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A Human Rights-Based Approach to Psychiatry: Is It Possible?

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Abstract

While it is becoming more common to hear calls for a human rights-based approach (HRBA) to health, documented efforts to apply the approach in practice remain scant. This paper presents a review of a pilot study applying an HRBA to psychiatric care in Gothenburg, Sweden. Based on the reflections of some involved in the pilot, and on the evaluation carried out, it presents the context, process, effects, and lessons learned. In the paper, we structure our experiences of an HRBA around the United Nations' guiding principles of dignity and empowerment, equality and non-discrimination, participation and inclusion, accountability, and transparency. We discuss challenges encountered during the project, such as realizing meaningful participation and challenging the hierarchies of different professions within care. We also discuss successes, such as contributing to an overall strategic goal to eliminate all coercive measures in psychiatric care. We then offer our reflections, as the core team involved in the pilot, on how to make an HRBA sustainable in a large organization and provide practical recommendations based on our experiences.

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Introduction

Translating international human rights law into practical work in Sweden is a relatively new process. Until the early 2000s, work on human rights was perceived above all as something related to foreign policy and development assistance in developing countries. Speaking about the promotion of human rights within Sweden has often been perceived as quite foreign.[1]

The purpose of this paper is to describe the lessons we learned through the adoption of a human rights-based approach (HRBA) to psychiatric care, as part of a regional governmental initiative. The authors are two rights holders from the relevant psychiatric care units, and two duty bearers from the regional authority. We adopt a narrative approach to discuss some of the challenges that were encountered during the project, such as realizing meaningful participation and challenging the hierarchies of different professions within care. We also discuss some of the successes, such as contributing to an overall strategic goal of a zero vision against coercive measures for the whole region. When an organization tests and develops new ways of working, this often takes place in the form of a pilot project in a smaller part of the organization. The organization has existing systems in place for optimization and measurement to ensure that we stay the course. The logic for the pilot project is different when the focus is on learning and exploration. Thus, a pilot project cannot be evaluated with the same tools or metrics that the organization uses. In an exploratory mode, it is not about how much you are doing but what you learned along the way. Even mistakes can be of great importance in a pilot project if you learn and offer feedback to the organization. The connection between the pilot project and the wider organization is therefore central, so that the exploration feeds into the wider goals.[2]

We begin the paper with a short description of how regional authorities and psychiatric care are organized in Sweden. We then discuss the organization of the human rights project before turning to lessons learned based on the core principles of an HRBA.

Region Västra Götaland and HRBA pilot projects

Västra Götaland is a large region in southwest Sweden, with 1.7 million inhabitants and 49 municipalities, the largest being the city of Gothenburg. Västra Götalandsregionen (VGR) is the politically led regional government. VGR employs 55,000 people, 85% of whom work in health care. The remaining focus areas are public transport, regional development, and culture.

In 2011, a political committee for human rights was formed in VGR, tasked with initiating an HRBA and promoting and advising on human rights issues within the organization. The committee was transformed in 2019 into an advisory committee for human rights that is part of the regional executive board and has the mission to prepare and advise on policies and strategies concerning human rights.

An office of civil servants is attached to the advisory committee, and its main assignments are combating discrimination and promoting equality in VGR. As the committee for human rights was the only one in Sweden, politicians were keen to find out what a systematic HRBA could mean in practice at the regional level in a Swedish context, in terms of the added value it could bring to both the organization's work and, most importantly, to the region's residents.

A pilot project was formulated with three areas that would reflect the region's overall responsibilities concerning health care, culture, regional development, and public transport. Experiences from the pilot project would be continuously transferred to and exchanged with the region, with the goal of scaling up and mainstreaming the HRBA throughout the entire region. For the period of 2012–2015, the Angered Hospital, the Bohusläns Museum, and parts of the psychiatric clinic at Sahlgrenska University Hospital were selected to incorporate human rights into their regular work. Angered Hospital is a local hospital whose mission is to "serve the community with accessible, welcoming, quality health care based on the needs of the local residents." Bohusläns Museum is a regional museum based in Uddevalla. The reason for including the museum is that culture is a regional responsibility. Sahlgrenska University

