

Human Rights and Mental Health Policies

How to Empower Mental Health Care: A Dialogue in Geneva

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Abstract

The COVID-19 pandemic has had a devastating effect on mental health and highlighted the necessity to adapt quickly to new and unexpected needs. Especially young people, minorities and marginalized populations were at risk. Conflicts, traumatic events related to war and disasters caused by climate change have further increased the pressure on the mental health care system worldwide.

Currently, more than three years since the beginning of the pandemic, mental health services need to rediscover their roots and find a new path to move forward.

This article is the fruit of a conversation between an expert advocate for global mental health and a psychiatrist with a clinical background working in Switzerland. In this interview, the authors identify this global crisis as an opportunity to rethink and reshape the framework of mental health care. Reflections about psychiatry as a discipline, progresses achieved and challenges to come are presented. Obstacles due to the limited resources allocated to mental health, such as inadequate investment and lack of professionals, are a reality. It is highlighted that the mental health crisis is developing in every country, regardless of economic or human investment. Therefore, a rights-based approach, aiming to reduce coercion and discrimination is increasingly recognized as an essential route to achieve a transformation in the health care system. Ways to increase awareness about human rights violations, options for practical implementation and international guidelines are also discussed. Finally, four recommendations to implement these principles in the Swiss context are given.

Keywords: Mental health; global health; human rights; COVID-19 and mental health; mental health policies

Introduction

During the last three years, we witnessed an unprecedented health and social situation which made it necessary to adapt rapidly to new and unexpected needs. The COVID-19 pandemic has had a severe effect on all health care systems and pointed out their weaknesses in many countries[1]. Mental health has become a global concern, with an extreme rise in the prevalence of mental disorders, especially but not only among young people [2–8].

Since the beginning of the pandemic, the importance of mental health has been strongly emphasized in public and medical scientific opinions. As highlighted by V. Patel, mental health turned into a major health concern during the pandemic not because of a direct consequence of the virus itself, but rather a combination of its health, social and mediatic impacts [6]. The emergency measures that were urgently ordered and implemented by governments to fight the spread of the virus led

to measures such as physical distancing, hygiene regulations, quarantines and lockdowns that had a profound impact on the everyday life of most individuals. It is suggested that the minimization of physical contact and the subsequent focus on networking devices to maintain relationships may have led to overexposure to media and increased exposure to unreliable sources [9].

Despite these serious impacts on the population and on the healthcare staff in particular, ongoing mental health care and all non-essential activities were suspended, e.g., group therapy or social activities [7, 10, 11]. The absolute prioritization of measures to contain the virus over mental wellbeing added to the sense of isolation and further weakened the mental health care system.

Today, more than three years later and in the aftermath of the pandemic, it becomes clear that the crisis has not abated.

The prolonged uncertainty and the widening of preexisting health inequalities have exacerbated an already existing mental health crisis, with a dramatic rise in the prevalence of mental illness [12]. Later on, we have witnessed that minorities (e.g., LGBTQ+ people and indigenous communities), populations affected by trauma of war and by climate related disasters are disproportionately threatened by the inequalities and the shortage of resources in mental health care, especially the lack of professionals [12–14].

Aside from that, if one looks at the history of psychiatry, one must admit that, as a discipline, it had already been suffering for a long time. This medical specialty has been struggling since its inception, often finding itself

bewildered in a heterogeneous landscape of different fields between neurobiological sciences and humanities.

Consequently, we see the current prolonged crisis to serve as an opportunity to reshape the concept of psychiatry and to develop new responses to mental health needs. Lack of resources, both in mental health professionals and in investments in care services and research, has been identified univocally as a main cause of the mental health gap [15]. However, there is a growing acknowledgement that an increase in funding alone is often not enough to lighten the dramatic consequences mental health care is facing [12, 16, 17].

People living with mental health problems experience a long-standing discrimination regarding social interaction, employment, education and the judicial system [18]. Even in the healthcare system, mental health conditions are associated with a risk for neglect of physical disorders leading to premature mortality [18, 19]. The long history of coercion and excessive medication increases stigmatization and the reluctance to seek help [12, 20]. Therefore, eliminating discrimination, protecting human rights, fostering a respectful environment and ensuring the same level of care for mental as for physical health are a priority, as declared by the Lancet Commission on ending stigma and discrimination in mental health in 2022 [18].

Following this path, in this interview, a shift of paradigm is proposed recommending an approach of provision of mental health care strongly focused on the reduction of stigma and discrimination and to be more human rights-driven.

