



Moving Toward a Human Rights Approach to Mental Health

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Abstract

The University of Florida Counseling and Wellness Center (UFCWC) has implemented peer support and professional training programs to address human rights identified within advocacy groups comprised of individuals who have, themselves, been diagnosed with mental illness. These programs are moving the UFCWC toward fulfilling a 2017 United Nations report emphasizing rights-based professional training, provision of genuine informed consent, and availability of non-compromised peer support alternatives. Collaborating with student peers, four UFCWC faculty members have facilitated forms of peer support developed within service-user movements, while openly identifying experiences of reclaiming their own lives from the impacts of adversity, intense mental distress, and traumatizing responses of others to their distress. In the wake of the current pervasive health, economic, and social justice crises, professionals have a collective opportunity to recognize the human experience and rights of those suffering mental distress. These UFCWC programs offer one example of steps taken toward that goal.

Keywords Human rights · Rights-based training · Peer support · Informed consent · Service-user movement

Introduction

In 2010, National Public Radio (NPR) called Judi Chamberlin a “civil rights hero from a civil rights movement you may have never heard of” (Shapiro, 2010, para. 1). Today, many people remain unaware of international advocacy groups comprised of individuals who have, themselves, been diagnosed with mental illness and who have reclaimed or are working to reclaim their lives from the impacts of adversity and intense mental distress—and often from traumatizing responses of others to their distress. In 1990, Chamberlin observed common beliefs that mental patients are inherently “incompetent, unable to do things for themselves, constantly in need of supervision and assistance, unpredictable, [and] likely to be violent or irrational” (p. 325). As Chamberlin also noted, “Stigma and discrimination still make it difficult for people to identify themselves as ex-mental patients if they could otherwise pass as ‘normal,’ reinforcing public

perceptions” (pp. 324–325). Media accounts and government actions often perpetuate these biases (Davidson, 2013; Whitaker & Simonson, 2019; Probert, 2015c).

The psychiatrist and Special Rapporteur, Dainius Pūras, expressed a different view in a 2017 UN Human Rights Council report calling for “bold political commitments, urgent policy responses and immediate remedial action” to address worldwide mental health systems “in crisis” (UN, 2017, para. 5). Pūras commended “movements led by users and former users of mental health services and organizations of persons with disabilities” for highlighting “failures of traditional mental health services to meet their needs and secure their rights” (Pūras, 2017, p. 4). As Pūras observed, these movements have “challenged the drivers of human rights violations, developed alternative treatments and re-crafted a new narrative for mental health” (p. 4).

Considering these issues may be challenging even for compassionate professionals working in conventional settings. However, through years of cultivating collaborative relationships and difficult dialogues, the University of Florida Counseling and Wellness Center (UFCWC) has developed peer support and training programs which begin to address essential concerns identified within service user movements. These programs are also beginning to move the UFCWC toward meeting the two formally identified “critical

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indicators” of working in accordance with the UN report (Pūras, 2017, p. 19). These indicators are (1) education and training on the use of non-consensual measures and (2) availability of non-compromised peer support alternatives (Pūras, 2017; Probert & Nash, 2018).

There are few safeguards protecting rights of professionals who have received mental health services—or who acknowledge experiences conventionally understood as symptoms of mental illness. In 1972, John Fyer—the first psychiatrist to identify publicly as being gay at an American Psychiatric Association meeting—wore a mask as a disguise (Glass et al., 2002). Before that change process began, healthcare professionals were routinely trained to classify anyone who did not identify as heterosexual and cisgender as having an impairment so far-reaching, they were incapable of working professionally, regardless of their actual capacity. An NPR reporter described how this professional practice “gave scientific sanction for the rest of the country to see it the same way. Gays were routinely fired from teaching jobs, denied security clearances and U.S. citizenship.” (Glass et al., 2002, para 21).

David Rosenhan’s, 1973 study “On Being Sane in Insane Places” presented another opportunity for professionals to recognize the global invalidation individuals frequently experience after being diagnosed with mental illness. In that study, professionals acting as “pseudopatients” reported hearing an “unclear” voice saying something like “empty,” “hollow,” and “thud” (p. 180). They were then scripted to act naturally, trying to gain release from the psychiatric hospitals where they had been admitted. Once diagnosed with schizophrenia or manic-depressive psychosis, the pseudopatients observed everything they did was taken out of the potentially relevant contexts of the psychiatric ward, or their lives, and identified as an expression of illness. Gaining release required pseudopatients to promise to accept and comply with this exclusively diagnostic view of their lives. The experience of the pseudopatients reflects a wider experience of inescapable defeat suffered by mental health services users who, as the World Health Organization (n.d.) reports, are routinely “excluded from community life and denied basic rights such as shelter, food and clothing, and are discriminated against in the fields of employment, education and housing” (para. 3). For example, one service user described repeated experiences of receiving substandard medical care following the revelation of diagnosed bipolar disorder, which “changes everything. It wipes clean the rest of my résumé, my education, my accomplishments, reduces me to a diagnosis” (Garey, 2013, para. 4).

Professionals in the U.S. retain a collective opportunity to reclaim responsibility both for how their own perspectives and power can be crucial, relational aspects of what they have been trained to identify as individual pathology and for how their own practices impact the larger world’s responses

to mental distress. Unfortunately, many professionals are still trained to identify intense mental distress and a range of other experiences as symptoms of intractable disorders—often subsumed into a prevailing scientific perspective of strictly bottom-up physical causation (Kelly, et al, 2007)—and often understood to require a lifetime of medications and frequent involuntary or pressured professional interventions. In an exploratory study of ways that various health care professionals “conceptualize mental illness,” Aftab et al. (2020, p. 848) suggest that the understandings “of mental disorder held by respondents are complex, sometimes contradictory, and do not fit easily within the biological psychiatry paradigm” (p. 855). Yet, however expressive those results may well be of genuine personal beliefs, there is also a vital need to explore systemic pressures many professionals face (Probert, 2014c, 2018c; Whitaker, 2010) to provide narrowly medicalized explanations, especially to individuals who communicate experiences perceived as threatening, including suicide danger or experiences conventionally understood as symptoms of mania or psychosis.

For example, while acknowledging the absence of scientific validity and valid biomarkers, Thomas Insel (2013), then director of the National Institutes of Mental Health (NIMH), withdrew support for research based on categories from the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) (2013). Two weeks later, Insel and Jeffrey Lieberman (2013), then president-elect of the APA, clarified their positions, that while “no longer sufficient for researchers,” use of both the DSM and International Classification of Diseases (ICD) (World Health Organization, 2011) “[represent] the best information currently available for clinical diagnosis of mental disorders” and “remain the contemporary consensus standard for how mental disorders are diagnosed and treated” (para. 2). They also stated, “It is increasingly evident that mental illness will be best understood as disorders of brain structure and function...” (para. 3).

Neither of these statements included any support for providing informed consent to service users, family members, or the public regarding the scientific limitations acknowledged. However well-intentioned, this omission has had significant impact. For example, any reluctance of service users to accept their own experience as a literal illness for which psychiatric medications are indispensable has, itself, been claimed as a diagnosable symptom of a medically established brain dysfunction. This view—with little of the complexity reported by Aftab and colleagues (2020)—has been widely advanced in support of involuntary outpatient medication commitment order laws (Harris, 2020; McCance-Katz, 2018; NAMI, n.d.; Treatment Advocacy Center, n.d.; Whitaker & Simonson, 2019).