Hospital houses psychiatric clinics, which the committee for human rights noted should be part of the pilot project. At Sahlgrenska, therefore, the pilot site was Psychosis Care Chain Northeast, which consists of Psychosis Care Northeast (an outpatient clinic with voluntary care) and Ward 242 (an inpatient clinic with both voluntary and compulsory care).[3] Psychosis Care Northeast is an open community clinic belonging to Sahlgrenska University Hospital, and it serves about 500 patients from northeast Gothenburg. This part of the city has more than 100,000 residents from more than 100 countries. It has a slightly younger population, with lower income, education, and employment levels than the rest of Gothenburg.[4]

The organization of psychiatry and the situation of mental health in Sweden

The Swedish health care system is based on decentralization and on the principle that health care must be accessible to all without discrimination. While Parliament and the government provide the framework for mental health policy through laws and budgets, the regions and municipalities carry out organizational and administrative health work.[5] VGR is thus responsible for providing care and treatment to Västra Götaland, as well as creating the conditions for good quality and equal care. Consequently, the right to the highest attainable standard of health for every human being is central to VGR's work.[6]

In recent decades, mental health has been a priority in Swedish policy development. This was part of the de-institutionalization process in the 1960s, and the development of the 1995 suicide prevention program, updated in 2006, through which comprehensive reforms were carried out to increase the quality of life for people with mental health conditions, and where local care was at the center. Mental health policy has been further strengthened in recent years, such as through a comprehensive national plan for 2012–2016.[7]

Current developments in mental health in Sweden indicate improvements in some areas and deterioration in others. De-institutionalization and increased access to health care have increased the quality of life for many people suffering from serious mental health conditions. At the same time, mental health conditions, especially mild and moderate, are increasing in certain groups, especially among young people and in the workplace.[8] The proportion of people affected by severe conditions, however, has remained relatively unchanged. Each year, some 1,500–2,000 people in Sweden are affected by some form of psychosis. The lifetime risk of developing schizophrenia is about 0.8%. About 30,000 people with schizophrenia in Sweden need community support and care.[9]

The importance of human rights in psychiatry

Psychiatry tests and challenges human rights in Sweden through, for example, the law on psychiatric compulsory care.[10] This legislation states that under certain circumstances, a person may be treated against their will—for example, if the responsible doctor considers that the person needs continuous psychiatric care, or if the doctor considers the person a risk to themselves or others. The law strictly regulates permissible coercive measures, such as forced medication, straps, and belts, yet situations arise in practice that present ethical dilemmas. This includes instances where the law permits and there is a need for coercive measures in order to protect a person's life and dignity, even though the measures go against the person's rights to self-determination, participation, and integrity. These coercive measures challenge human rights.

In their reviews of Sweden's compliance with human rights, the United Nations (UN) Committee on the Rights of Persons with Disabilities and Committee on the Rights of the Child have criticized Sweden for using too many coercive measures in psychiatry and for having insufficient documentation in this area. These treaty bodies have therefore called on Sweden to develop work and attitudes that reduce the number of coercive measures and increase transparency in psychiatry. As the two committees note, the regulations in relation to psychiatric care are in accordance with human rights standards, but the application violates these standards.[11] Therefore, it is of great importance to incorporate an HRBA into the daily work of psychiatry.

What does it mean to work according to a human rights-based approach?

In 2003, the United Nations Development Group (now the United Nations Sustainable Development Group) adopted a "Statement of Common Understanding on Human Rights-Based Approaches to Development Cooperation and Programming."[12] In it, UN agencies agreed on the principles that characterize an HRBA.

The starting point for the work in VGR was to test whether this model of an HRBA would work in a regional, decentralized context. The short answer to that question: yes, it works. The longer answer: yes, it works, but it is not necessarily easy to understand, and it needs a lot of guidance in order to be applicable in day-to-day Swedish health care. An initial challenge was simply about language. While the statement of common understanding is brief, it is jargon heavy, which brings translation challenges, not only into Swedish but also into simpler and clearer language that relates more directly to everyday health care. Thus, we developed two sets of guidelines based on the common understanding but adapted to Swedish and regional conditions. The two documents follow the same steps and principles, but one is targeted at rights holders and the other at duty bearers.[13] In each guideline, we have adopted four principles that should permeate the HRBA in our region: dignity and empowerment, equality and non-discrimination, participation and inclusion, and accountability and transparency. In addition, we follow five steps for an HRBA that is more adapted to the conditions of VGR and where all steps except the first are consistent with the steps commonly used in quality development work.[14] The four principles mentioned above permeate all five steps, which are as follows:

