all for participating in this roundtable discussion about the impact of Dainius Pūras's reports to the Human Rights Council on mental health. We start with a general question: Was the 2017 report used and welcomed by activists, civil society, and mental health service users in your countries?*

Cristian: In Chile, the report created interest among professionals working on human rights issues related to mental health and from activists, including service users, family groups, and other civil society groups working across the mental health and disability fields. Mental health professionals, policy makers, and civil society groups saw the report as a robust framework that gave support and credence to their local demands and as a tool to engage stakeholders.

Victor: It was similar in Mexico, where the report was used by activists, organizations, and peo-

ple with psychosocial disabilities in the Mental Health with Rights coalition to build a proposal for a mental health reform to the General Health Law. These reforms, promoting human rights standards and international principles, have since been approved in the Mexican Federal Congress. They recognize the full rights of users and seek to transform mental health care services into community-type services.

The Mental Health with Rights coalition carried out a social media campaign from 2017 to 2020 to stop three pieces of legislation from being passed that were promoting a biomedical approach to mental health treatment. The coalition was successful in promoting an alternative bill that transforms mental health and which was passed this year. The new law is recognized internationally as a success for human rights defenders, people with psychosocial disabilities, and mental health professionals seeking the transformation of services.

Two additional elements that served in this

advocacy process were the letter that Catalina Devandas, then Special Rapporteur for the rights of persons with disabilities, and Dainius Pūras jointly addressed to the Mexican government in 2017, and the latter's participation in the seminar "Towards the Transformation of the Mental Health System in Mexico," held in Mexico City in September 2018.

Mette: It's great to hear of the success in Mexico. This achievement serves as a great encouragement for everyone working on national law reform in compliance with the CRPD. In Norway, the 2017 report was of course welcomed by users and survivors who already had embraced the CRPD and the paradigm shift it represents, but it also received attention from some mental health professional groups. I think the language in the report spoke to mental health professionals and made it possible to understand and connect human rights more directly to already recognized problems in the mental health system. The report directly linked the conventional biomedical model, the use of psychotropic medication, and human rights in ways that mental health professionals could relate to. The call for a revolution in the mental health system connected to different groups working with recovery and humanistic approaches, many of whom already opposed the conventional biomedical model, and this created a bridge between human rights and the more general professional opposition to various oppressive elements in the mental health system.

Carmel: *Japan and the United States can be more resistant to reports of UN Special Rapporteurs. What kind of response to the report was seen in these countries?*

Yoshi: In Japan, the report caught the attention of people with psychosocial disabilities and their advocates, whom I expect will initiate a movement to reform mental health.

The mental health system here is very conventional, with large numbers of inpatients, extended periods of hospitalization (including involuntary admissions), overprescribing of pharmaceuticals,

and inadequate social and community resources. To date there has been no movement toward deinstitutionalization. The number of people in psychiatric hospitals peaked in about 1990, and since then it has remained almost at that same level.

Many mental health professionals think that psychiatric interventions should be prioritized over human rights. They believe that a person's refusal to take psychiatric medicines is evidence of irrational thinking that justifies involuntary hospitalization.

So the 2017 UN report helped people with psychosocial disabilities and their advocates argue that a radical change in the conventional mental health system is urgently needed in Japan. Although there are, of course, some mental health professionals who are skeptical about abolishing mandatory hospitalization, it has been pleasing to see the increasing number of mental health professionals who are interested in or support change. There is now a growing network of lawyers and users of mental health services committed to changing the mental health system, and the UN reports have been very helpful with our work.

Keris: In the United States, the consumer/survivor/ex-patient and peer movement groups were excited about the report and shared it through social media and in webinars and meetings. It was used a lot. For our peer movement in particular, the report provided validation for the advocacy and essential practice work we had carried out over the years. It has been widely used and shared by disability rights groups at the national and state level and is a foundational piece of work toward rights-based approaches to mental health. Five years on and it continues to feature in conferences focused on reimagining psychiatry.

Faraaz: It is encouraging to hear of Keris's experience in the United States. That is my adopted country/partial home, and I did not really witness significant attention being paid to the Special Rapporteur's work and reports outside of academic settings. In part this is because the Americans for Disability Act is the primary reference instrument for rights-based approaches as opposed to

international human rights norms and standards. The United States also has a number of very strong alternative or radical mental health movements, which have approached the subject largely from a mad pride/radical mental health and increasingly from a kindness lens rather than a human rights lens, and while these are not mutually exclusive, human rights is often treated as a legally oriented framework—so I'm pleased Keris saw things differently, and optimistically.