These stated challenges to conventional systems may seem polemic when separated from the author’s own experiences,

first of crushing invalidation after being hospitalized and diagnosed with incurable mental illness, and then of a harrowing journey into the mental health fields as a graduate student. A highlight of this journey has been observing the values of the service user movements becoming “part of the fabric of social justice efforts embraced” by UFCWC clinical staff (Probert, 2018a, p. 4). As the author explained in an invited presentation to a SAMHSA-funded *Roundtable on Collegiate Recovery Supports for Underrepresented Student Populations*, this journey also:

included years spent working with other campus clinicians—whom I grew to respect and even love for their dedication and passionate efforts to support students, even when I did not agree with their approach. It broke my heart to see therapists—with tremendous capacity for supporting trauma recovery and individual empowerment—stop doing this same work with individual students whose distress they perceived to be caused by an intractable genetic condition. (Probert, 2018a, p. 4)

In 2021, with impacts of health disparities and violence impacting people of color in general and Black people in specific demanding action, it is relevant and essential to recognize studies demonstrating Black people being disproportionately impacted by involuntary outpatient medication commitment orders (Swanson, et al., 2009) and non-Hispanic Black and Hispanic people being diagnosed with schizophrenia more often than non-Hispanic White people (Coleman et al., 2016; Gara et al., 2019). Yet, the British Psychological Society’s (BPS) Division of Clinical Psychology (2015) has recognized a “large and growing body of evidence suggesting... experiences described in functional diagnostic terms may be better understood as a response to psychosocial factors such as loss, trauma, poverty, inequality, unemployment, discrimination, and other social, relational and societal factors” (p. 3). The National Coalition for Mental Health Recovery’s (NCMHR) (2011) *Guidelines for Promoting Recovery through Choice and Alternatives* has directed professionals to, “Educate individuals accurately about what is known and not known about a psychiatric diagnosis and about the wide range of possible explanations of mental health symptoms” (guideline 5). These issues have broad implications, given organized efforts to expand conventional mental health practices domestically and internationally (Cosgrove et al., 2020). In 2021, as human impacts of health, economic, and social justice crises multiply, professionals retain a collective opportunity to respond to appeals for revising communal approaches to mental distress (BPS, 2011; Kinderman, et al, 2020).

Rights-Based Professional Training at the UFCWC

In 2010, the UFCWC began addressing these issues, locally, with training seminars provided to its American Psychological Association internship program (Probert, 2012, 2014d, 2019) and, subsequently, to remaining trainees and therapy staff. These seminars have supported trauma-informed, rights-based approaches to suicide prevention and reframing mental health recovery with an essential focus on reclaiming human rights. One training goal is to open dialogue, moving beyond pressures training seminar participants have acknowledged experiencing, to avoid challenging conventional approaches. As one participant reported to the author (Probert, 2014c, para. 2), “I’m afraid if I do anything unconventional, I’ll be sued or fired.” Yet, the 2017 UN Human Rights Council report identifies informed consent as a “core element of the right to health, both as a freedom and an integral safeguard to its enjoyment” (Pūras, p. 14). Accordingly, these seminars include citations of evidence and position statements, from mainstream sources, which participants frequently report were not included in previous education.

For example, the 2020 UFCWC seminars included citation of statements, in 2013, from Thomas Insel acknowledging the lack of scientific validity of conventional diagnostic categories, and from Steven Hyman, then a former NIMH director, acknowledging the “molecular and cellular underpinnings of psychiatric disorders remain unknown” (p. 3). (Hyman also described a crisis in psychopharmacology, reporting available psychiatric medications work well for some individuals, have partial effectiveness for others, and do not work at all for the rest.) The seminars included citation of a 2011 British Psychological Society (BPS) statement expressing concern that conventional diagnostic systems which identify “problems as located within individuals” miss the “relational context of problems” (p. 2). The BPS recommended, “a revision of the way mental distress is thought about, starting with recognition of the overwhelming evidence that it is on a spectrum with ‘normal’ experience, and that psychosocial factors such as poverty, unemployment and trauma are the most strongly-evidenced causal factors” (p. 3).

The UFCWC seminars presented other evidence and position statements—reporting, for example, that

- the overwhelming majority of individuals diagnosed with mental illness will never be violent toward others (Binder, 2015; Davidson, 2013);

- after being diagnosed with serious mental illness, far more people reclaim their lives, or move into the process of reclaiming their lives, than most professionals or members of the public realize (Davidson & Roe, 2007; Harding et al., 1987);
- kinds of support available are distinctly related to recovery rates (DeSisto et al., 1995; Whitaker, 2010);
- literature reviews indicate continuing risks for electroconvulsive therapy, including high risk of long-term memory loss (Read & Arnold, 2017; Read & Bentall, 2010; see also Dundas, 2013);
- while many do find them helpful, the role of medications in all this is not nearly as simple, nor are medications as universally helpful, safe, and necessary as often conventionally portrayed (Guy et al., 2019; Harrow & Jobe, 2013; Horowitz & Taylor, 2019; Ostrow et al., 2017).

[Multimedia presentation, with complete references, available online (Probert, 2020).]

Addressing Suicide Danger and Traumatic Impacts of Non-Consensual Measures

Professionals and trainees practicing at the UFCWC are also supported to move toward developing a clinically thorough, humanly engaging approach to suicide danger (Probert, 2007, 2015a), consistent with the 2017 UN report, calling for “immediate measures towards... radical reduction” of “non-consensual measures” (Pūras, p. 15). This is consistent with another 2011 NCMHR guideline (3), “The use of involuntary interventions, which should never be considered treatment, is indicative of a failure to effectively engage the individual(s) involved. Involuntary interventions should only be used as a last resort, when all other approaches have been exhausted,”

These rights-based, trauma-informed seminars are the formal UFCWC clinical lethality assessment training. One guiding document for participants—available online (Probert, 2014b)—describes a philosophy and practice for addressing suicide danger within a process intended to support “recovery and healing” (p. 12). This was written by the author, and first published by the American Association of Suicidology (AAS) in 2011. It was a revision and expansion of an earlier essay (Probert, 2006) published as part of the lethality assessment standard within the AAS *Organizational Accreditation Standards Manual*. The revised article was republished to a larger audience by SAMHSA’s Recovery to Practice (RTP) Initiative (Probert, 2014b)—with an invited introductory article (Probert, 2014a)—and then also posted as a Crisis Alternative by the peer-run National Empowerment Center.

As explained in the introductory RTP article:

It is not possible to estimate suicide danger, or respond to it appropriately, without understanding the depth of terror, rage, hopelessness, and powerlessness—and the potential for escalation of suicide danger—that can be evoked within many distressed individuals by the threat of involuntary hospitalization and all that can go with it. Yet instead of being heard with empathy—and with an awareness of the potential for either trauma reenactment or trauma renegotiation—the resistance of suicidal individuals to hospitalization, if it is voiced at all, may be dismissed as merely an indication of a symptomatic lack of insight into the necessity of medical stabilization for their disorders. (Probert, 2014a, para. 1)

In “Confessions of a Non-Compliant Patient,” Judi Chamberlin (1998) explained why professionals may not realize the depth of trauma many service users have suffered through involuntary interventions. Chamberlin’s description of what allowed her and others to reclaim their lives, after hospitalization, evokes both Martin Luther King Jr.’s description of the “transformed nonconformist” (1963, p. 8), and holistic surgeon Bernie Siegel’s description of “good/bad” cancer patients (1989, p. 144). Yet, as Chamberlin explained, getting and staying out of the hospital—and avoiding escalation of adverse interventions while hospitalized—frequently requires mental patients to avoid openly expressing suicide danger and painful emotions or challenging anything done to them.

Well-intending professionals might accept that escalated suicide danger is optimally addressed through interventions aimed to treat disordered brains in controlled hospital environments. Yet, in 2019, Lisa Brophy and colleagues suggested the “experience of coercion, or being subjected to restrictive interventions associated with involuntary admissions,” often leads to a “potentially spirit-breaking” vicious cycle of repeated hospitalizations (p. 974). Researchers have also begun exploring how intersecting perceptions of madness, race, and dangerousness (Keating, 2016)—as well as responses to gender identity, sexual orientation, and other intersecting, marginalized identities—can amplify traumatic impacts of non-consensual interventions (Trac et al., 2020). In a 2019 statement calling for a rights-based approach to suicide prevention, Special Rapporteur Pūras wrote, “There is an urgent need to transition from addressing depression and suicide as the products of chemical imbalances toward examining how distress arises within power imbalances” (para. 10).

