THE GRANT FAMILY CHARITABLE TRUST (GFCT)
RESPONSE TO PRODUCTIVITY COMMISSION REVIEW INTO MENTAL HEALTH
MARCH 2019

WHO ARE WE

GFCT ('the Trust') was established in 2009 and funded by John Grant AM, a venture capitalist, as a registered philanthropic organisation.

One of the two key areas of support for the Trust is improved care in **mental health** and allied areas in Australia. The Trust believes **mental health** is a significant health issue for an increasing number of Australians and encompasses a wide range of disorders – including depression, anxiety, stress, eating disorders, schizophrenia and bipolar disorder. The Trust sees mental health impacting all segments of the Australian population and their endeavours. It is linked with many social conditions, including juvenile misconduct, domestic violence, substance abuse, social isolation and homelessness. Long term mental health poses very significant cost and outcome challenges to the very good health care system that Australians currently access and benefit from.

The Trust believes that mental health in Australia is poorly understood; poorly resourced; and not driven by the necessary commitment to innovation to bring about significantly enhanced, sustainable outcomes.

The Trust, through its Board and advisers, aims to contribute to better mental health outcomes for all Australians, with a particular focus on the young and the disadvantaged in our communities.

The Trust does this in three ways:

1. We support efforts to make mental health better **understood**; through active advocacy for improvement via decision makers and people of influence;

2. We work to build deeper mental health **capabilities** of health sector workers through supporting education, training and recognition of that training; and

3. We support **innovation** in mental health service delivery through encouraging linkages, collaboration, research and trialling of new approaches.

Our interest ***in innovation*** in mental health focusses on the following four areas:

- Models of care that operate with lower costs through adoption of **technology, multi skilled team development and active inclusion of families and peer workers;**
- Models of care that produce **better long term recovery and life expectancy** outcomes; through consumer centric dialogue and care, led by appropriately skilled professionals;

- Models of care that support **young people** experiencing mental illness; while drawing on and supporting families in treatment teams; and
- Models of care that **link** mental health services with other relevant parts of the health system and to other systems ordinarily outside the health and disability systems.

SUGGESTED LINES OF INVESTIGATION BY THE COMMISSIONER

We in particular make the following comments to the Commissioner about the Inquiry:

- We welcome and strongly support the Commissioner's focus on determinants of mental health, and emphasis on social participation as a key part of the Inquiry. We believe that there is an alternative to biomedical treatment, particularly for mild to moderate mental health issues that will deliver sustained, more cost-effective outcomes. This will require a much more holistic view of communities, at a local level, and targeting of solutions specific to each communities' needs. We believe the greatest impact that could be had through this endeavour is to genuinely shift the focus to prevention and be much more radical about primary prevention at a community level.

- We note the report to the UN General Assembly of March 2017 (The Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health – appendix 1), which highlights the dominance in mental health frameworks of the biomedical model, and the power asymmetries that ensue. We also note the shortage of evidence of the effectiveness of community based mental health service models and the biased use of evidence in mental health that drives mental health policies and funding arrangements.

- There are some real examples of where community based models have been very successful that we encourage the Commissioner to investigate further:
    - Open Dialogue
      Open dialogue is a need-adapted approach that mobilizes psychosocial resources in a crisis-struck person's social network. Evidence is still emerging, but a recent study showed a significant reduction in emergency psychiatric treatment and a significantly reduced risk of unemployment over a 10-year time period.[1]

    - BC Foundry, Canada
      The Foundry model in Canada provides stepped and integrated care for young people across primary care, mental health, youth & family peer support, substance use services and social services, with a particular emphasis on active monitoring of 'at risk' populations and providing low intensity services, focussed on wellness and prevention. The model is underpinned by a suite of online tools. A series of evaluations are underway,

[1] Buus, N et al. (2018) *The association between Open Dialogue to young Danes in acute psychiatric crisis and their use of health care and social services: A retrospective register-based cohort study*, International Journal of Nursing Studies

but early results are positive. In a survey of 718 youths who had been through one of the centres, 95% would recommend the facility to their friends.

- Trieste, Italy
  The Trieste model developed from a focus on deinstitutionalisation of the San Giovanni Mental Hospital, a former home for 1,200 inpatients. To phase it out, a complete alternative network of community services was set up, including community mental health centres for each population of 50,000, supported housing run by a series of NGOs, commissioned through a single government service and one small inpatient unit for emergency stays (of usually less than 24 hours). The services are complemented by a network of 15 social cooperatives who promote a range of other NGO services. The outcomes are profound – there are no homeless clients; no people from Trieste are in forensic hospitals; and the suicide rate has halved.[2]

- The opportunities for innovation in mental health service delivery, particularly in lower cost community based mental health, are considerable (See The Economist article and leaders from March 14, 2019) but they are hampered by the lack of evidence, and limited capabilities and accountabilities within the system to deliver new models. We offer to work with the Commissioner to identify where we see emerging evidence in community based health care and where we think more work on generating evidence can be directed. We also think there is considerable opportunity to review further overseas experience in this area.

- We believe there are a number of ways in which the national building blocks can be improved:
  - **Funding:** We encourage the Commissioner to review and analyse the funding models of mental health service delivery in Australia, particularly the use of all forms of public funds, and to investigate where and how biases have developed in (a) the respective funding and support for mental health workforce training; (b) the poor current organisational structures for community mental health improvement; and (c) the insufficient linkages between the mental health services and other health and well-being service delivery; and (d) the use of MBS item numbers.

  - **Accountabilities:** We recommend a review of the current accountabilities for mental health outcomes, , to identify where incentives could be created and accountabilities strengthened to encourage more meaningful collaboration between PHNs and State Government (healthcare and beyond), and with consumers and the community. There are lessons to be learned from UK approaches here, including the Better Care Fund (primarily aimed at discharging patients from hospital)[3] and the implementation of the Health

[2] Mezzina, R. (2014) *Community Mental Health in Trieste and Beyond*, accessed at: http://www.wales.nhs.uk/sitesplus/documents/862/TMHCommunityMentalHealthCareInTrieste.pdf
[3] Evaluation here: https://www.pssru.ac.uk/pub/5424.pdf

and Social Care Act 2012.[4] This tells us two things: 1) That providing incentives to enable better integration of services can work; and 2) that top-down reorganisation is extremely risky and can slow progress and lead to worse outcomes for the population. The Commissioner should consider models of pooled funding for mental health outcomes across Federal and State government agencies, through current organisational forms. We also encourage the Commissioner to review the Report of the PHN Advisory Panel on Mental Health of September 2018.

- **Data:** We observe the lack of transparency and consistency in the collection of mental health data, which makes it challenging for mental health consumers, service providers, commissioners and advocates to learn from best practice. We encourage the Commissioner to explore opportunities for greater transparency in the availability of services and progress against the outcomes set out within the 5th National Mental Health Plan. This should include: collation of the data collected through the PHN Mental Health Atlases into a useable form that is maintained online and can be accessed by anyone; and National reporting of progress against the outcomes of the 5th National Mental Health Plan through the AIHW.

