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HANDOVER DIALOGUES
UN Special Rapporteur on the Right to Health

Notes from Dialogue

Achieving an emancipatory future: rights-based approaches

Panellists:

Panel One
Kim Wichera, Runaway House, Berlin.
Inez Feria, NoBox, Philippines.
Dean Peacock, Women's International League for Peace and Freedom.
Cat Brooks, Anti Police-Terror Project, Oakland, California, USA.

Panel Two
Sera Davidow, Wildflower Alliance, USA.
Chris Hansen, Intentional Peer Support (IPS), USA.
Keris Myrick, Mental Health Strategic Impact Initiative at the Jed Foundation, USA.
Faraaz Mahomed, Harvard Law School Project on Disability, Center for Applied Legal
Studies at the University of the Witwatersrand, South Africa, and Open Society Foundation.

Special Rapporteurs: Tlaleng Mofokeng (current), Dainius Pūras (former).

Moderators: Liam MacGabhann, International Network Towards Alternatives and Rights-Based Supports (INTAR), Dublin City University, Ireland and Andrea Parra, Training for Change, Colombia.

Organising partners: International Network Towards Alternatives and Rights-Based Supports (INTAR); Open Excellence, and the Human Rights Center at the University of Essex.

Introduction

Dr. Dainius Pūras: This is the final event in our series of Handover Dialogues. Throughout the series we have examined, and especially through the work of our colleagues and partners, the right to health as a powerful tool to challenge, to deconstruct, to problematize ineffective and harmful policies, laws, and

practices that impact health - physical and mental health. Around the world I have seen efforts to simply improve the status quo in health. But this approach is never enough. Such efforts do not challenge and delegitimize the structures of power that maintain discriminatory laws, policies, and practices. This is especially important when it comes to mental health which remains the hostage of a legacy of discrimination. These are not just problems of the Global South; I think they are even bigger problems in the Global North.

My task as a special rapporteur, when I had decided that mental health would be my priority, was first to collect evidence to show the systemic failure of the status quo in the past three or four decades. But following that, I needed to advise on what should be done differently.

To this end, my advice is to stop investing in the status quo! Do not put new funding towards the legacy of helplessness and exclusion and discrimination; rather we need to invest in the delivery of alternatives that have eliminated coercion. Many people simply don't believe that change is possible, and this reflects, and contributes to, the learned helplessness in the field of mental health. All of us must work to convince others that it is possible to have services without coercion, without violence, both within and beyond mental health systems, especially in the police and other institutions. We need to build a critical mass of people who believe this is possible.

During my time in the mandate I was fortunate to visit many facilities and organisations offering good practices, both in the Global North and South. So positive things are happening, including World Health Organization's (WHO) recently published guidance on rights-based approaches to mental health care.[1] This is the result of all the work of people and organizations such as those attending today's dialogue, as well as other experts and different agencies within the United Nations. It is a great help to our cause that WHO has finally adopted this position. I hope that our combined efforts, globally, and in each of our countries, to promote rights-based mental health services also promotes and protects human rights in general.

Julie Hannah: Dainius has contextualized the purpose and the motivation for our final panel today. I was in the very privileged position of supporting Dainius in his thematic work throughout the past six years. Issues that constantly came up as we were working on reports was, "Well, what's the alternative? How is an alternative possible?" So we spent those years looking for and witnessing alternative practices. And really, they are simply community-led responses outside of coercive oppressive models. Alternatives exist everywhere, quietly in small scale, on the fringes, in so many different parts of the world.

Dainius was committed to elevating awareness of these possibilities and to driving a collective imagination for something that is better, that is grounded in human rights, and supports people to live lives of dignity. Most of you in the room represent that hope and that collective imagination. Our panellists will present on some of these alternatives which challenge oppressive structures and convey hope.

Panel One

Kim Wichera: The Runaway House in Berlin, an anti-psychiatric facility in Germany, has been going for over 25 years, since 1996.[2] Ex-users and survivors of psychiatry fought a long political struggle to win funds to create an institution in which support is based on the rights of the residents, and in which individual autonomy and self-determination are key considerations of the service offered. In order to move into the Runaway House, people must be homeless or threatened by homelessness, and wanting mental health support.