For example, evidence suggests lifetime suicide risk for service users is highest following discharge from psychiatric hospitalization (Crawford, 2004). Perceived coercion during the hospitalization process appears to increase risk of suicide attempts (Jordan & McNeil, 2019). A demonstrated

post-hospitalization impact on trust, among individuals aged 17–27, specifically included “unwillingness to disclose suicidal feelings and intentions” (Jones, et al, 2021, para. 3). In the Adverse Childhood Experience (ACE) study, individuals with the highest ACE Scores demonstrated a 3000–5100% increase in suicide attempts over those with the lowest scores (Dube et al., 2001). Other studies have also demonstrated a strong relationship between historical trauma and extreme states conventionally diagnosed as psychosis (Read et al., 2005).

If mental distress were understood to be caused (or even exacerbated) by adversity, professionals might be trained to be more aware of dangers of adding to the trauma burden of distressed individuals. As Special Rapporteur Pūras (2019) wrote, “Interventions are needed that avoid medicalizing emotional pain and empower individuals in vulnerable situations” (para. 16). As Pūras also wrote, “We must pursue new routes to suicide prevention that invest in fortifying healthy, respectful, and trustful relationships and community connectedness” (para. 4).

Individual Experience in Professional Training

The core sessions of these UFCWC seminars have been presented by the author, a psychologist who acknowledges reclaiming his own life and human rights after experiencing extreme states diagnosed as serious mental illness in the 1980s. As the author (Probert, 2014a) wrote for RTP:

I never thought about suicide at all until after my two hospitalizations, when I finally accepted what I was told to be true—that I had a severe and incurable mental illness. . . . In my case, the psychiatric medication I was taking did hold off my more extreme states—in which I heard commanding voices, became Superman and Jesus, experienced a terrifying demon seizing control of my face and mind, and had many other experiences a good southern Presbyterian choir boy and National Merit Scholar was not generally expected to have. The medications held off those experiences but did not alleviate the misery of severe depression, anxiety, panic, and so much inner torment that remained. And I understood, then, after the hospitalizations, that my continuing misery was caused by an incurable chemical imbalance in my brain—which was not corrected by medication and over which I had no possible influence. . . .

During my hospitalizations, no one even appeared to consider the potential impact of life experiences and childhood trauma. . . . No one addressed the teasing, repeated assaults, and death threats that I suffered

at the hands of childhood schoolmates or the sexual abuse by a mentor. No one addressed the traumatic impact of being overwhelmed as I was by my own inner states. No one addressed the traumatic impact of the hospitalization itself—of being handcuffed, put in isolation and restraint, and medicated with Haldol so I could barely walk and until my legs began to move uncontrollably, of being told what I must do to be released from the locked ward, and of becoming a mental patient, as we are conventionally treated in our world. (para. 5-8)

UFCWC seminar participants learn about individuals who experienced extreme states—not unlike those acknowledged by the presenter—but who were essentially erased as human beings, spending the last decades of their lives in a NY state psychiatric hospital. [After the hospital closed in 1995, their lives were restored to some degree of post-humous dignity through the breathtaking *Suitcase Project* (Penney & Stastny, 2008).] Seminar participants also learn about a Pulitzer Prize-winning report documenting horrifying conditions still existing in Florida state hospitals in 2015 and 2016 (Anton et al., n.d.; Pulitzer Prizes, n.d.). Learning from another professional, clinicians may understand more vividly the inescapable defeat and trauma that often still “occur when individuals experiencing a mental health crisis interact with emergency services and other systems of care”—including the “loss of rights... [and] social capital,” “substitute decision-making [which] can remain in force for years,” and/or “legally mandated treatment with psychiatric medications” (Stastny, et al, 2020, p. 109). The training includes exploration of recovery-oriented projects like Soteria (Mosher, 1999) and Open Dialogue (Seikkula et al, 2006) and varied forms of evidence emerging, internationally, through peer organizations—illustrating what has supported many individuals to reclaim their lives (Hall, 2012; Mead & Copeland, 2000; Romme et al., 2013). While these seminars are brief, participants may consult with peer support facilitators or observe the impact of these liberational principals, indirectly, as the students they work with as clients participate in peer support groups.

Providing the education necessary for clinicians to integrate all of this into their practice (e.g., Karter & Kamens, 2019) would likely require several full-semester courses incorporated into a larger graduate curriculum. From that perspective, providing several two-hour training sessions is clearly only a beginning of what is possible. None of these clinical practices are mandatory. The UFCWC has consequently not incorporated formal accountability measures nor does it incorporate the full range of other elements also identified as essential for thorough implementation of human rights-based responses to mental health crises (Stastny et al, 2020).

Yet, all these UFCWC programs together have, at least, provided formal validation for more rights-based clinical practice. Many UFCWC clinical staff members have also completed more extensive training in the empowerment based, trauma-informed-approach to suicide prevention practiced at the Alachua County (Florida) Crisis Center—from which the approach documented above was developed (Probert, 2014a, b). These clinicians include members of the dedicated on-call team and the two crisis services administrators who also serve as UFCWC representatives to the campus-wide Behavioral Consultation (threat assessment and management) Team. These two faculty members were also co-chairs of the task force which launched the peer support program (Nash, et al., 2015), and one was a founding co-coordinator of the program (Probert & Nash, 2015).

Accordingly, many but not all UFCWC clinicians practice a kind of harm reduction (Stastny, et al, 2020). Consistent with the training principals, they work, to support a vital reduction of non-consensual measures related both to suicide danger and to “extreme, ‘unusual,’... or alternative beliefs, perspectives, or experiences” (Probert, n.d., para. 2). These experiences might otherwise be understood, conventionally—as invariable symptoms of psychosis or mania—and without any essential clinical efforts, emphasized in the UFCWC training, to explore and support the readiness of individuals to navigate potential hazards in their lives. The students these clinicians work with in these ways are also frequently offered opportunities to meet with peer support group facilitators for rights-based, trauma-informed consultation sessions and/or to dialogue about possible participation in peer support groups. (Affiliated UF Student Health Care Center Psychiatry service providers have their own standards, practices, and individual differences, often addressed in the informed consent process included in these consultation sessions.)

Moving Toward Provision of Non-compromised Peer Support Alternatives

At the heart of struggles with mental distress is a psycho-spiritual-existential question recognizable as a human right to address. Psychiatrist Patte Randal has acknowledged reclaiming her own life after experiencing overwhelming mental distress and “‘out of the ordinary’ experiences” diagnosed as serious mental illness (Randal et al., 2008, p. 333). Randal and colleagues wrote about coming to terms with human experience based upon their own diverse backgrounds, including traditional Western spiritual perspectives, Maori tribal healing practices, and South African shamanic traditions. They advocated for increasing awareness of “the importance of power relationships in determining who is

allowed to provide an explanation” for experiences conventionally diagnosed as mental illness, which they described as “inherently contestable”—citing “Shotter’s (1981) notion of ‘authoring,’ as the ‘moral right’ of individuals to ‘decide what’ [their own] experience means to [them]” (Randal et al., 2008, pp. 333–335).

At the 2018 World Hearing Voices Congress, Special Rapporteur Pūras acknowledged hearing voices as a human right. In the 2017 UN report, Pūras addressed the universal rights of those experiencing mental distress:

Diversity must be broadly understood, recognizing the diversity of human experience and the variety of ways in which people process and experience life. Respecting that diversity is crucial to ending discrimination. Peer-led movements and self-help groups, which help to normalize human experiences that are considered unconventional, contribute towards more tolerant, peaceful and just societies. (p. 12)

In 2015, the UFCWC began offering forms of support, developed within these movements, which may be engaged as alternatives or compliments to conventional supports. Collaborating with pioneering student peers, four UFCWC faculty members have formally facilitated peer support groups while openly identifying their own varied experiences of overwhelming mental distress. Building this program, as a bridge between worlds, each of these UFCWC peer support group facilitators have borne an intensified mental load as they have worked to embody genuine integrity to two often conflicting cultures and identities. They have done this without wearing a disguise, as John Fyer did in 1972, and without formal protections from discrimination and human rights violations, including the potential for state-sanctioned, non-consensual psychiatric interventions. (UFCWC administrators and other colleagues, including available case managers, have shouldered their own mental loads, supporting these programs.)