1. Obtain knowledge about human rights related to mission and duties. This knowledge includes human rights in general and with a specific focus on the organization's core mission (such as human rights within psychiatry, at a museum, or at a school).
2. Analyze. Which human rights are the organization's main responsibilities? Who are the rights holders? Do different groups of rights holders have different access to their rights?
3. Set goals and plan. Link goals clearly to human rights. Use the language of human rights and try to reach those persons who are most in need first.
4. Carry out. Ensure that decisions are made as close to those affected as possible. Develop cooperation placing the rights holder at the center.
5. Follow up. Evaluate goals, results, and process.

Human rights-based approach at Psychosis Care Chain Northeast

The HRBA pilot at Psychosis Care Chain Northeast began in the spring of 2013. Early in the process, three service users (that is, rights holders), as well as representatives of civil society, were invited to join the project. The working group of the pilot at the psychosis care chain consisted of users, health care professionals, managers, representatives from two user organizations, and civil servants from the department for human rights. The project was also followed by two independent researchers. The makeup of this group proved very important.

In line with the first step of the guidelines mentioned above, the working group began by acquiring basic knowledge of human rights, specifically in relation to the right to the highest attainable standard of physical and mental health and in relation to psychiatry. The group studied relevant UN conventions, general comments of UN treaty bodies, and treaty bodies' concluding observations on Sweden. Continuous human rights training has, in fact, been one of the main themes throughout the work. This open-ended learning process was our foundation and one of the key factors for the success of the pilot and the work that followed.

The group also analyzed who was a rights holder and a duty bearer in relation to psychiatric care, and what those concepts mean. We agreed that service users and their relatives were rights holders. This means that they have the right to the highest possible attainable standard of health and that this right is protected by the UN covenants relating to health. It also means that care providers were duty bearers, and therefore the provision of care is an obligation stemming from the UN covenants relating to health. We also concluded that staff are rights holders in relation to their employer. It is an employer's duty to make sure that staff are safe and properly trained to perform their own duties. These duties include awareness of the human rights they are set to protect and safeguard for service users, as well as the human rights of their colleagues.

Another analysis focused on the perceptions of rights holders and duty bearers relating to dilemmas and challenges around human rights, what is already being done well, and how good practices can be further strengthened. Several ethical themes emerged through our working group discussions, including the difficult balance between the perceived need for coercion versus the right to self-determination and autonomy.

Based on these discussions, the working group planned and prioritized the remainder of its work, including linking existing governance to human rights objectives.

At the end of the pilot project in 2015, a new working group continued this work in a project titled "To Come to One's Own Right: Empowerment-Based Psychiatry." This group consisted of three people with personal experiences of psychosis and psychiatry, and two people employed in psychiatry (a nurse and a physiotherapist). In this project, which operated from 2016 to 2019, the working group used different methods and further developed the HRBA within psychiatry, using experiences from the pilot project.

Relating the work to HRBA principles

Below we share some of our experiences in applying an HRBA to psychiatry. We structured our rights-based approach around the following principles:

- dignity and empowerment
- equality and non-discrimination
- participation and inclusion
- accountability and transparency

The principles are intertwined, and some of our examples fit easily into other principles as well. We also elaborate on what it takes for an HRBA to be sustainable in a large organization such as ours.

Dignity and empowerment

Reduced coercive measures. Ward 242 worked actively to reduce the use of coercive measures, particularly belting. The employees made a direct link between the UN's criticism to Sweden about the use of coercion and their daily work. For instance, they suggested using low-impact treatment to reduce coercive measures and suggested removing unnecessary rules and procedures that existed in the ward that did not fill any direct care-related function but instead were mostly intended to control patients. One such rule dictated that patients were not allowed to drink coffee after 5 p.m. and were not allowed more than one pillow in bed. These seemingly small interventions in a person's life had great effects on their autonomy and sense of dignity. These kinds of rules and procedures created frustration that easily escalated and led to actions perceived by staff as destructive to self or others, which in many cases ended up in different coercive measures. Staff also observed that coercion can violate the dignity of the patient and create new traumas.