Carmel: *A follow-on question then: Did the 2017 report also attract the attention of politicians and the media?*

Faraaz: In my home country (South Africa), the report coincided with a very significant tragedy, the Esidemeni disaster, in which over 100 patients in mental health facilities died in under-resourced community-based settings. What happened to Esidemeni patients drew a significant amount of attention to mental health and human rights, and the official inquiry into the disaster required the South African Human Rights Commission to investigate the status of the mental health care system in the country writ large. I wrote the final report and relied heavily on the Special Rapporteur's work to describe a rights-based approach to mental health.⁸ The commission continues to monitor whether the recommendations of the report are being implemented, and while there are permanent structures in place to make the mental health system more accountable and more rights based, it remains a significant challenge, because the traditional mental health narrative of "care and treatment" remains dominant.

Yoshi: In Japan, the report has not received much political attention. However, our new network has just started a campaign to educate politicians, media, and the mental health profession about mental health and human rights.

Keris: Between 2017 and 2021, following the 2016 presidential elections in the United States, the focus shifted dramatically to nationalism and

conservatism, replacing any previous attention on issues such as race equity, LGBT+, and human rights. This shift was supported and disseminated through national policies and government agencies that stopped projects addressing social justice for marginalized communities. This resulted in the report receiving very little attention, and few policy makers or providers were aware of it.

Peter: I agree with Keris that the report had only a negligible response in the media and with politicians in the United States. It was welcomed primarily by people who were already on the same wavelength regarding rights-based approaches to mental health. Police killings of persons with psychiatric disabilities as well as other innocent individuals have certainly drawn a lot of attention in the last two years, and there are some discernible changes (like a non-police emergency number, 988, which was just launched). On the other hand, there is also a movement to increase inpatient and outpatient services, especially when it comes to homeless people, and how much any of this is shaped by or mitigated by the reports is really unclear.

Cristian: For decades, the media in Chile has drawn attention to the apparently high prevalence of mental health issues and the inadequate services available. But I don't think the 2017 report caught the attention of the media or politicians. However, many people will keep discovering the report, so it will continue to engage new readers, and its true impact won't be known for many more years yet.

Michelle: Although I agree that it is difficult to measure precise impacts at a national level, the reports accompanied by the Special Rapporteur's strong commitment to holding a mirror up to the current state of global mental health has shaken up the status quo and opened up new possibilities for rights-based initiatives to take root in countries.

Audrey: *Were you able to use the report in your own work, and if so, can you explain how and to what purposes?*

Yoshi: Yes. As chair of a taskforce developing a resolution adopted by the Japan Federation of Bar Associations (JFBA) in 2021, I was able to incorporate the 2017 report into the resolution.⁹ The resolution presents a roadmap toward abolishing involuntary hospitalization, recognizes actual harm from coercive psychiatric interventions, criticizes the dominant biomedical focus within mental health, and calls for rights-based approaches to mental health, including the commitment of social resources to support community responses to mental health needs. By adopting the resolution, the JFBA is working to restore the dignity of people with psychosocial disabilities by abolishing discriminatory involuntary hospitalization and other human rights abuses within the mental health system. The resolution and the 2017 UN report is now being disseminated among politicians, media, and mental health professionals.

We used a roadmap toward abolishing involuntary hospitalization rather than simply calling for an immediate end to the practice, because this approach is more persuasive. It presents a course of action that gets more support, as many people can commit to most of our suggestions but are skeptical about completely removing the option of involuntary hospitalization. Japan would not accept such a radical change in the conventional mental health system, but presenting a clear pathway to abolishing involuntary hospitalizations using a rights-based paradigm will move the system toward a large reduction in inpatients.

Audrey: *Would you say, Yoshi, that the report gave your work more authority? Or made your work appear less controversial?*

Yoshi: Yes, definitely. Mental health professionals and government mental health officials were receptive to the UN report, as it was written by a psychiatrist instead of a lawyer. We are able to persuade politicians and the media by explaining that the report presents a global standard of mental health in the 21st century and highlighting the relatively outdated state of the Japanese mental health system. This made our work and our res-

olution appear less controversial. Opponents of our position have long argued that involuntary hospitalization is necessary for people who do not have the insight to access psychiatric treatment for themselves. The arguments against our rights-based approaches have supported the present legal processes. Japan has amended the 1987 Mental Health and Welfare Act several times over the last 35 years, including studying the 1991 Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles) and ratifying the CRPD in 2014. But despite all this, Japanese psychiatry did not change. So the JFBA resolution has created a stir in this controversy by building a consensus among opposing sides; people who did not want complete abolition of involuntary hospitalizations can come part way with the abolitionists, and abolitionists can anticipate that the others will change their opinions in time, on the way to the goal.

Javiera: That is encouraging work, Yoshi. In Chile, I was able to use the conclusions in both the 2017 and 2019 reports for writing numerous institutional documents for the Ministry of Health. We were able to refer to the reports when challenging legal demands for the expansion of long-term mental health facilities and to promote change in institutionalization practices. Because the reports were UN documents, it promoted the engagement of key decision-makers, such as judges and politicians who have no expertise in mental health.