Alicia King and colleagues (2020) have summarized barriers to inclusion, safety, and actualization of the potential for “improving service users’ experience of care” which professionals with “lived experience” (p. 1047) have reported facing. Robert Whitaker (2010) also documented marginalization and exclusion suffered by mental health professionals who challenged conventional approaches without identifying any relevant lived experience. Elsewhere, the author (Probert, 2018a, c) has described his own experiences facing a number of these challenges. This included a decision, in 2006, to risk disclosing his own lived experience while advocating with UF Student Health Care Center psychiatric providers for more open dialogue about harm reduction approaches to medication use.

It is not the author’s role to breach the autonomy of other current or former service users to narrate their own

life stories. Yet, the other faculty members who have facilitated peer support groups at the UFCWC have also risked both advocating for more trauma-informed and rights-based approaches and working openly from personal lived experiences consistent with the sphere of lived experience shared by students within each type of group. Before beginning to facilitate or co-facilitate any peer support group, each faculty member has also completed the formal training required by the corresponding peer-run organizations (Intentional Peer Support, n.d.; Copeland Center for Wellness and Recovery, n.d.; Hearing Voices Network, U.S.A., n.d.).

To the greatest extent possible these faculty members have participated as peers in these groups, dialoguing from their own lives—including what they still struggle with and are working to learn as humans—and acknowledging that what has helped them may or may not help others. All three forms of peer support offered by the UFCWC, and described below, share a premise. Peers worldwide have experienced what happens when they create relatively safe spaces to dialogue about whatever they are experiencing, in the context of their own lives. If they can do this, without being disqualified as human beings and while respecting each other's choices and worldviews, they have found they often move toward living in more creative, meaningful, engaged, and productive ways.

Intentional Peer Support

Intentional Peer Support (IPS) group dialogues are informed by four *tasks*: connection, worldview, mutuality, and moving toward (Mead, 2014). The importance of *connection*, and dialoguing about experiences of disconnection, are emphasized. Individual participants retain authorship of their own *worldviews*, while exploring how they each have come to understand as they do and considering alternative possibilities. Attention is paid to *mutuality*—working to engage each other in mutually supportive and fulfilling ways that may translate more naturally into other life relationships than conventional clinical roles. Rather than avoiding or decreasing unwanted experiences, IPS focuses on *moving toward* desired goals, which may include finding more engaged, intentional ways of coming to terms with challenging experiences. (Given concerns they might not reach the fidelity of in-person groups, online IPS groups meeting during the pandemic have been named “Moving Toward Intentional Peer Support.”) Participants in IPS groups often describe realizing increased personal agency for coming to term with their own experiences of distress and marginalization, within their own chosen worldviews; for rebuilding goals and dreams, as needed; and for learning to communicate with others within more open, sustainable relationships that can include dialogues about both intense mental distress

and other life experiences—and without others responding reflexively to *fix* them. This is not written to minimize pain or ongoing exclusion still experienced by any group members, but to acknowledge many have continued to participate in these groups for multiple semesters or years, reporting to new members how that participation has supported them to continue moving forward in their lives.

IPS provides general values for UFCWC peer support groups. Participants frequently talk about suicide danger, and other taboo issues or potential dangers, in ways consistent with IPS training and the process described above. This is also consistent with shared efforts to cultivate a group value of members supporting each other to *live through* (Stage, 2020; Stage et al, 2014) any such danger and to work, whenever possible, toward more genuine healing. Facilitators acknowledge, in advance, in what have been uncommon circumstances, if they continue to perceive expressions of immediate danger after engaging extensively in peer support, they will move into clinical roles. Then, engagement will be guided by the approach, documented above (Probert, 2014a, b), supporting a radical reduction of non-consensual responses. Consistent with IPS training, facilitators and other participants engage in dialogue about the unavoidable impact of this power differential on mutuality (Probert, 2018a). This includes engaging in dialogue before students ever join a group, sometimes over multiple meetings. Then, a facilitator and student talk about their own lived experience, identities, and roles; power differentials; the coercion service users frequently experience through involuntary interventions; and whether or not they can co-create a more authentic practice of “shared risk” (Mead, n.d., p. 1) to engage with fidelity in the peer support process. Through this entire process, student peers become co-creators of a healing community, as well as in human-rights advocacy.

The UFCWC has also offered students semester-long IPS Core Trainings which cultivate deepened peer-value based communication and relationship skills and support consciousness-raising with a social justice emphasis. Students who have participated in these trainings have facilitated peer support in the off-campus community and/or moved into more involved informal co-facilitating roles within the UFCWC peer support groups. Before offering these trainings to students, several UFCWC faculty peer-support facilitators have been formally recognized by IPS administrators as *organizational trainers*—after applying for and completing a second round of required training.

Beyond all the trainings, the UFCWC peer support program has emerged through active immersion and personal identity-building within service-user movements—by the author and other facilitators, all individuals with lived experience. Engaging in ongoing dialogues and relationship-building with leaders and other participants in the wider service-user movements has been crucial—providing both

ongoing supports and challenges related to the integrity of these programs. The importance of this aspect of program development cannot likely be emphasized enough or reduced to any definitive formula, although Brown and Jones (2021) have described key elements of this process. With four or five peer support groups offered per typical semester, there is no assumption these supports yet adequately address the needs of a large UF student population. Decisions have been made to advance these programs only as fast as organic growth allows voices and practices which have emerged through participation in service user movements to remain authentic. Through all these efforts, UFCWC peer support facilitators have worked with determination to limit real dangers of contributing to the co-optation of peer support values and practices into conventional mental health values and practices (Davidow, 2013a, b; Penney, 2018), an occurrence which effectively eliminates alternatives identified as human rights by the UN (Pūras, 2017 & 2019).

Wellness Recovery Action Plan

Wellness Recovery Action Plan (WRAP) supports individuals to recognize what is already strong within themselves within a structured, self-directed group process (Copeland, 1997/2018). Building a WRAP includes creating a personalized daily plan for practicing wellness tools. It includes making a plan for getting through the worst possible crises each participant faces. It also includes working to recognize personal patterns of increasing distress, sooner, and then brainstorming which wellness tools each participant might try practicing then, with reasonable hope of learning, over time, to move through these patterns differently. For some, wellness tools may include conventional mental health resources, yet participants freely choose what to include in their own WRAP.

Experiential Peer Support and the Hearing Voices Network

Since 2017, the UFCWC has also offered Experiential Peer Support—a group incorporating Hearing Voices Network (HVN) facilitator training—and supporting individuals coming to terms with the full range of experiences acknowledged as human rights under the umbrella of the hearing voices movement (Probert, 2018a, b). These include “voices, visions, plurality, presences, premonitions, and other extreme, ‘unusual,’ poetic, spiritual or otherwise alternative beliefs, perspectives, or experiences” (Probert, n.d., para. 2). The Experiential Peer Support group is facilitated with awareness of evidence such experiences are far more common than openly acknowledged (British Psychological

Society Division of Clinical Psychology, 2000; Moss, 1990), and that whether individuals suffer having their capacity to cope overwhelmed is often impacted by a history of trauma/adversity (Corstens & Longden, 2013), and whether individuals respond to the experiences, themselves, as distressing and not “normal” (British Psychological Society Division of Clinical Psychology, 2000, pp. 13).