The staff noted that the reduced use of coercion was important not only for patients but also for the promotion of a better working environment and health for staff. Reduced coercion resulted in the decreased use of sick leave and in decreased patient deviations that needed reporting. Staff also stated that the new way of working increased their desire to remain in their jobs. The HRBA was an important part of this achievement, which was also supported by previous and present efforts and initiatives, such as person-centered care and "better care, less coercion." Human rights became the framework for ideas and initiatives that had previously existed at the ward and became the compass for further developing these initiatives. During the pilot project, staff reduced the use of belts from about four times per month to four times per year. Ward staff described this reduction thus:

> *The use of coercion, and above all belts, has decreased throughout the house. It's very rare that the alarms become a belting. The mindset may have spread. (employee, Ward 242)*[15]

> *The pain threshold for me has increased. When I started here, if the patients screamed then we sent them into the room. Now they may yell at me, it doesn't matter. I would also have been pretty upset if I had been here against my will. I think that we also are humbler in general about coercion measures in the group. Even the doctors who make decisions. We will do it if we have to—but preferably not—and we try to work with the participation of the patients more. (employee, Ward 242)*[16]

Moreover, the rights holders felt that the decrease in coercion was important for their improved dignity and health. As one service user stated, "That's what human rights is about—to change things … it is important to realize that it is possible to work in this way and to achieve real effects or changes."[17]

The working group continuously discussed the need to find a balance between empowerment and self-determination, on the one hand, and coercion, on the other; they raised the dilemma that allowing some patients too much self-determination could be neglectful, which would also violate patients' human rights and the staff's duty to protect them.

Ward 242 employees also described how an HRBA empowered them to question coercive measures prescribed by doctors. In this case, the employees found that the coercion was not necessary and risked the dignity of the patient.

> *We are now better equipped to question coercion. We have more strength in us against the doctors. [The staff] have internalised the information [from the human rights education] … that it risks the dignity of the patient. We've had good discussions even before, but now the working group is getting tighter … We have it in the back of our minds, how to do [coercion] in a better and more dignified way. (employee, Ward 242)*[18]

Visibility and legitimacy. Another experience in the project was that the very link to human rights itself increased the status of work within the health care sector and thus improved duty bearers' responses to different situations or dilemmas that may arise during their day-to-day work. Connecting one's daily work to UN covenants made their work more valuable and increased the importance of executing it as well as possible. This improved care providers' relationship with right holders. It also created a sense of pride for duty bearers in tasks that would previously have been viewed as trivial or mundane. Speaking of psychiatry and health in relation to human rights promoted empowerment among both rights holders and duty bearers. They expressed the feeling that everyday dilemmas and areas discussed were not trivialities but important and real. Human rights thus conferred greater legitimacy to thoughts and ideas that had existed for a long time, thereby offering a concrete tool for development.

Rights holders' hopes centered around making sure that everyone's voice was heard, that full participation was achieved, and that all forms of demeaning treatment were avoided.

> *That one, even if one is psychotic, is allowed to participate in all meetings, even during an active psychosis. That one is fully informed about what is happening is important for one's dignity and health. (service user, Ward 242)*[19]

Language. Human rights also highlighted the importance of language and of the words we choose. With the aim of improving their self-esteem and empowerment, right holders identified terms that they would prefer to be called, such as a "self-specialist" and "experience expert," rather than "patient." These names terms helped show that rights holders' personal experiences of mental illness and treatment are a valuable source of knowledge—just as important as health care professionals' knowledge and experiences. When an HRBA is employed, it becomes clear that a meeting between a health professional and a patient is a meeting between two experts whose knowledge is equally valued.

Another important aspect that emerged was the fact that rights holders and duty bearers, including interpreters who were used on a regular basis, often had different cultural and linguistic backgrounds. The working group discovered that speakers of different languages sometimes had different words for and views on mental health and illness. In some languages, the words for mental health issues all have a negative or even offensive meaning, which might severely affect the dialogue if not properly considered. And sometimes the needed words simply do not exist. Intercultural dialogue was therefore central to overcoming obstacles and achieving more inclusive health care provision.