The team at Runaway House does not work with biomedical models. Instead we give residents the space to find their own meaning and their own individual vision of well-being. We do not give advice or interpretation

without being asked. Residents can decide for themselves whether to start, come off, or stop taking psychotropic drugs. Our work is as transparent as possible so that residents can view their individual file at any time, change documents, attend shift changes to learn what is passed on about them from one shift to the next. All written reports and correspondence are completed collaboratively with residents. At least half the team members must be ex-users and survivors of psychiatry and all must have experience with life interrupting challenges. The team consists of social workers, students from different disciplines, and people with diverse backgrounds.

The passion of the entire team keeps Runaway House open. State funding is precarious and the bureaucratic hurdles are great. The social and economic situation for people in need in Berlin has deteriorated dramatically in recent years and it is becoming increasingly difficult to change the social and legal situation of the residents. Nevertheless, we achieve a lot with the residents; we secure residents' social benefits, apply for new ID cards and secure residency status; assist with management of their financial situations; arrange legal support; manage outpatient therapies; and work with the community. Most importantly, we work with residents to develop a follow-up perspective for when they leave Runaway House. Residents are heard, understood, accepted, and protected. They can be themselves again, in their own history, and with their own meanings. Since 1996, Runaway House has stood for non-coercive approaches, free, informed choice, and meaningful peer involvement. In the 26 years, almost 1700 people have lived there, as many as 13 residents at a time, and on average for 16 weeks and with many more than six months. Close friendships have developed between residents and some have formed living communities after their stay.

Inez Feria: NoBox is a non-profit organization whose work revolves around drugs in the Philippines.[3] For us to be able to do the work, we realized that we needed to shift the focus away from drugs. We started as a residential center over 20 years ago when we thought that everybody who uses drugs needed treatment because of the simple presence of drugs in their lives. The treatment and services were anchored even then on the principles of harm reduction which means respecting people at the stage they are at and working collaboratively with them. We have no preset program and no preconditions, rather we work with people to help them achieve the goals they set for themselves. People were not forced into treatment and this is an important difference because people can be forced into rehabilitation centers in the Philippines.

But we met challenges along the way: families didn't want to have their family members back home or being stigmatized when they went back into the community. It became obvious that residential centers were artificial environments and it made sense to keep people where they normally resided. So by 2013 we changed to make advocacy the primary focus of our work. We looked into the social, cultural, economic, and political contexts in which everything was happening, because we had learned that the drugs were not the problem, and the vast majority of people using drugs are not problematic. This is not said often enough. But it is key because the moment we understand that, we're able to ask the appropriate questions to identify the real problems that need addressing.

Our work is anchored in a harm reduction framework. In every situation we ask, "what is bringing risk?" Because it is not normally the drugs. We try to get as complete a picture as we can, working with our community partners, to try to understand personal and social contexts.

The only way to get a complete picture when we're working with people whose lives include drugs is to have them as partners, which is what meaningful involvement actually means. We share experiences which then empowers partners to create changes in their lives.

Before 2016, there were no community-based programs in the Philippines. Now there are, for example, local government officials who are mandated to respond to this need. We have to share an understanding

of a harm reduction framework with these partners requiring them to adopt a more comprehensive perspective which is actually liberating for a lot of them. If they focus exclusively on drugs, they experience a lot of frustration wondering why after all the programs provided, people continue to use drugs. By shifting their perspective, we work together to identify programs within their barangays (communities) that could actually be helpful to a person. These could be maternal health care programs, youth programs, or livelihood programs. These can all be incorporated into a program of support. This helps these partners see that drug use is not an isolated issue, but just one that has to be considered within the context of everything that's going on in the person's life. By working this way, we are able to promote a better understanding of specific harm reduction services.

It is not enough to simply provide services if they are delivered in a misinformed and punitive context. But when people have a broader understanding, it creates more options for people.

Our work also has an empowering element. Our community partners who have been associated with drugs in the barangays, or have been on the lists of targeted people in the Philippines that the world has heard about, would not access services because of the fear created by such lists. We had to work with them to create an environment of trust. It took time but we set up a drop-in center. In this space people have been able to share experiences and identify circumstances that might expose them to risk. This helps people understand how to be safe and healthy. But more than that, as we continue these discussions and sessions, people rediscover themselves and rediscover that their voices matter. We consider that to be the major shift. They learned to care for each other, because in the very repressive and punitive environment that had been created politically, they became suspicious of each other, because the community had been incentivized to report them to the authorities. Our approach sees the power of people caring for each other again and learning that within themselves they have the resources and strength to actually support each other. Our role becomes one of facilitating and supporting.