- **Workforce (formal):** It is well recognized (AIHW data) that there is a severe shortage of mental health nurses and a shortage of psychiatrists in Australia, with particular challenges in rural & remote areas. This appears to be exacerbated by a failure to adopt true multi-disciplinary and integrated working across many providers and systems. We do not believe that sufficient action is being taken to address these issues in both the short and long term. In the short term, Australia should explore: how to enable and support nurses, allied health professionals and GPs to work at the upper end of their scope of practice; how to expand the scope of practice for the workforce through nurse practitioner or other extended roles; and how to scale and roll-out existing good practice in use of technology to support care in rural & remote regional areas, such as the Older Person's Mental Health SOS program in place at St Vincent's Darlinghurst. Financial incentives, such as sign-on bonuses, should also be considered to address the immediate gap. In the longer term we need to identify ways to make working in mental health an attractive and sustainable option across all areas of clinical practice.

- **Workforce (informal):** We welcome the recognition of the importance of the role of the informal workforce within the Issues Paper, and would encourage further exploration and dialogue of opportunities to extend and support this workforce and mobilise communities to care for one another.

[4] Kings Fund Analysis here: https://www.kingsfund.org.uk/topics/health-social-care-act-2012

- **Research:** We encourage the Commissioner to consider the role of research in driving improved mental health outcomes and, in particular, how this should influence the Mental Health Research Strategy (due 2021) and Million Minds MRFF program.

- We also encourage the Commissioner to review ways in which the **Headspace** model and funding framework could be improved. The Headspace model has delivered significant benefits for Australia, however, the model now needs to evolve from the traditional biomedical approach where the service acts as the intermediary between young person and their family, to a more flexible and need-adapted approach where the service actively engages in dialogue with the young person and their family together, and does more to actively get the young person and their family reconnected. This is critical, given the time-bound nature of professional input. This, along with greater community ownership, is a key difference of the Foundry BC model described earlier. We also suggest to ensure operational efficiency and stability, that funding arrangements need to be longer than 12 months and there should be consideration of a greater emphasis on blended funding between government, community and philanthropic efforts to enable both greater flexibility in the services provided, and longevity and community ownership.

United Nations A/HRC/35/21

General Assembly

Distr.: General
28 March 2017

Original: English

Human Rights Council
Thirty-fifth session
6-23 June 2017
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the secretariat

Pursuant to Human Rights Council resolution 24/6, the secretariat has the honour to transmit to the Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In an attempt to contribute to the discussion around mental health as a global health priority, the Special Rapporteur focuses on the right of everyone to mental health and some of the core challenges and opportunities, urging that the promotion of mental health be addressed for all ages in all settings. He calls for a shift in the paradigm, based on the recurrence of human rights violations in mental health settings, all too often affecting persons with intellectual, cognitive and psychosocial disabilities.

The Special Rapporteur makes a number of recommendations for States and all stakeholders to move towards mental health systems that are based on and compliant with human rights.

GE.17-04875(E)
1704875

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Contents

I. Introduction

1. Mental health and emotional well-being are priority areas of focus for the Special Rapporteur (see A/HRC/29/33). In each thematic report, he has attempted to bring mental health into focus as a human rights and development priority in the context of early childhood development (see A/70/213), adolescence (see A/HRC/32/32) and the Sustainable Development Goals (see A/71/304).

2. In the present report, the Special Rapporteur expands on this issue and provides a basic introduction to some of the core challenges and opportunities for advancing the realization of the right to mental health of everyone. In the light of the scope and complexity of the issue and of the evolving human rights framework and evidence base, in his report the Special Rapporteur seeks to make a contribution to the important discussions under way as mental health emerges from the shadows as a global health priority.

3. The present report is the result of extensive consultations among a wide range of stakeholders, including representatives of the disability community, users and former users of mental health services, civil society representatives, mental health practitioners, including representatives of the psychiatric community and the World Health Organization (WHO), academic experts, members of United Nations human rights mechanisms and representatives of Member States.

A note on terminology[1]

4. Everyone, throughout their lifetime, requires an environment that supports their mental health and well-being; in that connection, we are all potential users of mental health services. Many will experience occasional and short-lived psychosocial difficulties or distress that require additional support. Some have cognitive, intellectual and psychosocial disabilities, or are persons with autism who, regardless of self-identification or diagnosis, face barriers in the exercise of their rights on the basis of a real or perceived impairment and are therefore disproportionately exposed to human rights violations in mental health settings. Many may have a diagnosis related to mental health or identify with the term, while others may choose to identify themselves in other ways, including as survivors.

5. The present report distinguishes between users of services and persons with disabilities, based on the barriers faced by the latter, considering in an inclusive manner that everyone is a rights holder.

II. Context

6. Despite clear evidence that there can be no health without mental health, nowhere in the world does mental health enjoy parity with physical health in national policies and budgets or in medical education and practice. Globally, it is estimated that less than 7 per cent of health budgets is allocated to address mental health. In lower-income countries, less than $2 per person is spent annually on it.[2] Most investment is focused on long-term institutional care and psychiatric hospitals, resulting in a near total policy failure to promote mental health holistically for all.[3] The arbitrary division of physical and mental health and the subsequent isolation and abandonment of mental health has contributed to an untenable situation of unmet needs and human rights violations (see A/HRC/34/32, paras. 11-21), including of the right to the highest attainable standard of mental and physical health.[4]

[1] See WHO, "Advocacy actions to promote human rights in mental health and related areas" (2017).

[2] WHO, Mental Health Atlas 2014, p. 9, and PLOS medicine editors, "The paradox of mental health: over-treatment and under-recognition", *PLOS Medicine*, vol. 10, No. 5 (May 2013).

[3] WHO, Mental Health Atlas 2014, p. 9.

[4] See also Human Rights Watch, "Living in hell: abuses against people with psychosocial disabilities in Indonesia" (March 2016).

7. Forgotten issues beget forgotten people. The history of psychiatry and mental health care is marked by egregious rights violations, such as lobotomy, performed in the name of medicine. Since the Second World War and the adoption of the Universal Declaration of Human Rights, together with other international conventions, increasing attention has been paid to human rights in global mental health and psychiatry. However, whether the global community has actually learned from the painful past remains an open question.

8. For decades, mental health services have been governed by a reductionist biomedical paradigm that has contributed to the exclusion, neglect, coercion and abuse of people with intellectual, cognitive and psychosocial disabilities, persons with autism and those who deviate from prevailing cultural, social and political norms. Notably, the political abuse of psychiatry remains an issue of serious concern. While mental health services are starved of resources, any scaled-up investment must be shaped by the experiences of the past to ensure that history does not repeat itself.

