FACTSHEET

The right to mental health

Fostering a revolution in mental health care and policy

Summary. The Special Rapporteur on the right to health, Dainius Puras, presented his report to the Human Rights Council in June 2017 on the right of everyone to the enjoyment of the highest attainable standard of mental health (A/HRC/35/21). This report highlights the urgent need to confront the global burden of obstacles responsible for the grotesquely unmet need of rights-based mental health systems the world over. As mental health emerges from the shadows as a global health priority, it is vital that the right to health form a central component of the rapidly changing legal and policy landscape. While the right to health remains invaluable to scrutinise existing approaches to mental health, it can also be a tool to support the necessary transformation in public policy to enable the evolution of rights-based mental health care, support and promotion.

Rights-based mental health care, support, and promotion in communities around the world remain underfunded or absent, while exclusion, the excessive use of force and biomedical interventions often dominate existing care systems, research priorities, and medical education. This report aims to provide a comprehensive overview of the global state of mental health through the lens of the right to health. Importantly, it dedicates space to reframing mental health as a cross-cutting public policy issue and argues that there exists a human rights imperative to bring the social and psycho-social determinants of health to the forefront of mental health policy.

Inclusive participation is critical for rights-based change in mental health

A human rights framework for mental health must be guided by the recognition that a range of social actors are vital informants of public policy and clinical care.

Clinical level: respecting and engaging with individuals as rights-holders builds trust and the foundation for positive health and well-being.

Population level: policy related to mental health has relied almost exclusively on the insights of the psychiatric profession. While psychiatry plays and will continue to play a vital role in mental health policy, the dominance of that role inhibits the development of mental health policy as a robust, cross-sectoral issue. Acknowledging this bias and taking action to ensure the inclusion of social workers, psychologists, educators, and, crucially, individuals and communities most marginalized by existing mental health policies is necessary to secure the right to mental health for everyone.

Global Burden of Obstacles

While an effective tool to bring mental health out of the shadows, the current "burden of disease" approach firmly roots the global mental health crisis within a biomedical model, too narrow to be proactive and respond to addressing mental health issues locally, nationally, and globally. To address the unmet need for rights-based mental health for all and in all policies, an assessment of the "global burden of obstacles" that has maintained the status quo in mental health is necessary. This report identifies three mutually reinforcing obstacles:

1. The excessive use of the biomedical model: The biomedical model locates mental health as a biological phenomenon, and provides a framework for both explaining and developing responses to poor mental health. The dominance of this model means mental health has become excessively medicalised - beds, hospitals, specialised care, medications, etc. This stifles the scale up of innovative, evidence-based psychological and psycho-social interventions at the primary care level and the "scaling across" of mental health in public policy.

2. Power asymmetries: Decision making power in mental health remains concentrated in the hands of biomedical gatekeepers, in particular, biological psychiatry and the pharmaceutical industry. At the clinical level, this disempowers individuals in need of care. At the population level, it firmly roots mental health policy within a narrow, biomedical framework.

3. The biased use of evidence: Powerful biomedical gatekeepers rely upon the use of evidence to legitimise their role, influence, and their decisions around patient care, policy, and governance in mental health. This bias leads to the harmful dominance of biomedical interventions and policy arrangements.

An open invitation for constructive dialogue with the psychiatric profession

"The active involvement of the psychiatric profession and its leaders in the shift towards rights-compliant mental health policies and services is a crucial element for success in positive global mental health changes."
(para 24)

Parity of Esteem?

Where is the money and what does it fund?

0 Countries where mental health receives the same investment as physical health

.34 percent: International health aid assistance spending on mental health

<2 Less than $2/person spent on mental health in low income countries

7 percent: Average percentage of health budgets dedicated to mental health

>60 Percent of funding for mental health that is spent on inpatient treatment and hospital stays in high/middle income countries.

The evolving normative framework for mental health

Like all aspects of health, a range of biological, social, environmental and psychological factors affect mental health. It is from this understanding that duty bearers can more accurately understand their corresponding obligations to respect, protect and fulfil the right to mental health for all. Most of the current discussions around mental health and human rights have focused on informed consent in the context of psychiatric treatment. While that discourse is deeply meaningful, it has emerged as a result of systemic failures to protect the right to mental health and to provide non-coercive treatment alternatives.

The right to mental health framework

Obligations States have an obligation to respect, protect, and fulfil the right to mental health. States have an obligation to dedicate maximum available resources to mental health. Yet globally, mental health spending stands at or under 10% of spending on health.