Method

The context is that in January 2022, Isabella D'Orta (first author), a psychiatrist with a clinical background working at the Geneva University Hospitals, had the opportunity to meet Benedetto Saraceno, an expert in the field of global mental health, to discuss some crucial issues around the development and evolution of mental health care in these troubled times.

Benedetto Saraceno is a renowned and longtime advocate for human rights and mental health with extended expertise in global health and in reforming health services, especially for underserved populations, including people with intellectual disabilities. Among other prestigious assignments, he was the head of the department of mental health and substance abuse within the World Health Organization (WHO) for over ten years and oversaw the implementation of reforms in mental health care systems in several countries [21, 22].

This article is the result of the remarkably fruitful conversation with him about the evolution of psychiatry as a discipline and the crucial relevance of human rights in the practice of mental health care. Options for the practical implementation and international recommendations were also discussed.

The text is the transcript of a real face-to-face interview in three different parts. The dialogue was originally recorded in English.

Interview

The Evolution of Psychiatry Through the Crisis

Q: COVID-19 has put the mental health system under unprecedented tension revealing a great discrepancy between discourse and reality in psychiatric practice. However, this kind of disparity is not new and it seems like psychiatrists are familiar with this kind of contradiction. It is almost as if psychiatry was already experiencing a crisis over its role and profound meaning not only in society but also among similar scientific fields. Can we say that the pandemic exacerbated its already existing epistemological crisis?

A: Undoubtedly. In my opinion, psychiatry finds itself at the crossroads of different disciplines which all appear much more solid in their epistemological construct, namely neurosciences, psychological sciences and social sciences. Psychiatry seems to be navigating between inspirations coming from several fields: neurosciences, psychological and neuropsychological sciences, and social sciences. Indeed, it can be said that psychiatry per se lacks a certain degree of epistemological solidity. More than a discipline, it can be considered as a discipline built from bricks coming from different sciences.

One key element sheds light on this fragile state of the epistemology of psychiatry: the concept of diagnosis. Since ancient times and all the way up to the experimental works of the French scientist and medical doctor Claude Bernard, it is widely established that diagnosis has two main functions. The first is to inform about the evolution of the pathology, what we call prognosis, and the second, to inform on what has to be done, which we call therapeutic intervention. In the case of psychiatry, the therapeutic path is only minimally based on diagnosis. As clinical psychiatrists, we mainly use symptomatology, often regardless of diagnosis. If we are good clinicians, we found our assessment on the understanding of contextual variables, such as the

social context of the patient. In order to build our strategic intervention we explore the patient's resources, the patient's family's resources and their environment. In psychiatry, the diagnosis per se is not a very strong predictor of the care strategy and the prognostic capacity is very modest.

From an epidemiologic point of view, it is accepted that a large group of our patients will improve with time, another will worsen and a third group will remain stable with no significant change. So even if we bear in mind the famous empirical one-third rule (one third of patients will get better, one third will stay stable and one third will worsen), it is impossible to know in advance if a patient belongs to the first, second or third group. The prognostic capacity of psychiatrists is very scarce and this confirms that we are working somewhat far from sciences based on clear categories and evidence. Our branch of knowledge is quite empiric and it is possible for instance to consider information coming from neurosciences but not to use it to define a therapeutic plan. The latter will more likely be based on social determinants and information from the patient's environment or personal experience.

This can be frustrating, but, at the moment, there is definitely no solution to this problem!

As psychiatrists, we have to be aware of the epistemological fragility of our discipline, knowing that we are working in a practical and empirical framework using fragments of different sciences. Being aware of this fragmentation and considering it as a hallmark of psychiatry, is also important to avoid an excessive sense of scattering. Indeed, another historical and well-known phenomenon reflecting the fragile state of the epistemology of psychiatry, is the extreme multiplicity of different schools of thought, often with rigid adhesion to one or the other, psychodynamic, psychoanalytic or cognitive thinking, social psychiatry, neuroscience, just to mention a few. This inflation of approaches is real and to me, it represents the proof that psychiatrists experience a need to create a sort of artificial framework, a reassuring ensemble of theories and techniques that gives them the sense of operating on a solid ground.

On the contrary, I suggest considering the heritage of Franco Basaglia's recommendation [23] and accepting that the ground on which we are operating is not solid, but rather fluid and slippery. I have the feeling that the rigid belonging to one school or another, sometimes even with ridiculous dogmatic wars between the different members, is a sign of the extreme weakness of psychiatry. The

inflexible and acritical belonging to schools probably prevents psychiatrists from being intellectually curious and free. My only recommendation, in order to identify better ways to operate in the field, would be to accept this fluid state of knowledge not as a weakness but as a strength.