In general, hearing voices groups support participants to work toward making sense of whatever they experience within their own worldview. As Jaqui Dillon and Gail Hornstein (2013, p. 289) have written:

HVN sees voice-hearing as significant, decipherable and intimately connected to a person’s life story. Despite the well-established link between hearing voices and traumatic life experiences, HVN explicitly accepts all explanations for hearing voices, and encourages people to explore their own beliefs, be they spiritual, religious, paranormal, technological, cultural, counter-cultural, philosophical, medical, and so on.

From this perspective, recovery may be reframed as a process of decolonization and reclamation (Probert, 2018c; Dillon, 2013; Dillon & May, 2002). This may involve participants reading about or learning directly from others who have come to terms with similar experiences through perspectives that resonate with them personally. Through this process, if needed, participants may also learn to stand up to experiences that interfere with living, disparage them, or push them toward destructive acts (Intervoice, 2011; Probert, 2014e, 2015b).

Because attendance and very general, non-identifying group notes are recorded, Experiential Peer Support is not a charter Hearing Voices Network USA (2019) group. These limitations are addressed on the UFCWC website (Probert, n.d.) and in conversations with potential participants, before they join the group. Steps have also been taken to address the potential devastating impact of these limitations. For example, UFCWC therapists made a collective decision to stop routinely diagnosing students served as clients (Probert, 2018a).

Disability, Adversity, and Diversity

While individual practices vary, UFCWC clinical services are gradually being transformed by the impact of peer support groups and rights-based training seminars, which may best be understood within a larger context of inclusion and advocacy efforts necessary to improve supports for individuals with often intersecting marginalized social identities (Harris, 2019; Matai, 2020; UFCWC, 2021a, b; Probert & Nash, 2015). The seminars offer a framework, *Disability,*

Adversity, and Diversity, highlighting essential rights of individuals experiencing mental distress (Probert, 2018a). Seminar participants generally understand that overwhelming mental distress—widely understood as mental illness—can be disabling and that choosing to engage essential disability rights or conventional mental health resources may support individuals to maintain or reclaim valued social roles.

However, these UFCWC seminars also invite dialogue about social justice implications of defining mental distress narrowly as individual psychopathology (e.g., Coleman et al., 2016; Gara et al., 2019; Swanson, et al., 2009). The significance of this concern could become more widely recognizable while the economic and psychological impacts of the COVID-19 pandemic multiply and while support for addressing the devastating intergenerational impacts of anti-Black racism and other experiences of systemic oppression deepens. As written in an open letter from the American Psychological Association’s Society for Humanistic Psychology, “A true paradigm shift would start with recognition of the overwhelming empirical evidence that the experiences we call mental illness are understandable and essentially ‘normal’ human responses, and that psychosocial and structural factors such as inequity, abuse, poverty, housing insecurity, unemployment and trauma are the most robustly evidenced social determinants” (Kinderman, et al, 2020, para. 8). These factors include experiences of adversity disproportionately impacting vulnerable individuals, including members of historically marginalized social groups.

Accordingly, the seminars emphasize offering distressed individuals support for coming to terms with whatever external/communal or internal/private experiences have overwhelmed their capacity to cope—whether or not they also find more conventional mental health supports or perspectives helpful. UFCWC clinicians have opportunities to question why they would limit the potential value of their engagement with students by pressuring them to understand their own mental distress strictly within professional worldviews. Clinicians may understand why the seminar presenter describes his own diagnosis and treatment while experiencing extreme states, however well-intended, as involving another form of conversion therapy (Probert, 2014a, paras. 16–20):

I experienced falling into the grip of that exclusively medical approach to my life, and all the power behind it, as a profound violation of my innermost self. This experience stripped me of my remaining capacity to author my own life in even the most basic ways.
 . . . I have heard researchers and even clinicians disparage those who try to understand and negotiate ‘mental illness’ in terms of religion, spirituality, or other traditional and nonscientific terms. Yet I did eventu-

ally reclaim my human right to make sense of my own ‘inner experience’—which is not in any event subject to verifiable empirical measurement. This included reclaiming my right to understand my experience from many very different perspectives.

For instance, I can now view and experience my emotions as emotions again—drawing on my experiences of heart-to-heart connection with so many individuals experiencing a full range of painful and joyous life events. I can look at the impact of traumatic experience—continuing to heal the deepest roots of old traumas as well as the impact of working as a therapist with so many traumatized people. I have also reclaimed my right to look at my spiritual experience—and my whole life—from a spiritual perspective.

A commitment to honoring each individual’s freely chosen and developing worldview is consistent with a broader philosophy informing UFCWC services. Students retain access to conventional approaches for addressing mental distress, including psychiatry. At the same time, increasingly, therapists acknowledge students deserve the same fluidity for establishing social identities which include what Special Rapporteur Pūras called “the diversity of human experience and the variety of ways in which people process and experience life” (Pūras, 2017, p. 12; see also Kadic, 2017) as they do for other historically marginalized social identities.

Given allocated resources and the size of the student body, the UFCWC’s overall mission is focused on providing predominantly short-term services. Efforts are made to offset this real limitation through trauma-informed case management services; a range of therapy groups and clinical trainings aimed to address social justice goals (e.g., UFCWC, n.d., 2021a, b); the rights-based programs outlined in this article; and efforts to serve at least a meaningful number of students who may benefit fundamentally from longer-term or intermittent, trauma-informed, rights-based clinical services—and who lack resources to engage adequate community-based clinical services.

Conclusion

These UFCWC training and peer support programs offer one example of a campus mental health agency beginning to acknowledge and honor human rights identified by service users and the UN. Efforts have been made to vet and document each step of establishing these programs, within service-user movement and professional circles, as cited throughout the article. The goal of this effort has not been to create a proprietary, manualized practice, but to advocate for rights-based system change, while detailing localized

(Sastny, et al., 2020) programs implementing these principles in a mainstream setting. (As the heart of these programs were pre-pandemic creations; reworking, rebuilding, and even continuing to offer them all remain ongoing challenges.)

In the wake of current health, economic, and social justice crises, as experiences of trauma and loss multiply, mental health professionals have a crucial opportunity to recognize the human experience and rights of those suffering mental distress. Professionals might collectively acknowledge responsibilities to move toward implementing more rights-based clinical approaches—with “increased service-user leadership and influence” to promote authentic “engagement with a plurality of critical perspectives” (Brown & Jones, 2021, para. 2)—and to support cultivation of more trauma-informed communities (Stevens, 2014)—through both addressing the “cultural, political, and economic conditions that produce distress and disability” (Cosgrove et al., 2020, p. 5) and restoring communal capacities for supporting those coming to terms with overwhelming life experiences.