Participant comment: We also need to ensure specific services for women using drugs in situations of gender-based violence. We have produced a guideline that may be helpful for others wanting to develop these support systems.[4]

Dean Peacock: In 1993 I started a youth program and organization in San Francisco, called Men Overcoming Violence. Our intention was to establish community-based education, for young people and particularly young men, in partnership with San Francisco Women Against Rape, about teen dating violence and violence against women more specifically. A year later, the Violence Against Women Act was passed. We had an activist energy which carried over from the anti-apartheid movement and work to end US wars in the Middle East and Central America.

This activist energy was quickly absorbed by the criminal legal system which offered us funding to collaborate with the juvenile probation department and officers in San Francisco to establish a batterer intervention program for young men who had used violence against their partners. As a small NGO we were asked to channel funds directly to the San Francisco Probation Department so we became a conduit of funding from the National Department of Justice to the probation department.

Soon we were working with a group of young men whose lives were significantly controlled and influenced by the criminal legal system. Research shows that early involvement in the criminal legal system ensnares people in that criminal legal system for long periods of time. A whole body of research done mostly by Women of Color in the United States has taught us much about the unintended but foreseeable consequences of close partnership with the criminal legal system. A focus on criminalization, on mandatory arrest and mandatory prosecution has not been very good for survivors themselves. We've seen failure to

protect laws being used to take children away from survivors of domestic violence. We've seen mandatory arrest policies lead to high rates of incarceration for survivors of violence. Researchers are now scrutinizing just how effective the criminal legal system has been in addressing domestic and sexual violence and their conclusion is, "not very."

In South Africa we also have incredibly high rates of men's violence against women. I say specifically "men's violence against women", because I think sometimes we euphemize that by talking about gender-based violence or violence against women, and we don't name the perpetrators. Not only does South Africa have some of the highest levels of men's violence against women in the world, but there is a predictable response from our government in South Africa, that I would characterize as opportunistic: great outrage and indignation from government officials in the wake of high profile killings, and then inaction.

In the wake of several gruesome high profile domestic and sexual violence homicides in South Africa, the call has been to ratchet up criminal legal sanctions: African National Congress Women's League calling for the introduction of chemical castration; a number of politicians and some women's rights advocates calling for the reinstatement of the death penalty. The president is promising to abolish bail in cases of domestic and sexual violence and to implement mandatory minimum sentences, including life sentences. This is all part of the belief that harsh criminal legal sanction serves as a deterrent, that it shifts social norms, and deters violence. This is a pretty firmly held belief in many parts of the world.

But the problem with these responses is that it doesn't serve survivors well and it doesn't serve as a deterrent. There's no evidence in any of the international literature that it serves as a deterrent to men's violence. It also fuels mass incarceration—and often incarceration in conditions that are violating human rights as well as being incubators for violence.

So our work has been to advance gender equality and address gender-based violence with a strong focus on prevention.

Our research in Diepsloot, a large township with people living in desperate circumstances and with very high levels of unemployment, has taught us a lot about the root causes of violence. We surveyed 2500 men and learnt that 56% of those men had used domestic and sexual violence in the last 12 months. Many of them both, many of them multiple times. We found there was a very clear relationship between hunger and men's use of violence, and between alcohol use, trauma, mental health issues, and particularly childhood abuse. Children's exposure to domestic violence in the home and children's experience of violence were the strongest predictors of men's use of violence.

So despite all the evidence of the range of predictable drivers of men's violence against women, mostly we continue to say to men, "if you use violence, we're going to arrest you and we're going to throw the book at you." Harsh criminal legal sanctions may appeal to the public, and may be useful to politicians, but they are not addressing the root causes of violence, don't serve survivors well, and don't serve as a deterrent. We have to think differently about how we respond to violence.