International cooperation and assistance Higher income States have a particular duty to provide assistance to support mental health in lower income countries. This duty contains an immediate obligation to refrain from providing support towards mental health systems that are discriminatory and where human rights violations occur. Rights-based development cooperation should support a balance of health promotion programmes and psycho-social services that provide care integrated in the community. International cooperation and assistance also includes technical support from international organisations including the WHO and World Bank. This report commends the work of such institutions for elevating mental health on the international development agenda.

Participation The effective realization of the right to health requires the participation of everyone, particularly those living in poverty and in vulnerable situations, in decision-making at the legal, policy, community and health service level. Participation in mental health services is complicated by power asymmetries within mental health systems. It is important to facilitate the empowerment of individuals through the support of self-advocacy initiatives, peer support networks, trialogues and other user-led advocacy initiatives, as well as new working methods, such as co-production, which ensure representative and meaningful participation in health-service development and provision. In that regard, creating space for civil society and supporting their activities is crucial to restoring trust between care providers and rights holders using services.

Non-discrimination International human rights law guarantees the right to non-discrimination in the access to and delivery of mental health-care services and the underlying determinants of mental health. Discrimination and inequality are both a cause and a consequence of poor mental health, with long-term implications for morbidity, mortality and societal well-being. Discrimination, harmful stereotypes (including gender) and stigma in the community, family, schools and workplace disable healthy relationships, social connections and the supportive and inclusive environments that are required for the good mental health and well-being of everyone. Likewise, discriminatory attitudes influencing policies, laws and practices constitute barriers for those requiring emotional and social support and/or treatment. Consequently, individuals and groups in vulnerable situations who are discriminated against by law and/or in practice are denied their right to mental health.

"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. "

Accountability depends on three elements: 1. monitoring; 2. independent and non-independent review; and 3. remedies and redress. At the international level, the State party reporting process established under the Convention on the Rights of Persons with Disabilities provides an important new avenue for accountability for the right to mental health of persons with psychosocial, cognitive and intellectual disabilities. By contrast, at the national level, accountability mechanisms for the right to mental health are often not fit for purpose. Of particular concern is the growing prevalence of mental health tribunals, which instead of providing a mechanism for accountability, legitimize coercion and further isolate people within mental health systems from access to justice. Persons with lived experience, their families and civil society should be engaged in the development and implementation of monitoring and accountability arrangements.

Informed Consent & Coercion Informed consent is a core element of the right to health, both as a freedom and an integral safeguard to its enjoyment. The right to provide consent to treatment and hospitalization includes the right to refuse treatment. The proliferation of mental health legislation and lack of community alternatives means medical coercion is commonplace. Justification for using coercion is generally based on the subjective principles of **"medical necessity"** and **"dangerousness"** and their application is open to broad interpretation, raising questions of arbitrariness. The reality in many countries is that alternatives do not exist and reliance on the use of coercion is the result of a systemic failure to protect the rights of individuals.

To ensure rights-based change immediate measures are necessary and the Special Rapporteur has identified five deliberate, targeted, and concrete actions:

1. Mainstream alternatives to coercion in policy with a view to legal reform
2. Develop a well-stocked basket of non-coercive alternatives in practice
3. Develop a road map to radically reduce coercive medical practices, with a view to their elimination, with the participation of diverse stakeholders, including rights holders
4. Establish an exchange of good practices between and within countries
5. Scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals

Shifting the paradigm

The human rights imperative to address mental health promotion

Individual and social factors, cultural values and the social experiences of everyday life in families, schools, the workplace and communities influence the mental health of each person. Likewise, a person's mental health affects life within these domains and is integral to shaping the health of communities and populations. Therefore, population-based approaches to mental health promotion can move health systems beyond individualized responses towards action on a range of structural barriers and inequalities (social determinants) that negatively affect mental health.

The obligation to secure social determinants to promote mental health requires cross-sectoral public policy action.

"There exists an almost universal commitment to pay for hospitals, beds and medications instead of building a society in which everyone can thrive. Regrettably, prevention and promotion are forgotten components of mental health action. Harmful assumptions that goodwill and sacrifice alone will enable populations to achieve mental health and well-being have excused this inaction."

Individualised, biomedical responses:

Population-based, cross-sectoral action:

States should first and foremost address emotional and psychosocial environments, targeting relationships rather than individuals

Case study: The paradox of mental health promotion in early childhood

Research has shown the damaging mental health and social impact of adversities and trauma experienced throughout childhood. Toxic stress, abusive family and intimate relationships, the placement of young children in institutional care, bullying, sexual, physical and emotional child abuse and parental loss negatively affect brain development and the ability to form healthy relationships, all affecting the ability of children to fully realize their right to health.