Declarations

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References

- Aftab, A., Joshi, Y., & Sewell, D. (2020). Conceptualizations of mental disorder at a US Academic Medical Center. *The Journal of Nervous and Mental Disease*, 208(11), 848–856. <https://doi.org/10.1097/NMD.0000000000001227>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>
- Anton, L. L., Braga, M., Cormier, A., & Pandygraft, J. (n.d.) Insane. Invisible. In danger. Florida cut \$100 million from its mental hospitals. Chaos quickly followed. *Tampa Bay Times and Sarasota Herald-Tribune*. Retrieved October 25, 2020 from <http://projects.heraldtribune.com/florida-mental-health-hospitals/>
- Binder, R. (2015, October 3). Responsible gun laws are a public health necessity. *American Psychiatric Association Blog*. <http://psychiatry.org/news-room/apa-blogs/apa-blog/2015/10/responsible-gun-laws-are-a-public-health-necessity>
- British Psychological Society. (2011, June). *Response to the American Psychiatric Association: DSM-5 development*.
- British Psychological Society Division of Clinical Psychology. (2000, June). *Recent advances in understanding mental illness and psychotic experiences*.
- British Psychological Society Division of Clinical Psychology. (2015, March.) *Guidelines on language in relation to functional psychiatric diagnoses*.
- Brophy, L., Roper, C., & Grant, K. (2019). Risk factors for involuntary psychiatric hospitalization. *Lancet Psychiatry*, 6(12), 974–975. [https://doi.org/10.1016/S2215-0366\(19\)30442-0](https://doi.org/10.1016/S2215-0366(19)30442-0)
- Brown, J., & Jones, N. (2021). Service user participation within the mental health system: Deepening engagement. *Psychiatric Services in Advance*. <https://doi.org/10.1176/appi.ps.202000494>
- Chamberlin, J. (1990). The ex-patients’ movement: Where we’ve been and where we’re going. *Journal of Mind and Behavior*, 11(3), 323–336
- Chamberlin, J. (1998). Confessions of a non-compliant patient. *Journal of Psychosocial Nursing*, 36(4), 49–52
- Coleman, K. J., Stewart, C., Waitzfelder, B. E., Zeber, J. E., Morales, L. S., Ahmed, A. T., Ahmedani, B. K., Beck, A., Copeland, L. A., Cummings, J. R., Hunkeler, E. M., Lindberg, N. M., Lynch, F., Lu, C. Y., Owen-Smith, A. A., Trinacty, C. M., Whitebird, R. R., & Simon, G. E. (2016). Racial-ethnic differences in psychiatric diagnoses and treatment across 11 health care systems in the mental health research network. *Psychiatric Services*, 67(7), 749–757. <https://doi.org/10.1176/appi.ps.201500217>
- Copeland, M. E. (2018). *Wellness recovery action plan, updated edition* (Advocates for Human Potential, Ed.). Human Potential Press. (Original work published 1997)
- Copeland Center for Wellness and Recovery. (n.d.). *Program implementation*. <https://copelandcenter.com/our-services-facilitator-training/wrap-trainings-and-workshops>
- Corstens, D., & Longden, E. (2013). The origins of voices: Links between life history and voice hearing in a survey of 100 cases. *Psychosis*, 5(3), 270–285. <https://doi.org/10.1080/17522439.2013.816337>
- Cosgrove, L., Morrill, Z., Karter, J. M., Valdes, E., & Cheng, C.-P. (2020). The cultural politics of mental illness: Toward a rights-based approach to global mental health. *Community Mental Health Journal*. <https://doi.org/10.1007/s10597-020-00720-6>
- Crawford, M. J. (2004). Suicide following discharge from in-patient psychiatric care. *Advances in Psychiatric Treatment*, 10(6), 434–438. <https://doi.org/10.1192/apt.10.6.434>
- Davidow, S. (2013a, July 4). *Cheers for peers*. Mad in America: Science, Psychiatry and Social Justice. <https://www.madinamerica.com/2013/07/cheers-for-peers/>
- Davidow, S. (2013b, August 31). *In ‘peer’ we trust*. Mad in America: Science, Psychiatry and Social Justice. <https://www.madinamerica.com/2013/08/peer-trust/>
- Davidson, L. (2013, February 6). *Recovery to practice special feature: One response to one reaction to the Newtown tragedy*.
- Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16(4), 459–470. <https://doi.org/10.1080/09638230701482394>
- DeSisto, M., Harding, C. M., McCormick, R. V., Ashikaga, T., & Brooks, G. W. (1995). The Maine and Vermont three-decade studies of serious mental illness: II. Longitudinal course comparisons. *British Journal of Psychiatry*, 167(3), 338–342. <https://doi.org/10.1192/bjp.167.3.338>
- Dillon, J. (2013). Just saying it as it is: Names matter; language matters; truth matters. *Clinical Psychology Forum*, 243, 15–19
- Dillon, J., & Hornstein, G. (2013). Hearing voices peer support groups: A powerful alternative for people in distress. *Psychosis*, 5(3), 286–295. <https://doi.org/10.1080/17522439.2013.843020>

- Dillon, J., & May, R. (2002). Reclaiming experience. *Clinical Psychology, 17*, 25–28
- Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences study. *JAMA, 286*(24), 3089–3096. <https://doi.org/10.1001/jama.286.24.3089>
- Dundas, D. (May 4, 2013). *I am a witness... fifty years later*. Mad in America: Science, Psychiatry and Social Justice. <http://www.madinamerica.com/2013/05/i-am-a-witness-50-years-later/>
- Gara, M. A., Minsky, S., Silverstein, S. M., Miskimen, T., & Strakowski, S. M. (2019). A naturalistic study of racial disparities in diagnoses at an outpatient behavioral health clinic. *Psychiatric Services, 70*(2), 130–134. <https://doi.org/10.1176/appi.ps.20180223>
- Garey, J. (Aug. 10, 2013). *When Doctors Discriminate*. New York Times. <https://www.nytimes.com/2013/08/11/opinion/sunday/when-doctors-discriminate.html>
- Glass, I., Spiegel, A., & Spiegel, J. P. (2002, January 18). *81 Words: The story of how the American Psychiatric Association decided in 1973 that homosexuality was no longer a mental illness*. [Radio Broadcast Transcript]. This American Life. <https://www.thisamericanlife.org/204/81-words>
- Guy, A., Davies, J., & Rizq, R. (eds). (2019, December). *Guidance for psychological therapists: Enabling conversations with clients taking or withdrawing from prescribed psychiatric drugs*. All-Party Parliamentary Group for Prescribed Drug Dependence. <https://www.bacp.co.uk/events-and-resources/ethics-and-standards/pdd-guidance/>
- Hall, W. (2012, June). *Harm reduction guide to coming off psychiatric drugs* (2nd ed.). The Icarus Project and Freedom Center. <https://willhall.net/comingoffmeds/>
- Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S., & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness, II: Long-term outcome of subjects who retrospectively met DSM–3 criteria for schizophrenia. *American Journal of Psychiatry, 144*(6), 727–735. <https://doi.org/10.1176/ajp.144.6.727>
- Harris, L. (2019, November 20). *On human rights and surviving race: A conversation with Celia Brown*. Mad in America: Science, Psychiatry and Social Justice. <https://www.madinamerica.com/2019/11/on-human-rights-and-surviving-race-a-conversation-with-celia-brown/>
- Harris, L. (2020, May 12). The “anosognosia” label is psychiatric gaslighting masquerading as science. *Rooted in Rights*. <https://rootedinrights.org/the-anosognosia-label-is-psychiatric-gaslighting-masquerading-as-science/>
- Harrow, M., & Jobe, T. (2013). Does long-term treatment of schizophrenia with antipsychotic medications facilitate recovery? *Schizophrenia Bulletin, 39*(5), 962–965. <https://doi.org/10.1093/schbul/sbt034>
- Hearing Voices Network USA. (n.d.). *HVN-USA trainings*. <http://www.hearingvoicesusa.org/hvn-usa-trainings>
- Hearing Voices Network USA. (2019, July). *HVN-USA Charter*. <http://www.hearingvoicesusa.org/hvn-usa-charter>
- Horowitz, M. A., & Taylor, D. (2019). Tapering of SSRI treatment to mitigate withdrawal symptoms. *Lancet Psychiatry, 6*(6), 538–546. [https://doi.org/10.1016/S2215-0366\(19\)30032-X](https://doi.org/10.1016/S2215-0366(19)30032-X)
- Hyman, S. E. (2013, April 2). Psychiatric drug development: Diagnosing a crisis. *Cerebrum: Dana Foundation*. <https://www.dana.org/article/psychiatric-drug-development-diagnosing-a-crisis/>
- Insel, T. (2013, April 29). Transforming diagnosis. *Posts by Former NIMH Director Thomas Insel*. <https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2013/transforming-diagnosis.shtml>
- Insel T., & Lieberman J. (2013, May 13). DSM-5 and RDoC: Shared interests. *NIMH Archive*. <https://www.nimh.nih.gov/archive/news/2013/dsm-5-and-rdoc-shared-interests.shtml>
- Intentional Peer Support. (n.d.). *Trainings*. <https://www.intentionalpeer-support.org/trainings/?v=7516fd43adaa>
- Intervoice: The International Hearing Voices Network. (2011, May 13). *What is “hearing voices”?* <https://www.intervoiceonline.org/2234/voices/what-is-hearing-voices/what-is-hearing-voices.html>
- Jones, N., Gius, B.K., Shields, M., Collings, S., Rosen, C., & Munson, M. (2021, March 9). Investigating the impact of involuntary psychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care. *Social Psychiatry and Psychiatric Epidemiology*. <https://doi.org/10.1007/s00127-021-02048-2>
- Jordan, J. T., & McNiel, D. E. (2019). Perceived coercion during admission into psychiatric hospitalization increases risk of suicide attempts after discharge. *Suicide and Life-Threatening Behavior, 50*(1), 180–188. <https://doi.org/10.1111/sltb.12560>
- Kadic, K. (2017, September 27). Fluidity of self: A way to connect by Ksenija Kadic. *Knowledge Quarter*. <https://www.knowledgequarter.london/fluidity-of-self-a-way-to-connect-by-ksenija-kadic/>
- Karter, J. M., & Kamens, S. R. (2019). Toward conceptual competence in psychiatric diagnosis: An ecological model for critiques of the DSM. In Steingard, S. (Ed.), *Critical Psychiatry: Controversies and Clinical Implications*. Springer. ISBN 978-3-030-02732-2
- Keating, F. (2016). Racialized communities, producing madness and dangerousness. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice, 5*(3), 173–185
- Kelly, E. F., Kelly, E. W., Crabtree, A., Gauld, A., Grosso, M., & Greyson, B. (2007). *Irreducible mind: Toward a psychology for the 21st century*. Rowman & Littlefield.
- Kinderman, P., Kamens, S., Robbins, B. D., Farley, F., & Karter, J. M. (2020, February 12). *Regarding the reform and revision of diagnostic systems: An open letter from Div. 32 (Society for Humanistic Psychology)*. Society for Humanistic Psychology. <https://www.apadivisions.org/division-32/leadership/task-forces/diagnostic-alternatives>
- King, A. J., Brophy, L. M., Fortune, T. L., & Byrne, L. (2020). Factors affecting mental health professionals’ sharing of their lived experience in the workplace: A scoping review. *Psychiatric Services in Advance*. <https://doi.org/10.1176/appi.ps.201900606>
- King, M. L. (1963). *Strength to love*. Harper Row.
- Matai, C. (2020, September 18). *Creating an anti-racism framework in the psychiatric survivor movement*. [Online training webinar]. MindFreedom International. <https://mindfreedom.org/front-page/creating-anti-racism-framework-psychiatric-survivors-chacku-mathai/>
- McCance-Katz, E.F. (2018, April 16). *Changing focus: The right to treatment of serious mental illness*. [Keynote presentation]. Saks Institute for Mental Health Law, Policy, and Ethics, Spring Symposium 2018. Los Angeles, CA, USA. https://www.samhsa.gov/sites/default/files/the_right_to_treatment.pdf
- Mead, S. (n.d.). *Shared risk: Redefining safety*. Intentional Peer Support. <https://docs.google.com/document/d/1NjOczrcgNqobiW4CCPqWNAgk-knnL9Jz6HBIWqQRHA/edit>
- Mead, S. (2014). *Intentional Peer Support: An alternative approach*. Intentional Peer Support.
- Mead, S., & Copeland, M. E. (2000). What recovery means to us: Consumers’ perspectives. *Community Mental Health Journal, 36*(3), 315–328. <https://doi.org/10.1023/A:1001917516869>
- Mosher, L. R. (1999). Soteria and other alternatives to acute psychiatric hospitalization: A personal and professional review. *Journal of Nervous and Mental Disease, 187*(3), 142–149. <https://doi.org/10.1097/00005053-199903000-00003>
- Moss, D. M. (1990). “On the margins”: a dialogue with Andrew Greeley. *Journal of Religion and Health, 29*, 261–283. <https://doi.org/10.1007/BF00992982>