Equality and non-discrimination

Power dynamics. In the joint learning of human rights in the working group, the discussions touched on power norms and hierarchies between patients and staff, among patients, and among different professions. We discussed the importance of reviewing one's own position of power, including the privileges and power that come with different positions. Techniques of ruling, counterstrategies, and affirming techniques became important tools. Both rights holders and duty bearers testified that these tools and the connection to human rights empowered them and thus also their own health.

Acquiring knowledge on human rights and learning that such rights are acknowledged by the UN gave the rights holders the strength to question certain decisions that had been made and to be more motivated to influence their own situation. For example, after participating in "to come to one's own right picnics" (see below) and lectures on human rights, one rights holder felt so empowered that she decided to demand a psychologist whom she had been previously denied and had not felt powerful enough to claim. The same could be seen for duty bearers, who stated that human rights gave them strength to be more active at staff meetings and challenge existing hierarchies at the workplace.

"Our lives are the story of ourselves." A narrative approach is an important part of approaching human rights-based work and a powerful tool in spreading human rights. It puts the rights holder and their story at the center, and it acknowledges and highlights the value of one's own experience. "To come to one's own right" conversation groups created safe rooms where participants felt free to share their stories. When a person's story is told and listened to in a safe room, a seed is planted that can grow stronger on the path to recovery. By allowing a person to tell and transform their story, the image can also become more cohesive for the person herself, allowing a better opportunity for healing.

The rights holders who were part of the working group used their personal experiences, histories, and stories in meetings with staff, as well as in meetings with other rights holders (such as in the conversation groups).[20] These stories created a great impact on duty bearers, for seeing and understanding another human being's perspective is a strong experience. This increased the legitimacy of the work within psychiatric care and the staff's sense of belonging. At Ward 242, initiatives were taken to capture rights holders' personal stories; for example, rights holders who had previously been hospitalized were offered the opportunity to come back and talk about how they experienced care and any coercive measures. Individuals who had the opportunity to make such a return visit were very pleased and stated that it had helped them in their recovery. This also provided a valuable learning opportunity for duty bearers.

Compensating for obstacles to human rights enjoyment. The pilot project understood that access to activities for rights holders was severely reduced in the summer due to the holidays. In order to fill this gap, the project started arranging human rights picnics. To reach as many people as possible, the group worked to identify obstacles and help people overcome them. For example, one of the ideas was to make the city's green areas accessible to rights holders. Here, the working group identified and compensated for the following barriers:

- Financial barriers: Many rights holders lack financial resources due to their ill health. Parks are usually free to visit, but public transportation is not. Therefore, the project offered to pay for rights holders' public transportation. Participation in the picnic and refreshments were free of charge.
- Cognitive and social barriers: Many rights holders felt insecure about finding their way or taking public transportation by themselves. Therefore, participants were invited to meet up and travel together to the places they usually visited.
- Various physical obstacles: Some rights holders found it difficult to walk long distances, others had a hard time sitting on blankets on the ground, and some needed to know that there was a toilet nearby. The locations were chosen with great consideration so that participants would not have to walk too far, so that there would be access to folding chairs and toilets, and so on.

Participation and inclusion

A focus on preparation. All decision-making in the work group was taken with the rights holder at the center and with the ambition to achieve as equal conditions as possible between rights holders and duty bearers. To do this, we used a checklist called "The aim of the meeting" that was based on the human rights principles mentioned above. In preparation for each meeting, we considered how the meeting would fulfill the principles of an HRBA, wrote it down on the meeting agenda, and distributed it prior to the meeting. Each meeting ended with a joint evaluation to see whether and how the principles were met, what worked well, and what needed to be adjusted before the next meeting.

Continuous improvement. During the project period, the working group grew as more participants were included. After a while, it became clear that this growth had become an obstacle to participation for some of the rights holders. It was difficult for them to be heard and to raise questions in such a large group. Therefore, a small working group was formed in which questions were processed before meetings with the larger group. The small working group consisted of the three rights holders and two employees. This is an example of recognizing that nothing is perfect but that it is possible to constantly thrive to compensate shortcomings as they arise.