The Human Rights Dimension

Q: The complexity of mental health conditions is undeniable, with so many elements playing a role in their management. However, it is possible to identify one key factor which is essential and particular to mental health care: the human rights dimension. Why are human rights so relevant and why must they be kept at the heart of the reflection concerning mental health services?

A: Psychiatry is undoubtedly a unique medical discipline in which human rights are central. Clearly, this is not the same for other specialties of medicine and it is appropriate to understand why this dimension is so predominant in psychiatry. As Henri Ey said, ‘mental disorders are a *pathology of freedom*’ [25, 26]. To what extent is there a connection between mental disorders and the practice of individual freedom, of people affected by mental disorders, is a type of question that is quite exclusive to psychiatry, which does not arise in other medical disciplines.

I believe that this connection is strong. If we look at the evolution of the psychiatric practice in the last 50 years or more, the most positive evolution in psychiatric practice clearly doesn’t result from the progress in pharmacology or the developments in psychotherapies, but from the recognition of human rights. Today, despite important differences worldwide, people suffering from mental disorders and persons with disabilities deriving from mental disorders are better treated and respected. Today, recovery is a central element in therapeutic reflection. We have accepted that maybe there is a difference between the notion of recovery from a strict clinical point of view and recovery from the point of view of the persons who directly experience a mental disorder. We have learned that listening to the person experiencing it is crucial to understand what full recovery means to them.

This simple realization and recognition led us to change our attitude. In many places, human rights violations are less frequent and in institutions where human rights are an issue to be addressed, there is a real concern which did not exist 50 to 100 years ago. Today, human rights have become an important component of therapeutic intervention. Re-

specting human rights is not only an ethical imperative but is also necessary because we are increasingly aware that it very often has a positive effect on the clinical outcome. Listening, respecting, considering the strategic vision of the patient about their own recovery is a perspective that makes our therapeutic strategies more effective and more efficient. This vision of human rights as a concern of the therapeutic strategy is described by Franco Basaglia as the *risk of freedom* [23].

To summarize, according to Henri Ey, it is the pathology of freedom that defines the disease and according to Franco Basaglia, the risk of freedom that builds up the therapeutic intervention. It is now clear that human rights play a more substantial role, which goes well beyond the formal respect of rules and laws and is intrinsically connected to psychopathology and therapeutic strategy.

A Moral Case

Q: It is encouraging to observe that practice in psychiatry is improving in many places through the increasing respect of patients’ human rights. However, the Arthur Kleinmann’s caveat highlights the importance of remaining vigilant at all times because violations of human rights of people with mental health disabilities occur everywhere and all the time [27]. Even in modern institutions and in high income countries, this kind of violation occurs regularly. Alertness and work on this issue is always necessary. Nobody is immune. How can we be more aware of this phenomenon and concretely implement these recommendations?

A: Human rights violations occur everywhere and contrarily to general belief, are not a prerogative of LMIC (Low- and Middle-Income Countries). As I explained in a notorious editorial written with Arthur Kleinman and Vikram Patel, there is a long history of human rights violation of persons with mental disabilities, to such an extent that it was defined a moral case [28].

Indeed, we should not confuse structural poverty and the violation of human rights. The fact that a hospital is particularly miserable in a low-income country, does not automatically imply that human rights are violated there. I personally used to have a very simple rule when I worked for the WHO to differentiate poverty from human rights violation. For instance, when I visited the psychiatric hospital in Congo Brazzaville, where only one source of water was available for the entire campus, I asked myself if I was witness-

ing a human rights violation. The answer is very direct: if the General Hospital of the capital also has only one water source, then the lack of water is a sign of a generalized poverty. But if the General Hospital is well equipped in terms of water sources and this is not the case in the psychiatric hospital, it is clearly a violation of human rights which is independent from poverty.

One element that proves the non-respect of human rights everywhere, is the great fear of the UN (United Nations) Convention on the Rights of Persons with Disabilities (CRPD), a convention which is still little known, ignored, unapplied and unimplemented even in wealthy countries. Even in Switzerland, a country which has ratified the CRPD, psychiatrists working in cantonal hospitals are often unaware of it.

Another useful tool that is too rarely used, is the Quality Rights Package. This WHO initiative consists of an easy checklist to assess the degree of respect of human rights. Despite its simplicity, I’ve observed that the health staff in most countries is extremely resistant to using this tool. Why this resistance? Why does nobody want to assess the quality of their work in terms of respect of human rights?

It is essential to change our mentality when regarding the violation of human rights. We should stop believing this problem only exists elsewhere, as conveyed by terrible pictures of poor naked men who are chained and beaten. Although this is a major failure of human rights, which we hopefully don’t witness in Switzerland, Italy or other European countries, it does not mean that here, human rights are necessarily respected. There are so many invisible ways of violating a person’s human rights!