Julie Hannah: Dainius grappled with some of these challenging issues raised by Dean, especially in his report on mental health promotion in the section on a public health approach to violence prevention.[5] https://undocs.org/A/HRC/41/34

Cat Brooks: I'm the co-founder of the Anti Police-Terror Project (APTP) based in Oakland, California with an additional chapter in Sacramento.[6] We started eight years ago and although we are Black-led, we are multiracial and multigenerational. The only requirement for membership in our organization is that you

can envision and commit to building a world where all of us can thrive. Our mission at APTP is to rapidly respond to, interrupt, and ultimately eradicate state violence from communities of color.

We were born out of a collective of Black organizers who were responding to the multiple incidents of state sanctioned violence in the United States, in California, against Black, brown and Indigenous bodies. After organizing years of protests, we realized we wanted to be both a reactionary and visionary organization. We were doing that protesting with thousands of people in the streets for years in response to the violence of the Oakland Police Department and law enforcement agencies across the country. This predated Black Lives Matter but we wanted to have a conversation about what was leading up to the murders of our people. Here in America, really, since the War on Drugs began under President Nixon, police have become the "answer" for every single social ill. No matter what the problem, you call the cops. And so, if we are talking about reducing, interrupting, eliminating state-sponsored terror from our communities, what we are really talking about is reducing and eliminating the number of engagements, particularly unnecessary engagements, that our folk have with law enforcement. And for us, the first place that we wanted to look was mental health crisis. Here in the United States, upwards of 50% of all people that are killed by US law enforcement are in the middle of a mental health crisis, which begs a very simple question: why do we continue to send badges and guns to situations that require care and compassion?

We had to ask whether police actually mean safety for our communities. We had to ask what public safety means, and consider what the expression, "reimagine public safety" could actually look like. For us, it means decriminalizing a lot of behaviors, engagements, situations that are only criminalized because of the color of the people that are involved in those engagements. Oakland (MH First) had started to turn to APTP to ask us to be that answer – they did not want to be calling the police in those situations. But who else is there to call? Just because we remove the inadequate, ineffective, and often violent response system that we have, we're not necessarily removing the difficult situations that were causing people to make those calls to the police to begin with. So we started rather informally. One of the co-founders of APTP, Asantewaa Boykin, is a registered nurse. She spent most of her career working in mental health institutions and calling out the criminalization of Black bodies and mental health crisis by law enforcement. With others, she created MH First, which is Oakland and Sacramento's first and only non-911 response to mental health crisis. In Oakland, as a result of our organizing, the city is creating a model called MACRO (Mobile Assistance Crisis Responders of Oakland) where they will send EMTs and a trained community member to a mental health crisis situation. The service will be housed with the fire department. The problem, however, is that you can only access Macro by dialing 911. But many Black, brown, and Indigenous people in our communities will never dial that number no matter what the emergency is. Because our lived experience, our truth is, that when we dial that number, things get worse, not better. That's why we have the non-911 service. It's a volunteer run program which necessarily limits its hours of operation both in Sacramento and Oakland to the weekends. Weekends because that's when people need help the most, and it is also when services were not available.

Our human rights-based approach reflects the understanding that the people closest to the problem are the ones that have the solution. And far too often, the people closest to the problem are being criminalized, and their wisdom is not being heard.

Funding comes from a mix of foundations, the people of Oakland and Sacramento, and from around the United States from people who want to see something different.

Panel Two

Keris Myrick: I'll start with a quote from Nelson Mandela: "for to be free is not to merely to cast off one's chains, but to live in a way that respects and enhances the freedoms of others." I've been a longtime advocate in the mental health consumer movement, peer movement, survivor movement, (it has many names in the United States), and I've been critically involved in raising the voice and experiences of people of color. When I think about rights-based issues, in particular for people who experience mental health distress, it's not equal, we are not all standing on equal ground. How do we understand intergenerational racial trauma and how do we understand it from a colonized perspective?

The work we do at the Mental Health Strategic Impact Initiative looks at intersectionality, not just in people and with various identities and how that affects their mental health and well-being, but also the social determinants of health. Currently in the United States, and I'm sure internationally as well, there is a focus on crisis response and police response to mental health crisis situations. We worked on a collaborative report, 'From Harm to Health' with Fountain House, the Technical Assistance Collaborative, the Center for Court Innovations, and the Hayward Burns Institute, to look at crisis response that centered on racial equity and lived experience.[7] A lot of the work that's happening nationally is not including people, especially people of color, with lived experience, who have had experiences of those crisis systems. So as we started to design and develop this report we had a primary principle that it must be centered on race, equity, and lived experience. We had a large group of people with lived experience, people of color, immigrants, people who do not have English as a first language, who were participants throughout the development of the report. We then created a NorthStar vision.