Accountability and transparency

Administrative aspects of the interdependence of rights. The project used the AAAQ framework (availability, accessibility, acceptability, and quality) to assess whether duty bearers were living up to their obligations under the right to health.[21] In the discussions, the right to housing arose beside the right to health. It is a problem that some patients remain in the inpatient ward even after finishing their treatment, simply because they do not have a home that meets their needs. The working group therefore conducted an analysis on the right to health and housing. It became clear that these two rights are strongly linked to each other. One conclusion drawn was that cooperation between VGR (responsible for health) and the municipalities (responsible for housing) is needed to fulfil both of these rights.[22] This was raised in the health care cooperation body, where the regional and municipality levels meet, so that the fulfillment of these human rights could be effectively addressed.

Sustainability: Creation of user council. Another result of the HRBA was that regular meetings were initiated for rights holders in Psychosis Care Chain Northeast. These meetings were later transformed into a user council. The user council now has its own office connected to the waiting room. The office is usually staffed with someone from the user council so that right holders can ask questions, make comments, or perhaps become involved in the user council.

Policy impact. In 2017, VGR systematized some of the experiences from our pilot project into its strategic action plan for human rights, entitled *For Every Human Being*. The plan describes and substantiates the work of realizing human rights within VGR during 2017–2020. The action plan, which contains 12 goals with their respective measures and indicators, was developed in collaboration with businesses and civil society in Västra Götaland.[23] The 10th goal of the action plan contains a "zero vision" for the use of coercive measures, meaning that it seeks their complete abolishment. This goal was a direct result of the project, and the working group was involved in its formulation and content. The goal also specifically states that patients subject to coercive measures should be offered a structured follow-up talk after the application of the measure in order to prevent new trauma.

Striving for transparency. A direct effect of talking about duty bearers' obligation to monitor rights holders' human rights from a broad perspective could be seen during the time of elections to the European Parliament in 2014. The employees at the inpatient ward involved in the project secured the right to vote in general elections for the patients at the ward, a human right that in practice is often limited when a person entitled to vote is subjected to compulsory care. The patients at the ward were given the opportunity to vote inside the ward, which ensured their right to participation in democratic elections.

Working toward transparency as far as possible and opening up a fairly closed business as psychiatry was also considered a success factor. The unusual interaction and equal participation of both rights holders and civil servants, and allowing them to pose their sometimes naïve questions, also improved transparency and demonstrated a willingness to embrace shifts in perspectives.

Conclusion: Lessons learned from the project

At the end of the project, we carried out interviews with participants from the pilot, which allowed us to extract a number of key lessons:

1. **The importance of broad representation.** Broad representation from representatives of rights holders and duty bearers is needed to achieve legitimacy. Otherwise, there is a risk that only one unit, group of staff, or organization will become involved in the work, which will not be integrated throughout the different strategic interests and levels of organization needed to ensure sustainability. It is also difficult for one single rights holder to represent the entire group and gain an empowered voice.
2. **Meaningful involvement of rights holders.** It is important for rights holders to become involved at the start of the process and all the way forward. This allows the stories and experiences of rights holders to be placed at the heart of the work, and it helps ensure that all participants work together on equal terms. We met several challenges related to, for example, the real participation of rights holders and the reactions they received when trying to change hierarchies in health care. These prompted us to find new ways of looking at things, which allowed us to improve our approach.
3. **Time for reflection.** One lesson learned is that it is possible to work with human rights in practice if there is mutual learning. There is great value in learning during the journey, and it is important to understand that changes take time and must be *allowed* to take time in order to be sustainable. Time for reflection and education was the single most important investment in this project. In each meeting, time should be taken to agree on the next step and who is responsible for it.
4. **Active use of human rights principles.** Using the principles actively helps ensure that everyone is allowed to speak and take part in meetings on equal terms, and it supports the right of everyone to express themselves on their own terms. The document "The aim of the meeting" became, as stated above, an important tool for us to keep the principles in mind during meetings. Since we made it clear that the principles of human rights would permeate our work, each one of us felt supported in raising issues regarding equality, participation, and influence.
5. **Linking human rights to what is already being done.** Human rights can sometimes feel abstract and large. It is thus helpful to start with something specific within an organization or sector as

a clear, relatable example and as an inspiration for change. An HRBA is an ongoing endeavor.