9. The modern understanding of mental health is shaped by paradigm shifts often marked by a combination of improvements and failures in evidence-based and ethical care. This began 200 years ago with the desire to unchain the "mad" in prison dungeons and moved to the introduction of psychotherapies, shock treatments, and psychotropic medications in the 20th century. The pendulum of how individual pathology is explained has swung between the extremes of a "brainless mind" and a "mindless brain". Recently, through the disability framework, the limitations of focusing on individual pathology alone have been acknowledged, locating disability and well-being in the broader terrain of personal, social, political, and economic lives.

10. Finding an equilibrium between the aforesaid extremes of the twentieth century has created a momentum for deinstitutionalization and the identification of a balanced, biopsychosocial model of care. Those efforts were reinforced by WHO in a report in 2001, in which it called for a modern public health framework and the liberation of mental health and those using mental health services from isolation, stigma and discrimination.[5] A growing research base has produced evidence indicating that the status quo, preoccupied with biomedical interventions, including psychotropic medications and non-consensual measures, is no longer defensible in the context of improving mental health. Most important have been the organized efforts of civil society, particularly movements led by users and former users of mental health services and organizations of persons with disabilities, in calling attention to the failures of traditional mental health services to meet their needs and secure their rights. They have challenged the drivers of human rights violations, developed alternative treatments and recrafted a new narrative for mental health.

11. The momentum sustained by civil society towards a paradigm shift has contributed to an evolving human rights framework in the area of mental health. The adoption of the Convention on the Rights of Persons with Disabilities in 2006 laid the foundation for that paradigm shift, with the aim of leaving behind the legacy of human rights violations in mental health services. The right to the highest attainable standard of health has much to contribute to advancing that shift and provides a framework for the full realization of the right of everyone to mental health.

12. One decade later, progress is slow. Effective, acceptable and scalable treatment alternatives remain on the periphery of health-care systems, deinstitutionalization has stalled, mental health investment continues to be predominantly focused on a biomedical model and mental health legislative reform has proliferated, undermining legal capacity and equal protection under the law for people with cognitive, intellectual and psychosocial disabilities. In some countries, the abandonment of asylums has created an insidious pipeline to homelessness, hospital and prison. When international assistance is available, it often supports the renovation of large residential institutions and psychiatric hospitals, undermining progress.

13. Public policies continue to neglect the importance of the preconditions of poor mental health, such as violence, disempowerment, social exclusion and isolation and the

[5] See WHO, *World Health Report 2001. Mental Health: New Understanding, New Hope*.

breakdown of communities, systemic socioeconomic disadvantage and harmful conditions at work and in schools. Approaches to mental health that ignore the social, economic and cultural environment are not just failing people with disabilities, they are failing to promote the mental health of many others at different stages of their lives.

14. With the adoption of the 2030 Agenda for Sustainable Development and recent efforts by influential global actors such as WHO, the Movement for Global Mental Health and the World Bank, mental health is emerging at the international level as a human development imperative. The 2030 Agenda and most of its sustainable development goals implicate mental health: Goal 3 seeks to ensure healthy lives and promote well-being at all ages and target 3.4 includes the promotion of mental health and well-being in reducing mortality from non-communicable diseases. How national efforts harness the momentum of the 2030 Agenda to address mental health has important implications for the effective realization of the right to health.

15. The current momentum and opportunity to advance are unique. It is from this juncture in history, within a confluence of international processes, that the Special Rapporteur seeks to make a contribution with the present report.

III. Global burden of obstacles

16. An effective tool used to elevate global mental health is the use of alarming statistics to indicate the scale and economic burden of "mental disorders". While it is uncontroversial to note that millions of people around the world are grossly underserved, the current "burden of disease" approach firmly roots the global mental health crisis within a biomedical model, too narrow to be proactive and responsive in addressing mental health issues at the national and global level. The focus on treating individual conditions inevitably leads to policy arrangements, systems and services that create narrow, ineffective and potentially harmful outcomes. It paves the way for further medicalization of global mental health, distracting policymakers from addressing the main risk and protective factors affecting mental health for everyone. To address the grossly unmet need for rights-based mental health services for all, an assessment of the "global burden of obstacles" that has maintained the status quo in mental health is required.

17. Three major obstacles which reinforce each other are identified in the following sections.

A. Dominance of the biomedical model

18. The biomedical model regards neurobiological aspects and processes as the explanation for mental conditions and the basis for interventions. It was believed that biomedical explanations, such as "chemical imbalance", would bring mental health closer to physical health and general medicine, gradually eliminating stigma.[6] However, that has not happened and many of the concepts supporting the biomedical model in mental health have failed to be confirmed by further research. Diagnostic tools, such as the International Classification of Diseases and the Diagnostic and Statistical Manual of Mental Disorders, continue to expand the parameters of individual diagnosis, often without a solid scientific basis.[7] Critics warn that the overexpansion of diagnostic categories encroaches upon human experience in a way that could lead to a narrowing acceptance of human diversity.[8]

19. However, the field of mental health continues to be over-medicalized and the reductionist biomedical model, with support from psychiatry and the pharmaceutical

[6] See Derek Bolton and Jonathan Hill, *Mind, Meaning and Mental Disorder: the Nature of Causal Explanation in Psychology and Psychiatry* (Oxford, Oxford University Press, 2004).

[7] See Thomas Insel, "Transforming diagnosis" (April 2013), available from www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml.

[8] See Stefan Priebe, Tom Burns and Tom K.sJ. Craig, "The future of academic psychiatry may be social", *British Journal of Psychiatry*, vol. 202, No. 5 (May 2013).

industry, dominates clinical practice, policy, research agendas, medical education and investment in mental health around the world. The majority of mental health investments in low-, middle- and high-income countries disproportionately fund services based on the biomedical model of psychiatry.[9] There is also a bias towards first-line treatment with psychotropic medications, in spite of accumulating evidence that they are not as effective as previously thought, that they produce harmful side effects and, in the case of antidepressants, specifically for mild and moderate depression, the benefit experienced can be attributed to a placebo effect.[10] Despite those risks, psychotropic medications are increasingly being used in high-, middle- and low-income countries across the world.[11] We have been sold a myth that the best solutions for addressing mental health challenges are medications and other biomedical interventions.

20. The psychosocial model has emerged as an evidence-based response to the biomedical paradigm.[12] It looks beyond (without excluding) biological factors, understanding psychological and social experiences as risk factors contributing to poor mental health and as positive contributors to well-being. That can include short-term and low-cost interventions that can be integrated into regular care. When used appropriately, such interventions can empower the disadvantaged, improve parenting and other competencies, target individuals in their context, improve the quality of relationships and promote self-esteem and dignity. For any mental health system to be compliant with the right to health, the biomedical and psychosocial models and interventions must be appropriately balanced, avoiding the arbitrary assumption that biomedical interventions are more effective.[13]

B. Power asymmetries

21. The promotion and protection of human rights in mental health is reliant upon a redistribution of power in the clinical, research and public policy settings. Decision-making power in mental health is concentrated in the hands of biomedical gatekeepers, in particular biological psychiatry backed by the pharmaceutical industry. That undermines modern principles of holistic care, governance for mental health, innovative and independent interdisciplinary research and the formulation of rights-based priorities in mental health policy. International organizations, specifically WHO and the World Bank, are also influential stakeholders, whose role and relations interplay and overlap with the role of the psychiatric profession and the pharmaceutical industry.