Our goal was to create a preventive health-first approach, and to define a crisis from the perspective of the person with lived experience. We say things like 'crisis' or 'distress', as if everybody understands what that means, but people in the group said, 'this is what crisis looks like', 'these are some of the services like peer respite that we really need when we have a mental health crisis'.

And importantly, the overarching consensus was that mental health crisis happens, especially for people of color, when the police show up. We learned we have to meet people where they are, and we have to understand their cultural and historical context, in order to be able to provide the support that they need, especially when they're having the most distress.

We also look at the historical and institutional forces and social norms that drive a lot of the inequities, especially for people of color. When we talk about mental health and stigma or discrimination, we also have to consider the intersectionality of being a racialized minority, a person who is LGBTQ, or who has a disability; so there are multiple ways in which we have to look at human rights issues, as well as the inequity issues, in order to address them. Many of these, in the United States and internationally, are a result of colonization.

I started a podcast called Unapologetically Black Unicorns, to lift the voices of people of color who have lived experience of mental health and substance use disorders, who are leaders or emerging leaders.[8] People can hear their stories, learn about what they're doing, and hopefully reach out and include them as participants in the rights-based work for mental health reform.

Chris Hansen: I'm a user and survivor of psychiatry. I got into this work by being a member of the New Zealand delegation to the United Nations Convention for the Rights of Persons with Disabilities and a board member of the World Network of Users and Survivors of Psychiatry.[9] I realized that if we were opposing force, coercion, and other breaches of human rights, we needed to find ways to support rather than coerce and traumatize one another. Intentional Peer Support (IPS) is a grassroots organization, which

was started in the mid 1990s, by Sherry Mead, who after being hospitalized many times realized that the treatment, relationships, and sense of self that were created within the psychiatric system were toxic. IPS is a convergence of the civil rights and self-help movements, trying to provide ways of support for people who experienced extreme states which would otherwise result in treatment, coercion, hospitalization, incarceration and violation of human rights. It helped people stay connected to one another and to their lives and communities. IPS provides training, consultation, and support for people and organizations that promote a way of thinking about and practicing connected relationships that listen for and explore meaning and the context of what is happening for a person. It acknowledges the role of violence, colonization, poverty, and oppression in causing extreme states and considers mental health treatment or interventions as coercive and violent.

Healthy mutual relationships are the core of the IPS approach. These partnerships invite and inspire both parties to learn and grow, rather than considering just one person to be in need of help. The relationship doesn't start with the assumption of a problem; rather each person pays attention to how they have learned to make sense of experiences, and promotes a trauma-informed way of relating and listening for what has happened and what's going on. It encourages the partners to move towards what they want, instead of focusing on what they are afraid of, or what they need to stop doing.

IPS, which looks beyond the mere notion of individual responsibility for change, has three principles, each about shifting focus:

- from helping, to learning and growing together; "we're both in this";

- from the individual, and "what is wrong with one person", to the relationship and "how it can work for both of us";

- from fear, to hope and possibility.

It's practiced by people in grassroots networks and organizations, people who are in peer support roles, in a number of prisons, LGBTQIA communities, veterans, ex-military, in some hospitals and mental health services and has been adapted as a statewide model in a number of US states.

IPS offers what communities have done for generations, but which many of us have forgotten how. I'll finish with this quote from Sherry Mead: "As peer support and mental health proliferates, we must be mindful of our intention, which is social change. It is not about developing more effective services, but about creating dialogues that have influence on all of our understandings, conversations, and relationships."

Sera Davidow: I want to shift from human rights language into power language. Human rights-based language is important, but so many people use it without appreciating the tremendous loss of power and control that needs to be unpacked as a part of that conversation. Many of us go through our childhoods or early adulthood and experience great trauma and loss of power and control. And then that is replicated in the systems we encounter afterwards. For example, I'm someone who's a survivor of sexual, physical, and emotional abuse as a child, and I was told by the people who hurt me to comply or that otherwise I was bad. And then I entered a system for support that told me to do what I was told, or otherwise I was bad. Many of these messages get repeated.