6. **Committed senior management, enthusiasts, and strategic partnerships.** The success of this pilot was in many ways made possible by the commitment and engagement of enthusiasts and strategic individuals within the hospital's hierarchy. The commitment of senior management was a decisive factor for success. To take one example, one of the unit managers from Psychosis Care Chain Northeast recently moved to head another psychiatric ward, where she introduced the HRBA. As a result, the use of coercion has been reduced by 70%, and staff sick leave by 30%, in this new ward. This shows that an HRBA promotes empowerment and health among both rights holders and duty bearers and that the experience is transferable to departments that were not part of the pilot.[24] We also learned that it is important to develop strong collaborations with strategic partners who can help bring about change based on an HRBA. In this regard, the project collaborated with NSPHiG (a non-governmental users' organization), the Social Insurance Agency, the Employment Service, and the City of Gothenburg.
7. **Starting small and taking small steps.** Expecting too much too soon can paralyze the working process. Human rights can become overwhelming, with the result that nothing ends up being done. We realized that even if hierarchies cannot be—and perhaps should not be—eradicated within the health field, an inclusive attitude that avoids focusing on professional or disciplinary prestige, and a willingness to not always be right, is important in order to succeed with an HRBA. By striving to achieve trust among members of the group, we dared to try new ways of working, even if they were not always successful. It is also important to focus on the human rights that our organization is responsible for and thus narrow the workload down a bit.
8. **Human rights as a guide for prioritization.** The staff at Ward 242 had started an initiative prior to the pilot project to reduce coercive measures. They found additional support and guidance in human rights from the pilot project to continue processing these changes. Human rights helped provide an important answer to the question of why, for example, coercive measures should be reduced. Many of the processes the project started and scaled up might have been possible without the project. But we have good reason to believe that the pilot helped roll out these processes more quickly and more sustainably. With the help of human rights, we were able to see new areas that needed to be changed or improved. The fact that we focused on the human being as rights holder meant that we were able to confront dilemmas and challenges that we might otherwise have missed.
9. **Continuous evaluation and learning.** Our constant evaluation of the extent to which activities and processes were fulfilling HRBA principles meant that we got a good idea of what worked and what did not. It also allowed us to adjust fast. Central to this ability was the fact that everyone who participated in the work was also included in follow-up efforts. Mistakes were seen as opportunities to learn rather than something to be ashamed of.

As we have described, this project showed that it is fully possible to apply an HRBA to psychiatric care and that such an approach has great benefits for individuals and organizations alike. It can often be a challenge to create change on a large scale and to disseminate the effects across an entire organization. Many times, it is the small changes that effect change through a butterfly effect. Therefore, it is imperative to achieve a constructive and empowering process of mutual learning that occurs continuously and not only at the end of a project.

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17. Quote from rights holder at Psychosis Care Chain Norheast, *Follow-up to the project "To try a human rights-based approach in practice in Region Västra Götaland"* (2015), p. 78.

18. Jenny Eriksson, Malin Fryknäs, and MR-piloterna, *To try a human rights-based approach in practice: A pilot project carried out in three businesses in Region Västra Götaland 2012–2015* (2015), p. 77.

19. Quote from rights holder at Psychosis Care Chain Northeast, *Follow-up to the project "To try a human rights-based approach in practice in Region Västra Götaland"* (2015), p. 45.

20. See, for example, NSPH, Hjärnkoll, Handisam, Senus, *Your right: Think, discuss, act; A study material on everyone's rights*; D. Roe, I. Hasson-Ohayon, M. Mashiach-Eizenberg, et al., "Narrative enhancement cognitive therapy (NECT) effectiveness: A quasi experimental study," *Journal of Clinical Psychology* 70/4 (2014).

21. Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000).

22. F. Palm and J. Terneby, *The right to health and housing: A human rights analysis about the right to health and housing for patients within Psychosis Care Chain Northeast* (2015), p. 13.

23. *For every human being: Action plan for human rights work in Region Västra Götaland 2017–2020* (2016).

24. Interview with Marie Wennergren, care unit manager, Ward 365, Sahlgrenska University Hospital (November 14, 2019).