There are many examples of innovative early childhood interventions with convincing research on their effectiveness in promoting mental health and preventing poor mental health. Regrettably, those good practices often serve as pilot projects, owing to a lack of political will to replicate and mainstream. Underfunded early childhood interventions mean low-quality psychiatric services abound, leading to over-medicalization, violence and other forms of violations of children's rights. These must be abandoned and transformed into programmes that respond to childhood adversity and recognize children as rights holders, respect their evolving capacities and empower them and their families to improve their mental health and well-being.

From isolation to community: Mental health treatment and support

The right to health is a powerful guide for States towards a paradigm shift that is recovery and community-based, promotes social inclusion and offers a range of rights-based treatments and psychosocial support at primary and specialized care levels.

Reductive biomedical approaches to treatment that do not adequately address contexts and relationships can no longer be considered compliant with the right to health. A biomedical component will remain important, but its dominance has become counterproductive, disempowering rights holders and reinforcing stigma and exclusion. In many parts of the world, community care is not available, accessible, acceptable and/or of sufficient quality (often limited to psychotropic medications).

Key actions are required to transform mental healthcare services into rights-based systems of care and support:

Mainstream mental health services: Mental health care must be brought closer to primary care and general medicine, integrating mental with physical health, professionally, politically and geographically.

Scale up essential psycho-social interventions: Despite the right to health obligation to provide psychosocial interventions and support, they are sadly viewed as luxuries, rather than essential treatments, lacking sustainable investment. These are essential and low-cost interventions, which produce positive health outcomes and safeguard individuals from potentially harmful, more invasive medicalization.

Invest in rights-based models to mental distress and recovery: While a paradigm shift in mental health requires a move towards integrated services, mental distress will still occur and rights-based treatment responses are required. The legacy of coercive interventions used to address serious cases are perhaps the biggest indictment of the biomedical tradition. Peer support, can be an integral part of recovery-based services, including through peer support networks, recovery colleges, club houses and peer-led crisis houses. Open Dialogue, a successful mental health system, has entirely replaced emergency, medicalized treatment in Lapland. Other models include mental health crisis units, respite houses, community development models for social inclusion, personal ombudsmen, empowerment psychiatry and family support conferencing. Soteria House is a long-standing model, recreated in many countries.

Key messages and recommendations

Mental health is far too often neglected. When it does receive resources, it becomes dominated by ineffective and harmful models, attitudes and imbalances. People of all ages, when they have mental health needs, too often suffer from either an absence of care and support or from services that are ineffective and harmful.

There are already promising initiatives in place throughout the world, including in low- and middle-income countries, which challenge the status quo. Creating the space, through strong political leadership and resources, to enable those practices to take shape in communities is a powerful means to promote and advance the changes needed.

Today, there are unique opportunities for mental health. The international recognition of mental health as a global health imperative, including within the 2030 Sustainable Development Agenda, is welcome progress. The right to health framework offers guidance to States on how rights-based policies and investments must be directed to secure dignity and well-being for all. Effective psychosocial interventions in the community should be scaled up and the culture of coercion, isolation and excessive medicalization abandoned

Biomedical imbalances:

- Establish inclusive participatory frameworks in the design and development of mental health-related public policy
- Recalibrate mental health research priorities to promote independent, qualitative and participatory social science research platforms, including around alternative non-coercive service models

Social and underlying determinants of mental health:

- Prioritize mental health promotion and prevention in public policy, scaling investments across the relevant ministries
- Take immediate action to address mental health and holistic development in early childhood and adolescence, prioritizing promotion and psychosocial interventions in public policy
- Take immediate action to address harmful gender stereotypes, gender-based violence and access to sexual and reproductive health
- Take immediate steps to eliminate the corporal punishment of children and their institutionalization, including children with disabilities

International cooperation and assistance:

- End all financial support for segregated residential mental health institutions, large psychiatric hospitals and other segregated facilities and services and redirect funding to community-based support services.
- Mainstream the right to mental health into health, poverty-reduction and development strategies and interventions

Healthcare services:

- Invest in psychosocial services, that are integrated into primary care and community services to empower users and respect their autonomy
- Stop directing investment to institutional care and redirect it to community-based services
- Scale up investment in alternative mental health services and support models
- Develop a basic package of appropriate, acceptable (including culturally) and high-quality psychosocial interventions as a core component of universal health coverage
- Take targeted, concrete measures to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement

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