So we need to shift from that place of power and control over people to a place where we use our power to lift people, so "power over" moves to "power under" to lift people up so their voices get heard. They can take control and power back in their life. I don't know how we get to healing without that.

This is where Runaway House and IPS have really excelled. I want to offer another example, which offers peer respite, which is a part of my community with Wildflower Alliance. It is one of the communities that was cited in the recent WHO guidance on rights-based approaches to mental health.[10] An important part of our work is regaining control of information. In many countries, once people have signed consent forms regarding their care, they no longer have control over what information gets shared. People become so institutionalized by signing away that right, because they're so used to signing away all their power and control of themselves. Our role, regardless of what has been signed on paper, is to support people to get their voice and their power back. We will not talk about somebody unless that person is with us, and that person is in control of what is shared, or ideally, they share it themselves.

Another concept that relates to power is to move away from being responsible for someone else, and to being responsible to one another. This is about sitting in the darkness together, exploring and finding our way back out and figuring out how to navigate systems that frankly, are designed to take power and control away from us.

One of our community approaches is called the alternative to suicide. I want to highlight the outcomes when we have been able to create a space where people can talk about all the scary things that are happening for them and not fear what is going to happen to them for giving voice to that. People are usually afraid to talk honestly about what's going on for them for fear of loss of liberty, or other negative consequences. Our research has found that suicidal thoughts do not necessarily go away in these spaces where people can speak openly, but their relationship changes to them. They have more power over their suicidal thoughts when they have the space to speak openly about them. Furthermore, 90% of respondents said the most important factor in the alternative to suicide approach was that they could speak without fear of negative consequences.

The last thing that I want to highlight here is when doing this work, we need to stop just focusing on the modalities, the approaches. We need to understand that in order to support other people in their distress, we must look at ourselves, at what we're doing and how we're taking power away from people because we're afraid, unclear, and stuck. We then do things to people that cause harm.

Faraaz Mahomed: I'm a person with lived experience of a mental health condition and I'm also a researcher and a practitioner in the field of mental health. I'm discussing rights-based approaches to mental health which include the civil and political rights of people with mental health challenges such as the right to freedom of movement, the right to life in a community, the right to participation, and the right to equal recognition before the law, but also social, economic, and cultural rights. And as this has been mentioned by many of the speakers, these rights are all interdependent. I'm going to give examples of practices that recognize socioeconomic factors, such as a livelihood, are part of a rights-based approach to wellbeing.

COVID-19 has highlighted how economic loss can contribute to distress. Practices that focus on integrating livelihoods generation as part of a rights-based approach are fostering well-being and acknowledging the indivisibility of rights. Livelihoods approaches contribute significantly to community integration and inclusion, which is one of the core principles of instruments such as the Convention on the Rights of Persons with Disabilities. There are numerous examples of such efforts, many of which focus on the inclusion of people with lived experience, supporting self-efficacy, and recognizing the very specific contributions that people with mental health conditions can make. Social cooperatives have been extraordinarily successful in meeting the needs of people with mental health conditions by matching their specific needs to employment opportunities. BasicNeeds, a global mental health organization, engages with the social and economic determinants of mental health. It focuses on peer support as well as income generation alongside traditional mental health interventions, and operates in a multitude of contexts around the world. It challenges the notion that people with lived experience require charity.

While individualized plans are key to supporting people in distress, and while individualized approaches to economic well-being are essential to promote mental health, a rights-based approach also requires dismantling barriers to inclusion, such as economic exclusion, social inequity, discrimination, violence, criminalization, and many of the other factors that speakers have raised already. This speaks to the need for changes in macroeconomic policies, social protection, and provisions in law.

We are all clear that mental health policies need to change. But we should also be looking at structural determinants and the ways in which structural barriers affect well-being. An inclusive society can contribute to well-being by addressing many of the factors that cause distress in the first place. And to some extent, there have been efforts to engage with these concepts of well-being economies and well-being budgeting at macroeconomic levels. For example, New Zealand, Scotland, and Iceland have introduced well-being budgets, but their actual content continues to focus on simply adding funding for existing services. So these efforts remain nascent, and they often continue to locate the problem in individuals, rather than in society itself that might be unwell.