22. At the clinical level, power imbalances reinforce paternalism and even patriarchal approaches, which dominate the relationship between psychiatric professionals and users of mental health services. That asymmetry disempowers users and undermines their right to make decisions about their health, creating an environment where human rights violations can and do occur. Laws allowing the psychiatric profession to treat and confine by force legitimize that power and its misuse. That misuse of power asymmetries thrives, in part, because legal statutes often compel the profession and obligate the State to take coercive action.

23. The professional group in psychiatry is a powerful actor in mental health governance and advocacy. National mental health strategies tend to reflect biomedical agendas and obscure the views and meaningful participation of civil society, users and former users of

[9] See WHO, Mental Health Atlas 2014, p. 32.

[10] See Irving Kirsch, "Antidepressants and the placebo effect", *Zeitschrift für Psychologie*", vol. 222, No. 3 (February 2015) and David Healy, "Did regulators fail over selective serotonin reuptake inhibitors?", *BMJ*, vol. 333 (July 2006).

[11] See Ross White, "The globalisation of mental illness", *The Psychologist*, vol. 26 (March 2013).

[12] See Anne Cooke, ed., *Understanding Psychosis and Schizophrenia*, (Leicester, The British Psychological Society, 2014).

[13] See Nikolas Rose and Joelle M. Abi-Rached, *Neuro: the New Brain Sciences and the Management of the Mind* (Princeton, New Jersey, Princeton University Press, 2013) and Pat Bracken, "Towards a hermeneutic shift in psychiatry", *World Psychiatry*, vol. 13, No. 3 (October 2014).

mental health services and experts from various non-medical disciplines.[14] In that context, the 2005 *WHO Resource Book on Mental Health, Human Rights and Legislation*, developed using human rights guidelines at the time, was highly influential in the development of mental health laws that allowed "exceptions". Those legal "exceptions" normalized coercion in everyday practice, widening the space for human rights violations to occur and it is therefore a welcome development to see the laws being revisited and the *Resource Book* formally withdrawn, as a result of the framework brought about by the Convention on the Rights of Persons with Disabilities.[15]

24. The status quo in current psychiatry, based on power asymmetries, leads to the mistrust of many users and threatens and undermines the reputation of the psychiatric profession. Open and ongoing discussions within the psychiatric profession about its future, including its role in relation to other stakeholders, is critical.[16] The Special Rapporteur welcomes and encourages such discussions within the psychiatric profession and with other stakeholders, and he is convinced that the search for consensus and progress is to the advantage of everyone, including psychiatry. 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.

25. Conventional wisdom based on a reductionist biomedical interpretation of complex mental health-related issues dominates mental health policies and services, even when not supported by research. Persons with psychosocial disabilities continue to be falsely viewed as dangerous, despite clear evidence that they are commonly victims rather than perpetrators of violence.[17] Likewise, their capacity to make decisions is questioned, with many being labelled incompetent and denied the right to make decisions for themselves. That stereotype is now regularly shattered, as people show that they can live independently when empowered through appropriate legal protection and support.

26. Asymmetries have been furthered by the financial power of, and alliances with, the pharmaceutical industry. Where financial resources for research and innovation are absent, the industry fills the gap with little transparency in drug approval processes or in doubtful relationships with health-care professionals and providers. That context illustrates how overreliance in policy on the biomedical model has gone too far and is now so resistant to change.[18]

C. Biased use of evidence in mental health

27. The evidence base in support of mental health interventions has been problematic throughout history. That situation continues, as the evidence base for the efficacy of certain psychotropic medications and other biomedical psychiatric interventions is increasingly challenged from both a scientific and experiential perspective.[19] That these interventions

[14] See the WHO MiNDbank, available from www.mindbank.info/collection/type/mental_health_strategies_and_plans/all.

[15] See www.who.int/mental_health/policy/legislation/en/.

[16] See Heinz Katschnig, "Are psychiatrists an endangered species? Observations on internal and external challenges to the profession", *World Psychiatry*, vol. 9, No. 1 (February 2010).

[17] See Jillian K. Peterson and others, "How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness?", *Law and Human Behavior*, vol. 38, No. 5 (April 2014).

[18] See Ray Moynihan, Jenny Doust and David Henry, "Preventing overdiagnosis: how to stop harming the healthy", *BMJ*, vol. 344 (May 2012).

[19] See Peter Tyrer and Tim Kendall, "The spurious advance of antipsychotic drug therapy", *The Lancet*, vol., No. 9657 (January 2009); Lex Wunderink and others, "Recovery in remitted first-episode psychosis at 7 years of follow-up of an early dose reduction/discontinuation or maintenance treatment strategy", *JAMA Psychiatry*, vol. 70, No. 9 (2013); Joanna Le Noury and others, "Restoring Study 329: efficacy and harms of paroxetine and imipramine in treatment of major depression in adolescence", *BMJ*, vol. 351 (September 2015); and Andrea Cipriani and others, "Comparative efficacy and tolerability of antidepressants for major depressive disorder in children and adolescents: a network meta-analysis", *The Lancet*, vol., 388, No. 10047 (August 2016).

can be effective in managing certain conditions is not disputed, but there are increasing concerns about their overprescription and overuse in cases where they are not needed.[20] There is a long history of pharmaceutical companies not disclosing negative results of drug trials, which has obscured the evidence base for their use. That denies health professionals and users access to the information necessary for making informed decisions.[21]

28. Powerful actors influence the research domain, which shapes policy and the implementation of evidence. Scientific research in mental health and policy continues to suffer from a lack of diversified funding and remains focused on the neurobiological model. In particular, academic psychiatry has outsize influence, informing policymakers on resource allocation and guiding principles for mental health policies and services. Academic psychiatry has mostly confined its research agenda to the biological determinants of mental health. That bias also dominates the teaching in medical schools, restricting the knowledge transfer to the next generation of professionals and depriving them of an understanding of the range of factors that affect mental health and contribute to recovery.

29. Because of biomedical bias, there exists a worrying lag between emerging evidence and how it is used to inform policy development and practice. For decades now, an evidence base informed by experiential and scientific research has been accumulating in support of psychosocial, recovery-oriented services and support and non-coercive alternatives to existing services. Without promotion of and investment in such services and the stakeholders behind them, they will remain peripheral and will not be able to generate the changes they promise to bring.

IV. Evolving normative framework for mental health

30. The Constitution of WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Like all aspects of health, a range of biological, social and psychological factors affect mental health.[22] 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.