Carmel: *Did this use of the reports, and engagement of key decision-makers, lead to any real change in Chile?*

Javiera: Yes, recently we had a complex discussion with a local judge who holds traditional views on mental health and promotes the use of long-term psychiatric institutionalization for children. Using the authority and clarity of the UN reports, we were able to repeal his decision.

Although radical in its approach, the report opened a space for nuanced reflections and conversations, challenging the normal content and

dynamics in institutional settings, particularly between levels and positions of authority and power. For those of us who are professionally and personally engaged in promoting human rights in mental health, the report challenged us to be more vocal and explicit. The report is brave, calling out power imbalances in every aspect of the development and implementation of mental health policy, and introducing a sensitive social and cultural perspective on complex and usually polarized issues.

Cristian: Yes, we found that the report gave weight and legitimacy to what had previously seemed like solitary voices, in a field dominated by deep paternalistic views and where the experiences and interests of service users are often assumed but rarely explored or considered. Due to its technical consistency and its ability to thread traditionally separated issues (such as the right to health and the right to autonomy and freedom), the report became an immediate reference, a tool to easily communicate a complex set of arguments. Instead of having to explain the relevance and scope of human rights in mental health, and instead of having to insist on the potential harms of certain approaches to medication or coercion, we could refer others to an international UN report.

Many people across the state in Chile, and in civil society, treat the UN with respect, and so the reports created a pause which then gave way to the possibility of a deeper conversation. Before the report, human rights considerations could easily be read as “positions” in a debate, “your views” versus “my views,” preventing mutual learning and closing the conversation. The report shifted this logic and opened a different receptivity, an interest in learning more, especially among professionals.

Keris: Like Cristian, I have also seen change in professionals. In fact, one of the most moving impacts of the Special Rapporteur’s work on mental health I have experienced happened at a conference where a psychiatrist, a dean of a school of psychiatry, stood up to address the delegates, and said she wanted to apologize publicly for the harms that psychiatry has caused, and for any harms she

has caused as a psychiatrist to her patients. She had not previously been aware of the UN report or Dainius’s work, nor the stories of people who had been impacted by right violations and coercive treatments. She promised to do better in her work training future doctors. Though that is just one person, it is a powerful testimony to the impact of the Special Rapporteur’s work. Sometimes I think when we think of change, we want to think of grand things that happen at a structural level, like policies or regulations—and we should also acknowledge the impact that change in individuals can have.

Audrey: *Has the UN report lent authority to any other work?*

Faraaz: When I was drafting the South Africa Human Rights Commission report I mentioned earlier, I drew heavily on this report, and it certainly gave more authority to the commission’s conception of a rights-based approach. It still does.

Mette: Our organization, We Shall Overcome (Norway) has used the Special Rapporteur’s report in consultations with the government, as well as in promoting a human rights-based approach in numerous other ways. The reports have some very salient quotations that are easily understood without extensive understanding of human rights, and that makes them useful to speak to a broader audience. The increasing international call for the abolition of forced psychiatric practices is a strong and crucial support to the national work we do.

In 2009, we were part of a governmental task force for the reduction of forced practices, and we used the CRPD and the call for a paradigm shift, nondiscrimination, and the abolition of force in a dissenting paper. This paper was mostly ignored and rejected as unrealistic, ideological, and far from the real-life issues faced in the mental health system. In 2019, I witnessed a speech by a leading psychologist that referenced the Special Rapporteur’s report, together with a quote from our dissenting paper from 10 years before. This is a small example that

progress has been made, however slowly, and that even though an abolitionist approach in general still is considered controversial, it's more difficult to exclude and ignore it completely when it is supported by the Special Rapporteur and many other powerful agents within the UN system, including the World Health Organization and the Quality-Rights Initiative.

Javiera: This comment by Mette alludes to the temporal dimension of the report's impact. More than a sword swiftly cutting through ideas and practices, the report acts as an ongoing flow that erodes the paternalistic and harmful foundations that still pervade mental health policy and practice. If seen as a long-term, dialectical process, the report provides a milestone to reflect on and evaluate our achievements.

Peter: In the United States, it is hard to see change happen quickly or to see the impact of one report. The widespread institutional model of psychiatry is siloed away from all critical and transformative efforts, which tend to happen in a fairly well sealed echo chamber. While vigorous advocacy has achieved certain aims when it comes to the implementation of non-coercive crisis responses, it is hard to establish a correspondence between the report and these developments.