CRPD and the Quality Rights Package are important instruments designed to help professionals become more aware of their limitations and mistakes, and to suggest strategies for improvement. They are certainly not designed to implement public scandals! Unfortunately, the fear of scandal often discourages professionals, preventing them from being humble and open to change. It also creates a defensive attitude that inhibits self-reflection and self-assessment.

The Process of Change

Q: Fear seems to be a strong factor which prevents change. How can the process of transformation be initiated?

A: Change comes from a combination of many factors, but changing the mentality in health care starts with changing that of doc-

tors. We cannot blame nurses, if we, psychiatrists, are part of the system and do not make any effort to change.

Willingness to change comes from local leadership and local mentality. A proof of this comes from the evidence that the rate of physical constraints (PC) of patients may vary hugely even in the same geographical location. For instance, in my country, Italy, epidemiologic studies show that, in the last twelve months, the rate of PC ranges widely and daily from one SPDC (Psychiatric Service of Diagnosis and Treatment) to another, even in the same region and in the same city. How it is possible that in Trieste you have zero physical constraints in 24 months and in Milan you have one per day or more?

This enormous difference cannot be explained other than through medical culture, which determines the organization of the institutions and finally the way patients are treated. Changing mentality needs a strong willingness from leaderships and psychiatrists being aware that PC is a sentinel event of malpractice. If a group of psychiatrists decides in a given setting that they are willing to reduce their average use of PC in a year, they have to define a roadmap they seriously commit to and follow, to train themselves, to train nurses, to use CRPD and the Quality Rights Package. It is a moral engagement where culture is the key element. In Trieste, I learned that a physical constraint can become a physical hug, and yet there were violent patients there, as everywhere, but there was no violent staff.

Q: Psychiatrists can commit to this change and foster an environment that encourages the reduction of coercion. However, nurses are on the front line and the fear of being victims of violence is an undeniable reality. How can we better manage our units to lower the rate of violence?

A: Actually, many studies show that a psychiatric environment can be more or less violent according to the way it is organized. A few elements that influence the atmosphere of a unit are concentration of inactive patients in the same room, time dedicated to meaningful activities, the emotional distance between nurses and patients. The presence of psychiatrists is crucial. If psychiatrists are not there or too busy and only able to follow the pharmacological treatment, this resembles the traditional way to implement health care.

Changing the atmosphere of the ward would mean increasing the presence of psychiatrists working together with nurses to provide acute care. I also recommend the presence of non-professional people spend-

ing time with patients. In Italy, we used to have volunteers called *animatori* who simply spent time with patients and immediately transform the rigid atmosphere of the ward. There's no standard recipe but there are many different ways of creating a more humane environment to develop a collaboration between professional and non-professional interventions.

Q: Despite a conspicuous number of recommendations and guidelines it seems difficult to have an impact on the practice. How can this discrepancy be explained and what are the main barriers to change?

A: The fact that there is a discrepancy despite the existing declarations, documents, guidelines and seminars is undeniable. However, the implementation is very low. In part, this is natural and unavoidable just like the declaration of human rights of the UN, which dates back to 1948, is still not fully respected today. So, this does not only happen in mental health, but here the feeling is that the gap between discourse and implementation is huge. Improvements are meagre compared to the visionary documents that were produced. In my opinion, five factors represent the real obstacles to change.

1. **Strong cultural resistance from psychiatrists.** Deinstitutionalization is still considered an impossible goal while the reality has proven the contrary. Too often, psychiatrists think that their interests are better served by larger institutions. Sometimes, they even feel diminished if operating in the community, doing home visits and community activities. It is as if there were two types of psychiatry. One for seniors operating with beds, wards and hospitals, and the other one for juniors operating with ambulatory services and community visits. This is a huge mistake, a cultural blindness which stems from the inside of psychiatry. The most impressive cases are in Egypt and Argentina where, in spite of a bipartisan political and social willingness to make a mental health reform (parliament, human rights associations, patients, family and users associations), the strong resistance came from the local psychiatric association.

2. The second element, in a similar way, stems from the fact that the trade unions representing **nurses** help them feel better protected in a hospital-logic system. There is a sort of complicity between nurses and doctors in defending the status quo. Working as a community professional is much more demanding, so they often prefer to work in hospitals.

3. The third element of resistance is represented by **politicians**. They view psychiatric patients as a potential source of election disturbance. They prefer to keep the environment as quiet as possible and they usually don't want to take any risks, and, as we know, freedom implies risks.