31. The evolving normative context around mental health involves the intimate connection between the right to health, with the entitlement to underlying determinants, and the freedom to control one's own health and body. That is also linked to the right to liberty, freedom from non-consensual interference and respect for legal capacity. While informed consent is needed to receive treatment that is compliant with the right to health, legal capacity is needed to provide consent and must be distinguished from mental capacity. The right to health also includes a right to integration and treatment in the community with appropriate support to both live independently and to exercise legal capacity (see, for example, E/CN.4/2005/51, paras. 83-86, and A/64/272, para. 10).[23] The denial of legal capacity frequently leads to deprivation of liberty and forced medical interventions, which raises questions not only about the prohibition of arbitrary detention and cruel, inhuman or degrading treatment, but also the right to health.

32. Prior to the adoption of the Convention on the Rights of Persons with Disabilities, various non-binding instruments guided States in identifying their obligations to protect the rights of persons with disabilities in the context of treatment (see General Assembly resolutions 37/53, 46/119 and 48/96). While some of them recognized important rights and

[20] See Ray Moynihan, "Preventing overdiagnosis: how to stop harming the healthy".

[21] See Irving Kirsch and others, "Initial severity and antidepressant benefits: a meta-analysis of data submitted to the Food and Drug Administration", *PLOS Medicine* (February 2008).

[22] See WHO, Mental Health Action Plan 2013-2020 (2013), p. 7.

[23] See also Committee on the Rights of Persons with Disabilities, general comment No. 1 (2014) on equal recognition before the law, para. 13.

standards, the safeguards they contained were often rendered meaningless in everyday practice (see E/CN.4/2005/51, paras. 88-90, and A/58/181). As the right to health guarantees freedom from discrimination, involuntary treatment and confinement, it must also be understood to guarantee the entitlement to treatment and integration in the community. The failure to secure that entitlement and other freedoms is a primary driver of coercion and confinement.

33. The Committee on the Rights of Persons with Disabilities emphasizes full respect for legal capacity, the absolute prohibition of involuntary detention based on impairment and the elimination of forced treatment (see A/HRC/34/32, paras. 22-33).[24] That responds to the inadequacy of procedural safeguards alone, requiring sharpened attention to non-coercive alternatives and community inclusion to secure the rights of persons with disabilities. Within that evolving framework, not all human rights mechanisms have embraced the absolute ban on involuntary detention and treatment articulated by the Committee. They include the Subcommittee on the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (see CAT/OP/27/2), the Committee Against Torture[25] and the Human Rights Committee.[26] However, their interpretation of exceptions used to justify coercion is narrower, signalling ongoing discussions on the matter. Notably, in the United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court, the Working Group on Arbitrary Detention supported the provisions of the Convention on the Rights of Persons with Disabilities with regard to safeguards on the prohibition of arbitrary detention (see A/HRC/30/37, paras. 103-107).

34. At present, there is an impasse over how obligations in relation to non-consensual treatment are implemented in the light of the provisions of the Convention on the Rights of Persons with Disabilities, given the different interpretation by international human rights mechanisms. The Special Rapporteur has followed these developments and hopes that consensus can be reached to start the shift towards strengthened mental health policies and services without delay. He seeks to participate actively in these processes and potentially report again on the progress achieved.

V. Right to mental health framework

A. Obligations

35. The International Covenant on Economic, Social and Cultural Rights provides a legally binding framework for the right to the highest attainable standard of mental health. That is complemented by legal standards established, among others, by the Convention on the Rights of Persons with Disabilities, the Convention for the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child. States parties have an obligation to respect, protect and fulfil the right to mental health in national laws, regulations, policies, budgetary measures, programmes and other initiatives.

36. The right to mental health includes both immediate obligations and requirements to take deliberate, concrete, targeted action to progressively realize other obligations.[27] States must use appropriate indicators and benchmarks to monitor progress, including in respect of reducing and eliminating medical coercion. Indicators should be disaggregated by, among others, sex, age, race and ethnicity, disability and socioeconomic status. States must devote the maximum available resources to the right to health, yet globally, spending on mental health stands at less than 10 per cent of spending on physical health.

[24] See also Convention on the Rights of Persons with Disabilities, arts. 12 and14, Committee on the Rights of Persons with Disabilities, general comment No. 1 and guidelines on article 14 of the Convention.

[25] See CAT/C/FIN/CO/7, paras. 22-23; CAT/C/FRA/CO/7, paras. 29-30; CAT/C/AZE/CO/4, paras. 26-27; and CAT/C/DNK/CO/6-7, paras. 40-41.

[26] See general comment No. 35 (2014) on liberty and security of person.

[27] International Covenant on Economic, Social and Cultural Rights, art. 2 (1).

37. Some obligations are not subject to progressive realization and must be implemented immediately, including certain freedoms and core obligations. Core obligations include the elaboration of a national public health strategy and non-discriminatory access to services.[28] In terms of the right to mental health, that translates into the development of a national mental health strategy with a road map leading away from coercive treatment and towards equal access to rights-based mental health services, including the equitable distribution of services in the community.

B. International cooperation

38. International treaties recognize the obligation of international cooperation for the right to health, a responsibility reinforced by the commitment to a global partnership for sustainable development in Sustainable Development Goal 17. Higher-income States have a particular duty to provide assistance for the right to health, including mental health, in lower-income countries. There is an immediate obligation to refrain from providing development cooperation supporting mental health-care systems that are discriminatory or where violence, torture and other human rights violations occur. Rights-based development cooperation should support balanced health promotion and psychosocial interventions and other treatment alternatives, delivered in the community to effectively safeguard individuals from discriminatory, arbitrary, excessive, inappropriate and/or ineffective clinical care.

39. In view of that obligation, it is troubling that mental health is still neglected in development cooperation and other international policies on health financing. Between 2007 and 2013, only 1 per cent of international health aid went to mental health.[29] In times of humanitarian crises, in both the relief and recovery stages, international support must include psychosocial support to strengthen resilience in the face of enormous adversity and suffering. Elsewhere, where cooperation has been provided, it has prioritized the improvement of existing psychiatric hospitals and long-term care facilities that are inherently incompatible with human rights.[30]

40. International assistance and cooperation also includes technical support for rights-based mental health policies and practices. The WHO QualityRights initiative is a commendable example of such technical assistance. The Special Rapporteur also welcomes recent support by the World Bank and WHO for moving mental health to the centre of the global development agenda. However, he cautions that such global initiatives must incorporate the full range of human rights. In particular, multilateral agencies should give priority to ensuring the attainment of the right to health of those in the most vulnerable situations, such as persons with disabilities. A global agenda that focuses on anxiety and depression (common mental health conditions) may reflect a failure to include the persons most in need of rights-based changes in mental health services. Such selective agendas can reinforce practices based on the medicalization of human responses and inadequately address structural issues, such as poverty, inequality, gender stereotypes and violence.

41. States have an obligation to protect against harm by third parties, including the private sector, and should work to ensure that private actors support the realization of the right to mental health, while fully understanding their role and duties in that respect.