Keris: I have to agree generally with Peter about this. However, I have referred to the report when doing advocacy work with various organizations—in national and international meetings and also when presenting to US mental health advocacy organizations. When I worked for the local county department of mental health, I was able to share the report with leadership as well as with county-level behavioral health directors who were not aware of a human rights approach to mental health care or even, for example, the CRPD. At that time, I traveled with our county department of mental health along with other public health agencies, practitioners, legislators, county council members, and even judges to Trieste, Italy, to learn about a mental health system

developed by Franco Basgalia and at the time run by the former director Roberto Mezzina. His community center success in mental health was based on freedom first and a rights-based approach, but few were aware of that. I was able to share links to the Special Rapporteur's report along with the CRPD—unfortunately, I do not think this was ever truly understood by our county officials as they worked to emulate this Trieste freedom first and rights-based person-centered program in Los Angeles that included coercive mechanisms to get people in treatment such as assisted outpatient treatment. Sadly an oxymoron.

In the United States, there is an overarching focus on fear, liability, and risk aversion, as well as public pressure to remove “unwanted” people from society. This limits our ability to advance a rights-based approach in both policy and practice even though we now have authoritative work from the World Health Organization. On a positive note, however, the report supports our current rights-based peer-run programs and has helped justify and demonstrate that we are not alone in our drive to establish such programs.

Victor: I have cited the UN report in training sessions and conferences, and Documenta, the organization I work with in Mexico, produced the report *Por Razón Necesaria? Violations of Human Rights in Mental Health Services* based on it.¹⁰

Carmel: *Michelle, how has the report aligned with the World Health Organization's QualityRights program?*

Michelle: The World Health Organization is taking great strides to implement a person-centered human rights-based approach in mental health. It is a major focus of the QualityRights Initiative, which aims to improve the quality of care in the mental health sector and protect the rights of people with mental health conditions and psychosocial, intellectual, and cognitive disabilities.¹¹ Key actions through this initiative are building the capacity of all key stakeholder groups to combat stigma and discrimination and to promote a

rights-based approach; transforming and creating person-centered and rights-based mental health and related services; promoting the participation of persons with lived experience; and supporting civil society and countries in the reform of policies and laws in line with international human rights standards. All of this work is aligned with the CRPD. The Special Rapporteur's reports did not directly influence the aims, objectives, and approach being used in the QualityRights Initiative since they were already aligned, but his work has been instrumental in disseminating the work of the QualityRights Initiative—highlighting it as good practice and as an opportunity to transform the mental health sector.

Audrey: *In the 2017 report, and subsequent ones addressing mental health, the Special Rapporteur was forceful in his comments that pharmaceuticals are overused in psychiatry, globally. Has his call for a reduction in biomedical approaches to mental health assisted your work?*

Mette: We Shall Overcome is part of an initiative to create medication-free alternatives in the mental health system in Norway that started in 2012. When the Special Rapporteur was invited to Norway on an informal visit in 2019, he showed a particular interest in this initiative and visited the medication-free ward in Tromsø, which helped place our initiative within a human rights framework. There is extensive research about the harm and lack of positive outcomes from drugs in mental health care, particularly when forcibly administered. However, drugs are biomedical psychiatry's "holy grail," and the belief in the benefits and necessity of drugs is monumental within the system, and seemingly resistant to contrary evidence. A rights-based approach to mental health includes the right to free and informed consent and to make your own choices about treatment options regardless of the dominating expert opinion. The discussion should not be held between "medical experts" about what is the best approach, but must include a transfer of power and recognition to the

people directly affected. The Special Rapporteur's 2017 report frames the discussion of biomedical psychiatry around the power imbalance that is deeply rooted in mental health systems, and that is not exclusively about medications or diagnosis, but calls for people experiencing mental health stresses to be empowered to make their own decisions. So yes, this has helped our work.

Cristian: The idea that biomedical approaches are reductive and potentially harmful is not new or exactly radical within the mental health field in Chile. Starting in the 1970s and reinvigorated in the 1990s after the end of the dictatorship, a strong tradition of community-based mental health still guides the pillars of mental health policy in the country. Regardless, biomedical psychiatry and a narrow view of evidence continue to shape important decisions about treatments, funding, and the training of mental health workers. The orientation toward the community as the locus of care has not materialized fully. But the UN report has opened a space to discuss these uncomfortable issues.

Yoshi: The biomedical approach has dominated the mental health field in Japan. The majority of psychiatrists depend on medication and hospitalization. Although non-medical therapy has been introduced and locally practiced a little, the non-biomedical trend is still weak. But the report has helped my colleagues and I encourage psychiatrists interested in open dialogue and alternative treatments to introduce and practice new methods.

After the 1990s, the Japanese Family Organization welcomed biomedicalism, as mental illnesses had been often attributed to family relationships and poor parenting. The Japanese Family Organization thought that biomedicalism refuted this family aetiology, and so the organization endorsed it, and pharmaceutical companies welcomed the support. At the same time, a biomedical approach to mental health helped psychiatrists establish their identity as scientists. Consequently, biomedicalism

prevailed after the 1990s.