There are shifts taking place in small ways but there's much work to be done to promote mental health in a manner that is rights-based. Unfortunately, the dominant discourse retains an emphasis on psychiatric intervention which emphasizes promises and solutions, and of course is a profitable business. Hence there is an active interest in maintaining the status quo. In Africa, some governments, for example, Rwanda and Malawi, have signed MOUs with pharmaceutical corporations to develop mental health policies from scratch. This is indeed a disturbing development. The dominance of this model remains a key obstacle to a rights-based approach to mental health and well-being. Similarly, institutionalization continues and is reflected in policy making, in discourse, and it receives the bulk of the mental health budget. The narratives and perspectives of policymakers, clinicians, and broader society require transforming so that people recognize individuals' experiences of distress often arise from socioeconomic exclusion, not from pathology.

Only 2% of public health spending goes to mental health, and less than 0.5% of development assistance for health goes to mental health. I believe this reflects the stigma and discrimination against people with mental health challenges. So these are interdependent and interrelated challenges.

However, there are little glimmers of hope, including the recent WHO report on rights-based approaches to mental health, and Dainius' own reports and recommendations, as well as all the efforts being undertaken by fellow speakers today. As Dainius and others have mentioned, much of what is much of what is happening that is progressive, is emanating from the Global South. I wish the new special rapporteur every success in her work, to dismantle barriers to inclusion, that impede the right to health, and to promote the fostering of societies that recognize the value of socioeconomic equity, non-discrimination, and community building as key elements of our collective well-being.

Andrea Parra and Liam McGabhan

Throughout all the presentations and chats posted by participants, there are some themes emerging. All our speakers have one way or another addressed the indivisibility of human rights, and the need to look holistically at a person's whole life, history, and context and never to reduce them to one problem. Some of the specific comments in the chats include questions about how to integrate or mainstream some of the rights-based approaches that have been spoken about. How do we sensitize people to be open to new ways of viewing mental distress, and how does this shift start to happen? To what extent are state level actions opposing human rights standards? How do we change health professionals to recognize exclusion and social determinants as causes of mental distress?

Sera Davidow: Our work is to help people see problems within the system from their own experience. We

do some exercises to demonstrate loss of power and control. For example, I have a chart of 12 statements, such as, "I get to choose who's talking about me or not talking about me without me present", and so on. Then I ask participants to choose the one they are willing to give up first, then second, and I don't explain why – people get upset. At the end, we say, well, just so you know, people who go into a psychiatric facility, give all those up at the same time. Let's talk about that. And that changes the conversation. We have other similar exercises and through these creative conversations, we help people understand the impact of loss of power, control and human rights.

Chris Hansen: There are a few aspects we need to consider; one is hearing the stories and understanding the loss, the trauma, and the disconnection that traditional coercive mental health and other interventions cause. The second is, we have to provide alternatives which include ways of connecting with people. And thirdly, I find that I need to hold the grief of people who have gone into professions thinking they were doing good things, hearing that they're actually causing harm and trauma and that's painful.

Keris Myrick: In our *Harm to Health Report* we had a collective group of police officers, psychiatrists, mental health professionals, public health professionals, peer providers, and people with lived experience, so that we could hear and learn from each other. As we work with psychiatrists we hear the stigma and discrimination and loss of power that they also experience. As Chris said, they enter the profession to do one thing, but the policies and structures and regulations force them to do something completely different. When I speak, particularly with psychiatrists of color, especially African-American psychiatrists, the disdain for coercive treatment is really a conundrum for them, because they understand loss of power; taking away people's rights is problematic for Black people who have historically had their rights taken away. So they feel like it's a double-edged sword for them. And we don't get to hear that unless we partner with and share and then learn how to move forward.

Participant: Rather than sensitizing professionals, it is more important to sensitize our communities if we're looking towards community inclusion.

Liam McGabhan: A repeating theme in the chats is that we have wonderful community rights-based practice examples. However, we need to engage with the system so it shifts towards being rights-based. Do we integrate these examples into the mainstream, or do we overturn the current system?

Chris Hansen: It is really hard for those of us who have come from a grassroots level because we didn't set out to change the world. Often, we came trying to survive, and it has grown organically from there. I think we need to find partnerships with people who are working at a more systemic level.