C. Participation

42. 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. At the population level, empowering everyone to participate meaningfully in decisions about their health and well-being requires

[28] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, paras. 43-45.

[29] Seth Mnookin, “Out of the shadows: making mental health a global development priority”, World Bank Group and WHO (2016), p.13.

[30] Committee on Economic, Social and Cultural Rights, general comment No. 5, para. 15.

multisectoral and inclusive engagement with stakeholders, such as users and former users of mental health services, policymakers, service providers, health workers, social workers, the legal profession, the police, carers, family members and the wider community.

43. Health settings must empower users as rights holders to exercise autonomy and participate meaningfully and actively in all matters concerning them, to make their own choices about their health, including sexual and reproductive health, and their treatment, with appropriate support where needed.

44. Participation in mental health services is a relatively recent phenomenon and is complicated by deeply entrenched power asymmetries within mental health systems.[31] It is important to facilitate the empowerment of individuals, especially those with particular mental health needs, 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 the activities of non-governmental organizations is crucial to restoring trust between care providers and rights holders using services.

D. Non-discrimination

45. 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 health.[32] The right to mental health is also dependent on equality and non-discrimination in the enjoyment of all other human rights that can themselves be considered an underlying determinant.[33]

46. Multiple and intersectional forms of discrimination continue to impede the ability of individuals, including women and persons from racial and ethnic minorities with disabilities, to realize their right to 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.[34] 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.

47. Discrimination, de jure and de facto, continues to influence mental health services, depriving users of a variety of rights, including the rights to refuse treatment, to legal capacity and to privacy, and other civil and political rights. The role of psychiatry and other mental health professions is particularly important and measures are needed to ensure that their professional practices do not perpetuate stigma and discrimination.

48. It is important to recognize the complex role that a diagnosis of mental disorder plays in people's lives. While many people find diagnostic categories beneficial in allowing them to access services and better understand their mental health, others find them unhelpful and stigmatizing. Mental health diagnoses have been misused to pathologize identities and other diversities, including tendencies to medicalize human misery. The

[31] See Judi Chamberlin, "User/consumer involvement in mental health service delivery", *Epidemiology and Psychiatric* Sciences, vol. 14, No. 1 (March 2005).

[32] Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 18; A/61/338, para. 18 and Convention on the Rights of Persons with Disabilities, arts. 25 and 26.

[33] See Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009) on non-discrimination in economic, social and cultural rights.

[34] See Kate Pickett and Richard Wilkinson, *The Spirit Level: Why More Equal Societies Almost Always Do Better*, (London, Penguin Books, 2010).

pathologization of lesbian, gay, bisexual, transgender and intersex persons reduces their identities to diseases, which compounds stigma and discrimination.

49. The problem is not in diagnosing persons but in the discriminatory practices that affect the diagnosed person, which may cause more harm than the diagnosis itself. People frequently suffer more from discriminatory and inappropriate patterns of "care" than from the natural effects of mental health conditions.

50. 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.

E. Accountability

51. Accountability for the enjoyment of the right to mental health depends on three elements: (a) monitoring; (b) independent and non-independent review, such as by judicial, quasi-judicial, political and administrative bodies, as well as by social accountability mechanisms; and (c) remedies and redress. Accountability provides an opportunity for rights holders to understand how duty bearers have discharged their duties and claim redress where rights are violated. It also provides an opportunity for duty bearers to explain their actions and make amendments if required.

52. At the international level, the adoption of the Convention on the Rights of Persons with Disabilities and the relevant State party reporting processes provide 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. Despite commendable efforts by several national prevention mechanisms, human rights violations in mental health services are rife and occur with impunity.[35] Individuals often have limited access to justice, including independent accountability mechanisms. That may arise because they are deemed to lack legal capacity and have limited knowledge of their rights, legal aid cannot be accessed, or simply because oversight of complaints bodies does not exist.

53. The Convention establishes that all mental health services designed for persons with disabilities are to be effectively monitored by independent authorities (art. 16.3). Human rights must be incorporated into the framework of reference for all monitoring and review procedures in the field of mental health. The Special Rapporteur encourages national human rights institutions to pay attention to the right to mental health in their monitoring and promotion activities. Persons with lived experience, their families and civil society should be engaged in the development and implementation of monitoring and accountability arrangements.

F. Beyond mental health services towards care and support

54. The right to mental health requires care and support facilities, goods and services that are available, accessible, acceptable and of good quality. Rights-based care and support for mental health is an integral part of health care for all.

[35] See Association for the Prevention of Torture, "Monitoring psychiatric institutions" Jean-Jacques Gautier NPM symposium outcome report (2016), available from www.apt.ch/content/files_res/report-jjg-symposium-2016-en.pdf.

Availability

55. Adequate mental health services must be made available. In many countries, the limited mental health and social care available is based on a narrow biomedical model and institutionalization. The scaling-up of care must not involve the scaling-up of inappropriate care. For care to comply with the right to health, it must embrace a broad package of integrated and coordinated services for promotion, prevention, treatment, rehabilitation, care and recovery and the rhetoric of "scaling up" must be replaced with mental health actions to "scale across". That includes mental health services integrated into primary and general health care, which support early identification and intervention, with services designed to support a diverse community.[36] Evidence-based psychosocial interventions and trained community health workers to deliver them must be enhanced.[37] Services must support the rights of people with intellectual, cognitive and psychosocial disabilities and with autism to live independently and be included in the community, rather than being segregated in inappropriate care facilities.

56. Many countries are faced with a scarcity of human resources for mental health care and must undertake efforts to develop a workforce, including specialist and non-specialist health professionals, general practitioners and community health workers, as well as other professionals, such as teachers, social workers and other peer support and community workers with appropriate skills (including human rights education).

Accessibility

57. Mental health services must be geographically and financially accessible on the basis of non-discrimination. In many low- and middle-income countries they are concentrated in major cities and inaccessible to a large part of the population. The problem is acute in countries where there is inappropriate overreliance on segregated residential and in-patient psychiatric institutions, such as in Central and Eastern Europe, and a failure to develop rights-based models of care in the community.[38] Integrating mental health into general hospitals, primary care, and social care services and rights-compliant use of mobile technologies can support accessibility and enhance the enjoyment of the right to live and participate in the community. Accurate information on mental health must be made accessible to the public and evidence-based information on treatments, including side effects, must also be accessible, which requires the routine, complete and timely disclosure of all pharmacological information from clinical trials. A contextual understanding of the experiences of suffering and distress is critical for ensuring accessibility within systems of mental health care and support.