I expect the 2017 report will help change this, because family members whose loved ones experienced harmful side effects of antipsychotics, inhumane hospitalization, or treatment have doubts about the conventional mental health system and the biomedical approach. They are interested in the report and support it. Networks of people who have experienced poor mental health treatment, their families, and mental health professionals are working to change the biomedical trend.

Peter: Unfortunately, the reports have had very little impact on the use of psychopharmacology among psychiatrists and increasingly nurse practitioners in the United States. While there is a small but growing de-prescribing and “coming off” movement, I would say that the mainstream use of medications is getting even more widespread and more overwhelming. Polypharmacy now extends to ever younger populations, who have virtually no information about the risks or the availability of alternatives.

Carmel: *The report also introduced the Special Rapporteur’s reframing of mental health from disease to determinants, and he coined the phrase “the global burden of obstacles.” How difficult is it to get policy makers to shift their focus to the causes of mental stress rather than looking for solutions such as medicines?*

Cristian: There are two interconnected sources of change in mental health in Chile, related to “external shocks.” The first shock was the extensive wave of protests and social unrest manifesting in different cities at the end of 2019. Mental health was a concern and a demand, but it also conveyed a deeper revolt against neoliberalism, inequality, and its relationship with individual and collective suffering. The banner “It was not depression, it was capitalism”—popular during protests—summarizes the sentiment, producing a conversation within and outside the mental health field, an interrogation into the very meaning of mental

health services, treatments, and diagnosis in a context of extreme inequality and authoritarian legacies. A second shock, this time global, was the COVID-19 pandemic. This also pushed mental health into the media, especially the mental health effects of public health measures such as school closures and isolation, and the mental health of key groups such as children, young people, older people, and health care workers.

The results of these shocks are still ongoing in the country. The drafting of a new constitution during 2021–2022 (one of the outcomes of the protest process) gave hope of rights-based, guaranteed services, and support across the health, social, and disability sectors. Unfortunately, this new draft was rejected in a popular referendum. But it is clear that mental health is a concern in the population, and UN reports are vital tools in reshaping mental health in the direction of human rights.

Audrey: *As part of this reshaping both in Chile and elsewhere, are community-based support services gaining greater legitimacy and funding?*

Faraaz: In the United States, community-based supports are certainly growing, although they remain vastly outnumbered by privately run psychiatric facilities. The Biden administration’s commitment of US\$4 billion to mental health services, primarily to school-based support for young people, is an important development, even though the paradigm of that support is somewhat biomedically focused.

I think in South Africa there has been some questioning of the community-based support paradigm because of the Esidemeni tragedy, which was the result of underfunding for community-based organizations. And while there is still a strong emphasis on the need for a rights-based approach, resource allocation is dismally low and sufficient progress on issues such as deinstitutionalization and implementation has been hampered by a number of things, including the pandemic, the delays in the new National Mental Health Policy and Framework, and the concern that vast amounts

of money have been spent on building facilities that deinstitutionalization advocates want to see decommissioned.

Keris: As Peter mentioned earlier, in the United States there is no real move away from biomedical approaches and conventional psychiatry. However, I do see that there is movement toward funding more options. For example, Mental Health First in Sacramento and Oakland, California, is an example of a mental health crisis response alternative that was developed and run by people with lived experience and people of color to create a non-coercive and non-police response for the Black community in order to eliminate or reduce harms that disproportionately impact Black people in mental health or substance use crisis. This program is mainly funded through grants—not through legislative action or government funding. In the last year, I have seen peer respite grow via legislative action of a state or county (Oregon and Alameda County, California). In general, funding for peer respite comes from general health funds and philanthropy, which may not be as sustainable as ongoing government financial support. I would say that policy makers are reforming mental health crisis systems mainly to make programs available, rather than because they want to commit to rights-based programs.

Currently, mental health crises are still responded to with carceral systems such as courts and involuntary hospitalizations. The high cost of housing and the impact of the pandemic on people's employment and overall health are causing big increases in the number of unhoused people. Political leaders are now looping in "homelessness" alongside mental illness and using coercive programs to address both—such as CARE Court in California.¹² Despite the authoritative nature of the UN's 2017 report, which we used during advocacy and meetings with legislative aids and other policy makers, we were not able to sway the minds of people in support of using courts to mandate housing and treatment for those currently unhoused and believed to have psychosis or schizophrenia. It became an argument of whose rights supersede

whose—family over the person impacted, community over the person impacted, provider and or judge over the person impacted. At no point, even in the face of clear disparities for people of color, especially Black men, was there ever support for the rights of people to receive culturally aligned, voluntary community support and services at times and places that suit the person needing that care.