Inez Feria: We have to remember that change is very much a process especially when it comes to drugs. The vilification of drugs and the conventional negative attitude towards people whose lives include drugs is very deep seated. I agree that we have to find partners, and this is part of the constructive collaboration process, and must include people working in different disciplines. We have also learned that partners, including local government agencies, need to understand that drug use is not a separate issue in people's lives; it's just one part of their context which also includes other social and economic factors. Another aspect of constructive collaboration is understanding that people are coming from their own realities. When people operate from the principle that "drugs are bad" they do so because that's what they've been taught. But we have seen in our workshops and programs that when there is the space for honest conversations, even people with those views genuinely want to be able to help. So we have to unpack their understanding and experiences as well. It is a bit by bit movement, like any positive change. Harm reduction is not an either/or, binary conversation. It involves looking at common principles.

Tlaleng Mofokeng: Today's presentations have stressed the importance of the intersections between

mental health, gender-based violence, drug use, and issues of policing. When we talk about access to health and support services, we know that it's always the same people who are marginalized, who miss out. This leads to compounding experiences that strip people of their dignity.

The aim of my work is to be clear that respecting people's human rights means respecting their dignity, bodily integrity, autonomy, and their fundamental right to self-determine. These principles are important in issues of gender-based violence: who do we define as victims, and who do we see as perpetrators, because we can fall into the trap of operationalizing, and racially profiling, leading further to silencing and shaming of certain victims, because they are not seen as people who could be victims of violence.

I agree with the presenters today who have discussed the importance of power dynamics. As we move through every day, in different spaces, we carry different powers located differently within us, depending on those spaces. It's very important to be aware of that positionality. How do we come together to support and amplify each other? I think we cannot do that truly without understanding the issue of power dynamics.

It is also important, especially as a healthcare professional, to speak about medical ethics and professional standards. Their inclusion in healthcare education is so important, but they are often missing. So we need to look at the curriculum, to ask, who is training medical people and what is the content of that medical curriculum, and where do human rights fit in?

The funding and resourcing of community-led organizations is another important topic raised. At the moment, global funding and philanthropic aid mimics colonial patterns and perpetuate certain power dynamics that treat some people as the wise experts and saviours of other people. This results in programming that is disconnected from the needs of the people on the ground. The same can be said of research. Many of us in the Global South are still having to use tools that were not designed for us. It is important to develop relevant research that can also be used in advocacy.

All these issues feed into my vision for this role, including coloniality and advocating for the intentional institutionalization of anti-racism in public health architecture systems. I will look at the systems of policing, of access, of class privilege, gender, binaries, and the people who get punished for pushing back on patriarchy. You can trace all these issues to colonialism, and of course, slavery, which strips generations of people to this day of their dignity. I will advocate for the right to health framework to be used to deepen our understanding of the negative impact of coloniality and racism, as well as other oppressive structures, because we know that racism and coloniality compound other problems in society, and they reinforce other systems of oppression. And we know these disproportionately affect black people, people of African descent, indigenous communities, other racially discriminated groups in the Global South, LGBT and non-gender conforming individuals, people who use drugs, people experiencing homelessness, and people living with disabilities.

I plan to work with other mandate holders, for example, the Special Rapporteur on Contemporary forms of Racism, who, in her report in 2018, discussed the importance of an intersectional approach.[11] This is very important to help us amplify our work, and root it in something that unites us, as opposed to something that separates us.

My commitment is to further develop and understand intersectionality, and intersectional discrimination, and they ways it impacts on the right to health within national, legal, and policy level structures. We need to use the law as a tool to reach substantive equality, and make it possible to identify and eliminate power dynamics that perpetuate these systems and patterns of privilege that disadvantage other people. This is one way that we can realize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

References

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7   "From Harm to Health" https://fountainhouse.org/reports/from-harm-to-health

8   Unapologetically Black Unicorns: https://linktr.ee/UnapologeticallyBlackUnicorns

9   International Peer Support: https://www.intentionalpeersupport.org/   and see also, World Network of Users and Survivors of Psychiatry: http://wnusp.net/

10   International Peer Support: https://www.intentionalpeersupport.org/   and see also, World Network of Users and Survivors of Psychiatry: http://wnusp.net/

11   E. Tendayi Achiume, Special Rapporteur on contemporary forms of racism, https://undocs.org/en/A/73/305
Video of this session: https://www.handover-dialogues.org