Acceptability

58. Mental health services must be respectful of medical ethics and human rights, as well as culturally appropriate, sensitive to gender and life-cycle requirements and designed to respect confidentiality and empower individuals to control their health and well-being.[39] They must respect the principles of medical ethics and human rights (including "first, do no harm"), choice, control, autonomy, will, preference and dignity.[40] Overreliance on pharmacological interventions, coercive approaches and in-patient treatment is inconsistent with the principle of doing no harm, as well as with human rights. Human rights capacity-building should be routinely provided to mental health professionals. Services must be culturally appropriate and acceptable to persons with intellectual, cognitive or psychosocial disabilities and with autism, adolescents, women, older persons, indigenous persons, minorities, refugees and migrants, and lesbian, gay, bisexual, transgender and intersex

[36] Convention on the Rights of Persons with Disabilities, arts. 25-26, and J. Jaime Miranda and others, "Transitioning mental health into primary care", *The Lancet Psychiatry*, vol. 4, No. 2 (February 2017).

[37] WHO, Mental Health Action Plan 2013-2020, p. 9.

[38] Natalie Drew and others, "Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis", *The Lancet*, vol. 378, No. 9803 (November 2011).

[39] Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 12 (c).

[40] Convention on the Rights of Persons with Disabilities, preamble and arts. 12, 15 and 19.

persons. Many within those populations are needlessly medicalized and suffer from coercive practices, based on inappropriate and harmful gender stereotypes.

59. Special attention should be paid to women, who suffer disproportionately from mental health practices that are based on paternalistic and patriarchal traditions, inappropriate and harmful gender stereotypes, medicalization of women's feelings and behaviour, and coercion. Women who have suffered from violence and inequalities within their families, communities and societies, and who have mental health conditions very often face situations in mental health settings that amount to violence, coercion, humiliation and disrespect for their dignity. It is unacceptable that after suffering from violations in family and other settings, women suffer from violations again within services that are supposed to promote their mental health. In that regard, it is very important to emphasize that violations of sexual and reproductive health rights have a direct, negative impact on the mental health of women.

Quality

60. Mental health services must be of good quality. That requires the use of evidence-based practices to support prevention, promotion, treatment and recovery.[41] Effective collaboration between different service providers and people using the services and their families and care partners, also supports enhanced quality of care. The abuse of biomedical interventions, including the inappropriate use or overprescription of psychotropic medications and the use of coercion and forced admissions, compromise the right to quality care. Prioritizing the scaling-up of community-based psychosocial services and mobilizing social resources that can support everyone throughout their life course, will enhance the quality of services.

61. The element of quality compels going beyond the idea of users as mere recipients of care towards their full consideration as active holders of rights. To stop discriminatory practices, States should rethink the way they provide mental health care and support (see A/HRC/34/58).

62. In particular, children and adults with intellectual disabilities and with autism too often suffer from institutionalized approaches and excessively medicalized practices. Institutionalizing and medicating children with autism, based on their impairment, is unacceptable. Autism represents a critical challenge to modern systems of care and support, as medical attempts to "cure" the condition have often turned out to be harmful, leading to further mental health deterioration of children and adults with the condition. Support for them should not only address their right to health, but their rights to education, employment and living in the community on an equal basis with others.

G. Informed consent and coercion

63. Informed consent is a core element of the right to health, both as a freedom and an integral safeguard to its enjoyment (see A/64/272). The right to provide consent to treatment and hospitalization includes the right to refuse treatment (see E/CN.4/2006/120, para. 82). The proliferation of paternalistic mental health legislation and lack of alternatives has made medical coercion commonplace.

64. Justification for using coercion is generally based on "medical necessity" and "dangerousness". These subjective principles are not supported by research and their application is open to broad interpretation, raising questions of arbitrariness that has come under increasing legal scrutiny. "Dangerousness" is often based on inappropriate prejudice, rather than evidence. There also exist compelling arguments that forced treatment, including with psychotropic medications, is not effective, despite its widespread use.[42]

[41] WHO Mental Health Action Plan 2013-2020, p. 9.

[42] See Steve R. Kisely and Leslie A. Campbell, "Compulsory community and involuntary outpatient treatment for people with severe mental disorders", Cochrane database system (December 2014); and

Decisions to use coercion are exclusive to psychiatrists, who work in systems that lack the clinical tools to try non-coercive options. 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.

65. Coercion in psychiatry perpetuates power imbalances in care relationships, causes mistrust, exacerbates stigma and discrimination and has made many turn away, fearful of seeking help within mainstream mental health services. Considering that the right to health is now understood within the framework of the Convention on the Rights of Persons with Disabilities, immediate action is required to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement. In that connection, States must not permit substitute decision-makers to provide consent on behalf of persons with disabilities on decisions that concern their physical or mental integrity; instead, support should be provided at all times for them to make decisions, including in emergency and crisis situations.[43]

66. The Special Rapporteur takes note of the concerns of various stakeholders, particularly within the medical communities, regarding the absolute ban on all forms of non-consensual measures.[44] He acknowledges that their radical reduction and eventual elimination is a challenging process that will take time. However, there is shared agreement about the unacceptably high prevalence of human rights violations within mental health settings and that change is necessary. Instead of using legal or ethical arguments to justify the status quo, concerted efforts are needed to abandon it. Failure to take immediate measures towards such a change is no longer acceptable and the Special Rapporteur proposes five deliberate, targeted, and concrete actions as follows:

(a) Mainstream alternatives to coercion in policy with a view to legal reform;

(b) Develop a well-stocked basket of non-coercive alternatives in practice;

(c) 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;

(d) Establish an exchange of good practices between and within countries;

(e) Scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals.

H. Underlying and social determinants of mental health

67. The right to health is an inclusive right to both health care and the underlying and social determinants of health. Public health has individual and collective dimensions, which are essential in securing the right to the enjoyment of the underlying and social determinants of health.[45] Given the deep connections between mental health and the physical, psychosocial, political and economic environment, the right to determinants of health is a precondition for securing the right to mental health. Under international human rights law, States must act on a range of underlying determinants, such as violence, supportive family environments and discrimination, to secure in particular the right to health of children and women[46] and persons with disabilities.[47] In short, respecting,

Hans Joachim Salize and Harald Dressing, "Coercion, involuntary treatment and quality of mental health care: is there any link?", *Current Opinion in Psychiatry*, vol. 18, No. 5 (October 2005).

[43] Guidelines on article 14 of the Convention, para. 22.

[44] See Melvyn C. Freeman and others, "Reversing hard won victories in the name of human rights: a critique of the general comment on article 12 of the UN Convention on the Rights of Persons with Disabilities" *The Lancet Psychiatry*, vol. 2, No. 9 (September 2015).

[45] International Covenant on Economic, Social and Cultural Rights, art. 12 (2), and Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 37.

[46] Convention on the Rights of the Child, art. 24, and Convention on the Elimination of All Forms of Discrimination against Women, art. 12.

[47] Convention on the Rights of Persons with Disabilities, art. 25 (a) and (b).

protecting and fulfilling the right to mental health requires concerted action to secure certain preconditions that are associated with mental health.