Peter: While there are several exemplary alternative programs in the United States, such as peer respites and survivor-run organizations, these are quite exceptional and not available to the vast majority of people who would benefit from them. Very recently, the federal government redoubled its focus on "recovery," and it remains to be seen whether that means increased access to conventional biomedical interventions, or whether this would extend to empowering and socially transformative approaches. Consideration of economic independence and employment is especially neglected in the United States, leaving the vast majority of persons with psychiatric disabilities relying on permanent government pensions. One exception is the growing number of users and survivors who are able to become employed as peer workers and specialists.

Mette: Over many years, there has been a development in Norway of community-based, recovery-oriented services, and a focus on people living in the community and not in institutions. Some of these services offer good support that is less based on biomedical care and where there is no coercion. Unfortunately, these services are not developed for crisis situations or for people in need of more extensive support. Many professionals and service providers continue to believe that people in a crisis need to be under treatment in traditional psychiatry rather than receive psycho-social support in the community. If someone is deemed to have a serious mental illness, they will be dependent on specialized psychiatric services, where they are treated biomedically. This two-alley system has several negative effects of people being de facto institutionalized in the community,

living with outpatient treatment orders and with just as little freedom and inclusion in the community as if they were stuck in a hospital.

Javiera: Chile has a decades-long trajectory of promoting community-based mental health, with mental health services integrated into primary health care centers and general hospitals in a consistent and sustained way, as outlined in three national mental health plans (from 1993, 2000, and 2017). Although successful in extending the reach of mental health care throughout the country, three long-stay psychiatric hospitals still operate, concentrating resources and thereby preventing the development of a modern network of mental health services. Alternatives to psychiatric institutionalization and adequate support for the deinstitutionalization of this population are still lacking, and for many in the public the only possible answer to “madness” is isolation in institutions. There is, therefore, still work to do, and the reports have and will play an essential role in this process.

Currently, a commission of experts through experience, activists, and policy makers is working on a proposal for a national deinstitutionalization plan. This is part of the current administration’s agenda, showing that political will is favorable.

Yoshi: Japan also has mixed results here. The Ministry of Health and Labor and some political parties superficially recognize the importance of community-based support. However, more than 95% of the mental health and welfare budget is allocated to medical treatment, and 70% of that is allocated to hospitalization. Less than 5% is allocated to community-based support. Our network argues that this allocation needs to be reversed. The 2005 Act on Providing Comprehensive Support for Daily Life and Life in Society of Persons with Disabilities provides various kinds of welfare services, but those services are in short supply. Our roadmap shows that Japan needs to discharge at least 140,000 inpatients in the 2020s, and there will not be sufficient housing for these people to

move into, as the financial focus remains on biomedical support, not community support.

Carmel: *Has an increased public awareness of mental health associated with COVID-19 and the global economic downturn altered the response to mental health in your region?*

Faraaz: There has been a lot of conversation about the mental health impacts of COVID, the economic impacts of the pandemic, and so forth, but I am not sure that these factors have actually resulted in increased investment in mental health. In some ways, mental health and all other health issues are seen as secondary to COVID-19, and while the pandemic and climate anxiety and other factors have increased attention on mental health, the opposite is true for actual resource allocation.

Yoshi: COVID-19 had a disastrous effect on people in psychiatric hospitals in Japan, as the rate of infection and mortality of psychiatric inpatients was reported to be four times higher than in the general population. Psychiatric hospitals lacked adequate staff and equipment for COVID-19, and the ratio of health workers to psychiatric inpatients was lower than for other patients. Consequently, infection spread easily in psychiatric hospitals, inpatients did not receive appropriate treatment, and they also had contact with the outside world severely restricted.

Javiera: Mental health is an increasingly relevant issue in Chile in complex ways. The pandemic pushed a wider public sensitivity toward the existence and importance of mental health and well-being, mainly because of the suffering and pain caused by the virus across the population and the consequences of lockdown measures on key groups such as young people and the elderly. Another concern was about health care workers’ mental health during the different waves and phases of the pandemic due to the unprecedented demand on them. Chile has a long tradition of community-based mental health approaches, and

this was sustained during the crisis. The availability of mental health services was, nonetheless, affected as resources for COVID-19 patients were prioritized.

Peter: Just like in Chile, in the United States there has been a greater emphasis on the mental health of the population after demonstrations against police brutality, LGBTQ discrimination, and COVID-19. In some ways this means that mental health can no longer remain encapsulated in reductive biomedical models. In some areas, such as gun violence, communities are getting organized with mutual support that reaches well beyond a narrow mental health paradigm. Whether this can be extended to the epidemic of “anxietydepression” remains to be seen.

Audrey: *So would you say there is now greater awareness of mental health, and are approaches to it more in keeping with the recommendations of the report?*

Faraaz: Yes, I do think there is significantly greater awareness of mental health, but I don’t know that approaches have shifted drastically. As long as there is a great deal of profit to be made from “magical cures,” there will be incentives to maintain the status quo, and we are seeing history repeat itself with the influx of venture capital into psychedelic-assisted therapies.