4. **Low primary health care (PHC) literacy.** In many countries, PHC is highly inefficient in acting as a filter and all persons needing mental health care are referred to psychiatry. In this way, the psychiatric system is overwhelmed and there are fewer resources for those with severe disorders. We can find excellent examples in the UK (United Kingdom), where PHC professionals are well educated and able to manage common mental disorders with medication and psychological intervention. Doing so, they free up many resources and the system is more inclined to reform.

5. **Lack of investment in secondary community mental health (CMH).** It has to be made clear that working in the community is not the same as performing a traditional regular activity in ambulatory services. There must be a change in the system, CMH is not only working following a traditional appointments logic, but professionals should be in the community, develop alliances with the community, cultural associations, sports organizations, volunteer groups and religious groups. They have to create a link with advocates, foster the creation of protected apartments, do home visits, support and reassure patients and families suffering in acute situations. They should be able to manage a crisis even at home.

Practical implementation on the field

These inspiring reflections are relevant not only from a moral point of view, but are intended as powerful leverage for change, thus, questioning our own practice is unavoidable.

The first author is a psychiatrist working in the public University Hospital in Geneva. Even if it is a wealthy institution renowned for its high standard quality of care, it is difficult to remain insensitive to the core questions that have been highlighted by the teachings of Benedetto Saraceno.

Four main reflections stem from this interview. Hopefully, they can be ways for development and inspiration for professionals.

1. Promoting a Culture of Therapeutic Optimism

Geneva is a global city, the most populous of the French-speaking part of Switzerland and a

worldwide center for diplomacy. In Geneva, many international organizations, such as the Red Cross and many agencies of the United Nations find their headquarters. The Geneva Conventions, agreements concerning the treatment of wartime non-combatants and prisoners of war, were also signed here. The culture of respect of freedom of all individuals is a reality in Geneva and is also widespread in the health sector, where the compliance with the voluntary principle is declined through empowerment and respect for the patient's will. For instance, the use of anticipated directives of will is a utterly encouraged, common procedure, especially for patients suffering from mental health issues.

However, this open-minded attitude is somehow counterbalanced by a strong need for societal security. In the mental health field, issues of dangerousness are often evoked, especially with reference to compulsory hospitalizations. It has to be noted that in Switzerland, the rate of compulsory hospitalizations is relatively high (highest rate of involuntary hospitalizations in the last decade) [29, 30]. Moreover, the mean rate of involuntary hospitalizations in Geneva is among the highest in Switzerland [29, 30]. In this context, it might be difficult to develop an optimistic therapeutic view, especially for young psychiatrists in training. Therefore, it is crucial to advocate for a more comprehensive approach to patients and not to emphasize the dangerousness of people with severe mental disorders. Psychiatrists should promote a shift from a fear-centered approach to a human rights-driven culture on all levels.

2. Facilitating the Connection with International Organizations

As discussed, Geneva is a diplomatic and international hub. However, despite the geographical proximity, the link of clinician psychiatrists with the international health institutions, such as the WHO, could be stronger. A better knowledge and diffusion of the WHO tools and improved communication between the institutions would enhance the reflection and help develop new strategies.

3. Developing the Community Health System

According to the WHO and other studies, services organized around large mental hospitals are at higher risk of human rights violation [31]. Despite this evidence, Geneva has witnessed a progressive decline of community psychiatry in recent years. The reduction of opening hours of public outpatient psychiatric centers, the closure of most of crisis beds in the outpatient centers and the complete shutdown

of one outpatient center are deeply disturbing phenomena. There is a need to implement a reflection to strengthen community services and to make them more accessible and available to the public in a way that facilitates the defense of patients' rights.

4. Reducing and Eliminating Coercion

Finally, close attention must be paid to reducing coercion. Recently, promising studies have been conducted at the Belle-Idée Psychiatric Hospital to analyze the way constraint is perceived by patients and staff, and how to mitigate its impact [32, 33]. It is an urgent need to follow this example and to develop further approaches to reduce coercion.

Conclusion

In this interview, the authors discussed different ways to mitigate the global mental health crisis. First, the evolution and the history of psychiatry as discipline are reviewed, aiming to rediscover its roots and role in building the structure of health care services. Then, the authors develop the human rights dimension which is presented as a clear path to be expanded in order to achieve a transformation of the mental health system. Finally, resistances and ways to implement the process of change are elaborated.

Four ways are proposed to improve practice in the Geneva context: implementing a culture of therapeutic optimism and facilitating the connection with international organizations, developing the community health system and focusing on reducing and eliminating coercion.

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Conflict of Interest Statement

The authors have no potential conflicts of interest to declare.



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