- Nash, S., Sixbey, M., & Probert, J. (2015, March 5–8). *Peer support and mental health recovery on college campuses*. [Workshop presentation]. American College Personnel Association Conference, Tampa, FL, USA
- National Alliance on Mental Illness. (n.d.). *Anosognosia*. <https://www.nami.org/About-Mental-Illness/Common-with-Mental-Illness/Anosognosia>
- National Coalition for Mental Health Recovery. (2011). *Guidelines for promoting recovery through choice and alternatives*. <https://power2u.org/ncmhr-guidelines-for-promoting-recovery-through-choice-and-alternatives/>
- Ostrow, L., Jessell, L., Hurd, M., Darrow, S. M., & Cohen, D. (2017). Discontinuing psychiatric medications: A survey of long-term users. *Psychiatric Services*, 68(12), 1232–1238. <https://doi.org/10.1176/appi.ps.201700070>
- Penney, D. (2018, February 10). *Who gets to define “peer support?” Mad in America: Science, Psychiatry and Social Justice*. <https://www.madinamerica.com/2018/02/who-gets-to-define-peer-support/>
- Penney, D., & Stastny, P. (2008). *The lives they left behind: Suitcases from a state hospital attic*. Bellevue Literary Press.
- Probert, J. (n.d.). *About Experiential Peer Support*. University of Florida Counseling and Wellness Center. <https://counseling.ufl.edu/services/groups/experiential/>
- Probert, J. (2006). Further discussion for the need to develop more comprehensive guidelines for lethality assessment. In *American Association of Suicidology Organization Accreditation Standards Manual* (8th ed., pp.45–47). Washington, DC, USA.
- Probert, J. (2007, April 12–14). *Suicide lethality assessment in a college setting* [Workshop presentation]. American Association of Suicidology Conference, New Orleans, LA, USA
- Probert, J. (2011). *Further discussion for the need to develop more comprehensive guidelines for lethality assessment, revised, 2011*. American Association of Suicidology Crisis Centers Best Practice. Certified AAS members at <http://www.suicidology.org/certification-programs/crisis-centers/>
- Probert, J. (2012, August 1). *Recovery-based principles and practices: An introduction to mental health recovery*. [Invited presentation]. Minority Fellowship Program Professional Development Workshop, American Psychological Association National Convention, Orlando, FL, USA
- Probert, J. (2014a, February 27). Part 1. Toward a more trauma- and recovery-informed practice of lethality assessment and suicide prevention. *SAMHSA Recovery to Practice Highlights*, 5(4). Author’s ResearchGate page.
- Probert, J. (2014b, February 27). Part 2. Further discussion for the need to develop more comprehensive guidelines for lethality assessment, revised, 2011. *SAMHSA Recovery to Practice Highlights*, 5(4). Author’s ResearchGate page.
- Probert, J. (2014c, March 31). *What I might call my soul. What happens now? Life after suicidal thinking. A project for the American Association of Suicidology*. <https://attemptsurvivors.com/legacy/2014/03/31/what-i-might-call-my-soul/#more-1104>
- Probert, J. (2014d, July 25). *Mental health recovery: Hope in a time of fear*. [Invited presentation]. 12th annual Psychology Summer Institute, American Psychological Association’s Minority Fellowship Program, Washington, DC, USA
- Probert, J. (2014e, October 22–26). *Mental health recovery and emotional fitness: Practicing compassion for ourselves*. [Workshop presentation]. Alternatives Conference, Orlando, FL, USA. Author’s ResearchGate page.
- Probert, J. (2015a, April 15–17). *Toward a more trauma-informed and recovery-oriented practice of lethality assessment and suicide prevention* [Workshop presentation]. American Association of Suicidology Conference, Atlanta, GA, USA
- Probert, J. (2015b, October 14–18). *The “two-story” approach to trauma recovery for wellness recovery action plan® (WRAP) users . . . and anyone else!* [Workshop presentation]. Alternatives Conference, Memphis, TN, USA. Author’s ResearchGate page
- Probert, J. (2015c, December 13). *Guest column: Legislation threatens civil rights of “mentally ill.”* The Gainesville Sun.
- Probert, J. (2018a, May 30 & June 14). *Building bridges: Introducing recovery supports and peer values on a university campus*. [Invited presentation]. Virtual roundtable on collegiate recovery supports for underrepresented student populations, substance abuse and mental health services administration bringing recovery supports to scale technical assistance center strategy. Author’s ResearchGate page.
- Probert, J. (2018b, September 12–15). *For individuals living under the umbrella of the hearing voices movement: A vision of human rights on college campuses and beyond* [Symposium presentation]. World Hearing Voices Congress, The Hague, Netherlands.
- Probert, J. (2018c, November 9–11). *A human rights approach to supporting individuals experiencing extreme states on a college campus* [Workshop presentation]. International Society for Psychological and Social Approaches to Psychosis, USA Chapter, Annual Meeting, Philadelphia, PA, USA. Author’s ResearchGate page
- Probert, J. (2019b, August 7). *The recovery journey: Reclaiming our lives, voices, and human rights* [Invited presentation]. Minority Fellowship Program Professional Development Workshop, American Psychological Association National Convention, Chicago, IL, USA
- Probert, J. (2020, August 28). *Mental health recovery: Reclaiming our voices & human rights* [Training seminar]. University of Florida Counseling and Wellness Center, Gainesville, FL, USA. [Multimedia presentation and references available on author’s ResearchGate page].
- Probert, J., & Nash, S. (2015, November 12). *Mental health recovery and peer support at UF: A social justice perspective* [Poster session]. University of Florida Social Justice Summit, Gainesville, FL, USA.
- Probert, J., & Nash, S. (2018, January 29). *A human rights approach to mental health. Centered: Mental Health News, Resources, and Information from the Counseling and Wellness Center*. <https://counseling.ufl.edu/rights-based-approach/>
- Pulitzer Prizes. (n.d.). *The 2016 Pulitzer Prize winner in investigating reporting: Leonora LaPeter Anton and Anthony Cormier of the Tampa Bay Times and Michael Braga of the Sarasota Herald-Tribune*. Retrieved October 25, 2020 from <https://www.pulitzer.org/winners/leonora-lapeter-anton-and-anthony-cormier-tampa-bay-times-and-michael-braga-sarasota-herald>
- Pūras D. (2017, June). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (Report A/HRC/35/21). United Nations General Assembly. Human Rights Council. <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/076/04/PDF/G1707604.pdf?OpenElement>
- Pūras, D. (2018, September 12–15). *Closure of the ceremony* [Conference presentation]. World Hearing Voices Congress, The Hague, Netherlands.
- Pūras, D. (2019, October 10). *Open Statement by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Removing obstacles to liveable lives: A rights-based approach to suicide prevention*. United Nations Human Rights Office of the High Commissioner. <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25117&LangID=E>
- Randal, P., Geekie, J., Lambrecht, I., & Taitimu, M. (2008). *Dissociation, psychosis and spirituality: Whose voices are we hearing?* In A. Moskowitz, I. Schäfer, & M. J. Dorahy (Eds.), *Psychosis*,