Even so, in my role at UNICEF, I work on mental health promotion and prevention of distress, and I think it’s important to recognize that this is a multisectoral approach rather than one that focuses purely on health systems, through the education sector, through supporting caregivers, etc. The same is true of the GCC Global Initiative on Youth Mental Health, which is seeking to place lived experience at the center of interventions that contribute to well-being and looking for culturally appropriate ways to do that, and Jack.org, with its “Be There” campaign, which is focused on kindness and community as a mental health intervention. This is not dissimilar to the Friendship Bench, which is also focused on peer support. Livelihoods approaches by organizations like Basic Needs and

Huertomanias also address community needs and build self-efficacy, demonstrating the links between economic justice and mental health. These aren’t specifically related to the work of the Special Rapporteur, but they have in common that they’re trying to seek avenues to alter the paradigm in much the same way that Dainius’s work has sought to do. I think what’s clear is that there is greater space for this type of work than there used to be, but I’m not sure that governments are as progressive as advocates for the “human rights” paradigm would like them to be.

Cristian: I agree with Faraaz that greater mental health awareness is not immediately equivalent to a human rights-based orientation. A powerful aspect of the reports is the recognition that a “right to health” approach, on its own, can operate in ways that go against individual autonomy and liberty. The boundaries are blurry, and a nuanced approach is needed. Unfortunately, wider public sensitivity usually lacks nuance. As stated before, these UN reports are vital in shaping this process toward the promotion of human rights.

Yoshi: Yes. Japan has received its first concluding observations from the Committee on the Rights of Persons with Disabilities this September. It calls on Japan to

- a. Recognize the involuntary hospitalization of persons with disabilities as discrimination on the grounds of impairment, amounting to the deprivation of liberty, and repeal all legal provisions allowing for the deprivation of liberty through involuntary hospitalization of persons with disabilities on the basis of actual or perceived impairments or dangerousness;
- b. Repeal all legal provisions that legitimize non-consensual psychiatric treatment on the grounds of perceived or actual impairments, and establish a monitoring mechanism to ensure that persons with disabilities are not subjected to forced treatment and have access to the same range, quality, and standard of health care on equal basis with others.

JFBA and other nongovernmental organizations submitted parallel reports to the committee, and this process has increased awareness of mental health. Now that Japan has received clear recommendations from the committee, we hope this will help change the conventional mental health system. But in the meantime, Japan has still not fulfilled 1991 MI Principles, which required a more serious likelihood of immediate or imminent harm to self/others or severe mental illness to force hospitalization than the previous 1987 Mental Health and Welfare Act had required, both of which were then outstripped by the CRPD. Although the MI Principles are criticized because people with psychosocial disabilities were not involved in the drafting process, and they lean toward the medical/individual model of disability, they will still help reduce involuntary hospitalizations to about a quarter of the current rate, as the ratio of involuntary hospitalization is four times that of the average in OECD countries.

Carmel: *Is there a growing movement to stop mandatory confinement and treatment in your country?*

Javiera: In Chile, it is slow going. We've been working on this for 30 years, and while there are some small steps in terms of legislation and attitude, more work needs to be done. Recently, the Ministry of Health mandated a commission to make recommendations for the creation of a new mental health law covering a broader range of topics and aligned with contemporary standards of human rights protection for people with mental health problems.

Keris: In the United States, mandatory confinement has not ended. I think the pandemic has put political pressure on local and state leaders on mental health awareness, and I fear I am seeing a growth of new ways to advance mandatory treatment.

Yoshi: Yes, in Japan too, the trend of seclusion and restraint has been increasing. Mental health professionals seem to depend on those measures, and

to make matters worse, the judiciary gives mental health professionals plenty of discretion to use them. JFBA conducted a survey in 2020 on damage caused by mandatory confinement, to which we received more than 1,000 replies from people who had experienced an involuntary hospitalization. We found that approximately 80% of them felt hardship, sadness, trauma, fear, aversion, sense of loss, and hopelessness. The UN report endorses our survey, and when we announced our findings, we disseminated the UN report.

Our roadmap aims to abolish involuntary hospitalizations by 2034. We also call for Japan to establish a National Institution for the Protection and Promotion of Human Rights based on the Paris Principles.

Mette: In Norway, despite 25 years of activism against this, and statements made to the Committee on the Rights of Persons with Disabilities that forced detention and treatment should be used "in exceptional cases as a last resort," the numbers are increasing. The ideology in the mental health system, which is supported by the mental health law, is that the use of coercion is legitimate and the right thing to do in some cases. It's still left to mental health staff to decide what constitutes exceptional cases, and that relies heavily on their own approaches to mental health. One of the main arguments used to legitimize forced psychiatry is that it is necessary to protect a person's right to health, creating a false dichotomy between the right to autonomy and the right to health. The UN report is particularly important in this regard, as the Special Rapporteur on the right to health is emphasizing ending coercion as a requirement to protect human rights, including the right to health.