- trauma and dissociation: Emerging perspectives on severe psychopathology* (pp.333–345). Wiley-Blackwell.
- Read, J., & Arnold, C. (2017). Is electroconvulsive therapy for depression more effective than placebo? A systematic review of studies since 2009. *Ethical Human Psychology and Psychiatry: An International Journal of Critical Inquiry*, 19(1), 5–23. <https://doi.org/10.1891/1559-4343.19.1.5>
- Read, J., & Bentall, R. (2010). The Effectiveness of electroconvulsive therapy: A literature review. *Epidemiology and Psychiatric Science*, 19(4), 333–347. <https://doi.org/10.1017/s1121189x00000671>
- Read, J., van Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, 112(5), 330–350. <https://doi.org/10.1111/j.1600-0447.2005.00634.x>
- Romme, M., Escher, S., Dillon, J., Corstens, D., & Morris, M. (Eds.). (2013). *Living with voices: 50 Stories of Recovery*. PCCS Books.
- Rosenhan, D. L. (1973). On being sane in insane places. *Science*, 179(4070), 250–258. <https://doi.org/10.1126/science.179.4070.250>
- Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J., & Lehtinen, K. (2006). Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*, 16(2), 214–228. <https://doi.org/10.1080/1050330050268490>
- Shapiro, J. (2010, January 19). *Advocate for people with mental illnesses dies*. [Radio Broadcast Transcript]. National Public Radio. <http://www.npr.org/templates/story/story.php?storyId=122706192>
- Shotter, J. (1981). Vico: Moral worlds, accountability and personhood. In P. Hellas and A. Lock (Eds.), *Indigenous Psychologies: The Anthropology of the Self* (pp.266–284). Academic Press.
- Siegel, B. S. (1989). *Peace, love and healing: Bodymind communication & the path to self-healing: An exploration*. Harper Row.
- Stage, D. L. (2020, April 23–24). Live through this: A decade making art for social change & fighting to legitimize lived expertise in suicidology [Thought leader presentation]. American Association of Suicidology Virtual Conference.
- Stage, D., Lezine, D., Probert, J., & Harris, L. (2014, October 14–18). *The S word: The new movement of people who have been suicidal*. [Workshop presentation.] Alternatives Conference, Orlando, FL, USA
- Stastny, P., Lovell, A., Hannah, J., Goulart, D., Vasquez, A., O’Callaghan, S., & Pūras, D. (2020). Crisis response as a human rights flashpoint: Critical elements of community support for individuals experiencing significant emotional distress. *Health and Human Rights Journal*, 22(1), 105–119
- Stevens, J. E. (2014, September 17). Tarpon Springs, FL, first trauma-informed city, embraces messy path toward peace. *ACES Too High*. <https://acestoohigh.com/2014/09/17/tarponssprings/>
- Swanson, J., Swartz, M., Van Dorn, R. A., Monahan, J., McGuire, T. G., Steadman, H. J., & Robbins, P. C. (2009). Racial disparities in involuntary outpatient commitment: Are they real? *Health Affairs*, 28(3), 816–826. <https://doi.org/10.1377/hlthaff.28.3.816>
- Trac, O., Colson, A., McNeil, V., Sostre, J., & Mosley, D. V. (2020, April 2). Trauma narratives of people of color: A qualitative analysis of involuntary hospitalizations [Poster session]. University of Florida Virtual Spring Undergraduate Research Symposium. <https://cur.aa.ufl.edu/2020/04/14/trac-ollie-and-colson-alex/>
- Treatment Advocacy Center. (n.d.). *Anosognosia*. <https://www.treatmentadvocacycenter.org/key-issues/anosognosia>
- United Nations. (2017, June 6). *World needs ‘revolution’ in mental health care—UN rights expert* [Press release]. <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21689&LangID=E>
- University of Florida Counseling and Wellness Center. (n.d.). *Group Counseling*. <https://counseling.ufl.edu/services/groups/>
- University of Florida Counseling and Wellness Center. (2021a, February 5). *Spring 2021 LGBTQ+ events and workshops*. <https://counseling.ufl.edu/lgbtq-s21/>
- University of Florida Counseling and Wellness Center. (2021b, February 16). *Healing and transforming racial trauma in the counseling field*. <https://counseling.ufl.edu/healing-rt/>
- Whitaker, R. (2010). *Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. Crown.
- Whitaker, R., & Simonson, M. (2019, July 14). *Twenty years after Kendra’s Law: The case against AOT*. Mad in America: Science, Psychiatry and Social Justice. <https://www.madinamerica.com/2019/07/twenty-years-kendras-law-case-aot/>
- World Health Organization. (n.d.). *Mental health, human rights & legislation: A global human rights emergency in mental health*. https://www.who.int/mental_health/policy/legislation/en/
- World Health Organization. (2011). *ICD 10: International statistical classification of diseases and related health problems* (10th ed.). <https://icd.who.int/browse10/2016/en>

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