Carmel: *Are there other ways in which changes to mental health are becoming more apparent in your country?*

Faraaz: In South Africa, it's becoming much more apparent that there are links between issues such as social injustice and mental health. I think it has also become much more acceptable

to say that taking care of one's mental health involves non-biomedical interventions. There is an increased awareness of the way in which minoritized populations are disproportionately affected by mental health challenges and that the criminal justice system is used as a substitute for mental health support. But at a policy level, I am not sure whether there is sufficient engagement with what that means, and there is still a strong emphasis on "care and treatment" rather than on engaging with structural and political determinants of mental health.

Mette: In parts of the professional community in Norway, there is also a strengthening of the critique against the medical model, including the extensive use of drugs, but the majority of practice in the mental health system is not really affected by this critique. Norway has extensive mental health services and spends substantially more money on mental health than most other countries in Europe. This should give us the best opportunity to develop human rights-based services, but the reality is unfortunately that the system is highly invested in the biomedical model. The growth in mental health services does not solve our problems and is echoed by a demand for more funding to address poor results. Some of the value in the UN report is that it highlights this paradox—that prioritizing expenditure in mental health services does not automatically lead to good results or more respect for human rights.

Victor: The movement of people with psychosocial disabilities raises the need for greater community-support facilities as part of the mental health reform in Mexico. It also raises awareness of the emphasis placed on drugs that the biomedical approach generates.

Audrey: *Have the reports helped create space for re-imagining mental health and involving civil society?*

Cristian: Certainly in Chile, they have empowered activists and helped develop a much more sophisticated ecosystem of advocacy groups, who

despite their own internal tensions and differences have expressed an interest in the matter and have used the language and principles of the reports.

Mette: The UN reports and work play an important role in uniting and empowering an international push toward this goal. This provides crucial support for national advocacy and activism.

Yoshi: Yes, the UN reports led to the JFBA roadmap to abolish involuntary hospitalization and recognize the dignity of persons with psychosocial disabilities. Other advocacy organizations and some mental health professional groups welcomed our resolution and roadmap, as do some professionals. A consensus with these groups will eventually be effective in radically reducing mandatory confinement and treatment in psychiatry.

Victor: In Mexico, all the bad practices in mental health services continue, but people are calling for the transformation of services and for mandatory treatment interventions to stop. I am also involved in the Latin American regional advocacy movement, which is in its infancy compared to those in Europe, Asia, and Africa. The movement is uneven throughout the different countries in the region. As for the rest of the world, I identify three streams of activism or involvement of people with psychosocial disabilities in the mental health system: One stream is close to the biomedical model, in which users support the fight against stigma but without an analysis of the deficiencies of the current biomedical model and, to that extent, supporting the two fundamental slogans of that model: awareness of mental health as a disease and adherence to treatment; At the other extreme is critical activism such as Mad Pride; The middle stream fights for respect for people experiencing mental stress, recognizing their individuality and legal capacity. This stream seeks legal processes based on international human rights standards and principles, as well as public policies that adopt a disability rights approach to mental health.

There are countries, like Chile, in which there has been a strong critical self-management

movement toward the mental health system; other countries such as Mexico, Colombia, and Peru have a more moderate activism prevailing. But common throughout the region are user groups and organizations that remain strongly influenced by mental health specialists and family members.

Audrey and Carmel: *To end on a positive note, are there any final observations or projects that give evidence of a stronger role of human rights in mental health?*

Faraaz: I am part of a new Centre on Mental Health, Human Rights and Social Justice at the University of Essex, UK, which has been established to build on the legacy of the work of Dainius and the Special Rapporteur's mandate. There are strong linkages in the work of the center in terms of participatory approaches to mental health research; decolonizing global mental health; recognizing the role of social, political and economic determinants of mental health; decarceration and deinstitutionalization; and many other areas that were highlighted throughout Dainius's tenure as Special Rapporteur.

Victor: I am encouraged by my observations that human rights approaches are increasingly present in the discourse and orientation of groups and activists across Latin America, and this was not the case just a few years ago. For example, in most cases, the concept of psychosocial disability was not clearly identified as a legal category, nor was the CRPD invoked until fairly recently. In this sense, the UN reports have been an important reference for those of us who are mental health activists.

Javiera: At a more personal level, the reports give hope in an environment of harm and abandonment that can wear us down. They provide a sense that there is a better, virtuous path to follow, that institutions play a crucial role, and that our struggle is meaningful.

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