68. Various international and regional processes have helped to define the public health and social justice imperatives for addressing the social determinants of health. The final report of the Commission on Social Determinants of Health was a pioneering piece that brought greater visibility to social determinants.[48] Medicine, in particular its mental health component, is to a large extent a social science and this understanding should be used to guide its practice. To take full account of the evidence around the determinants of mental health, the right to those determinants must expand beyond inequities, discrimination and the physical environment to reflect the documented importance of healthy psychosocial environments (see A/70/213 para. 55 and A/71/304, paras. 16 and 19).[49] That includes developing public policies that promote non-violent and respectful relationships in families, schools, workplaces, communities and health and social services.

VI. Shifting the paradigm

A. The human rights imperative to address promotion and prevention in mental health

69. The recognition by WHO of the importance of developing rights-based strategies, which promote and protect the mental health of entire populations, is welcomed.[50] 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. The fact that children spend a significant amount of time in schools and most adults at the workplace, means that rights-based action must promote healthy, safe and enabling environments that are free from violence, discrimination and other forms of abuse. Likewise, a person's mental health affects life within those domains and is integral to shaping the health of communities and populations. Population-based approaches to mental health promotion move health systems beyond individualized responses towards action on a range of structural barriers and inequalities (social determinants) that can negatively affect mental health.

70. 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.

71. The obligation to secure social determinants to promote mental health requires cross-sectoral action to ensure a robust commitment from all relevant ministries. For example, suicide prevention strategies are traditionally targeted towards high-risk groups and address clinical depression as a biomedical phenomenon, while cross-sectoral programmes that address the social and environmental determinants of suicide through population-based approaches show more promise. Bullying in schools is another phenomenon to be considered as a global and national public health priority. States should first and foremost address emotional and psychosocial environments, targeting relationships rather than individuals.

72. An environment that respects, protects and fulfils human rights and is free from all forms of violence, including gender-based violence, is fundamental for effective health promotion. Public health and psychosocial interventions are essential components of a

[48] *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (Geneva, WHO, 2008).

[49] See also WHO, "Investing in mental health: evidence for action" (2013) and "Risks to mental health: an overview of vulnerabilities and risk factors", discussion paper (2012).

[50] WHO Mental Health Action Plan 2013-2020.

rights-based mental health system, not a luxury. Relevant action must be based upon empowerment so as to enable individuals to increase control over and improve their health.

Adversity in early childhood and adolescence

73. Research has shown the damaging mental health and social impact of adversities and trauma experienced throughout childhood.[51] 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 as they transition into adulthood (see A/HRC/32/32, paras. 67-73, and A/70/213, para. 67).

74. The Special Rapporteur highlights the devastating impact that institutionalization has on young children, particularly on their mental health and holistic development.[52] Mental health-related services for children receive inadequate investment and lack quality standards of care and staffing, thus creating an environment where abuse is common for children with disabilities or with difficulties in social and emotional development, especially for those in institutional care. There are many examples of innovative child mental health services and practices throughout the world and there is convincing research on their effectiveness in promoting mental health and preventing deterioration in mental health conditions.[53] However, those good practices often serve merely as pilot projects, owing to a lack of political will to replicate and mainstream them in general childcare services.

75. Considering that mental health services are often underfunded, the resulting low-quality residential and in-patient psychiatric services lead to over-medicalization, violence and other forms of violations of children's rights. These must be abandoned or substantially transformed and more importantly, programmes to respond to childhood adversity must be organized around participatory frameworks that recognize children as rights holders, respect their evolving capacities and empower children and families to improve their mental health and well-being.

B. Treatment: from isolation to community

76. 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.

77. Reductive biomedical approaches to treatment that do not adequately address contexts and relationships can no longer be considered compliant with the right to health. While a biomedical component remains important, its dominance has become counter-productive, 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). The largest concentration of mental hospitals and beds separated from regular health care is in higher-income countries, a cautionary note for lower and middle-income countries to forge a different path and shift to rights-based mental health care.[54]

[51] See Department of Economic and Social Affairs, "Mental health matters: social inclusion of youth with mental health conditions" (2014).

[52] See WHO and the Gulbenkian Global Mental Health Platform, "Promoting rights and community living for children with psychosocial disabilities" (2015) and United Nations Children's Fund, "Ending the placement of children under three in institutions: support nurturing families for all young children" (2012).

[53] International Association for Child and Adolescent Psychiatry and Allied Professions, "Textbook of child and adolescent mental health" (2015).

[54] WHO Mental Health Atlas 2014, table 4.1.1.

Mainstreaming mental health

78. The right to health requires that mental health care be brought closer to primary care and general medicine, integrating mental with physical health, professionally, politically and geographically. It not only integrates mental health services into mainstream health care so they can be accessible for everyone, it ensures that entire groups of people who are traditionally isolated from mainstream health care, including persons with disabilities, receive care and support on an equal basis with others. Inclusion also comes with socioeconomic advantages.[55] Mental health concerns everyone and when needed, services should be accessible and available to all at the primary and specialized care levels.

Essential psychosocial interventions

79. While psychotropic medications can be helpful, not everyone reacts well to them and in many cases they are not needed. Prescribing psychotropic medications, not because they are indicated and needed, but because effective psychosocial and public health interventions are not available, is incompatible with the right to health. For example, in most cases of mild and moderate depression "watchful waiting", psychosocial support and psychotherapy should be the frontline treatments.

80. Despite the right to health obligation to provide psychosocial interventions and support, they are sadly viewed as luxuries, rather than essential treatments, and therefore lack sustainable investment in health systems. That is despite evidence demonstrating that they are effective.[56] These are essential interventions, which produce positive health outcomes and safeguard individuals from potentially harmful, more invasive medicalization. Importantly, they can include simple, low-cost, short-term interventions delivered within regular community health-care settings. Nurses, general practitioners, midwives, social workers and community health workers must be equipped with psychosocial skills to ensure accessibility, integration and sustainability.[57] Psychosocial interventions, not medication, should be the first-line treatment options for the majority of people who experience mental health issues.

Mental distress and recovery

81. While the paradigm shift in mental health requires a move towards integrated and population-based services, mental distress will still occur and rights-based treatment responses are required. The interventions used to address serious cases are perhaps the biggest indictment of the biomedical tradition. Coercion, medicalization and exclusion, which are vestiges of traditional psychiatric care relationships, must be replaced with a modern understanding of recovery and evidence-based services that restore dignity and return rights holders to their families and communities. People can and do recover from even the most severe mental health conditions and go on to live full and rich lives.[58]

82. There is no single definition of recovery, often described as a personal journey towards regaining a meaningful life and becoming more resilient. The recovery approach, when implemented in conformity with human rights, has helped to break down power asymmetries, empowering individuals and making them agents of change rather than passive recipients of care. Tremendous strides have been made in this area, with evidence and recovery-based support and services in practice across the world today that restore people's hope (and trust) in services, as well as in themselves.

[55] Lena Morgon Banks and Sarah Polack, "The economic costs of exclusion and gains of inclusion of people with disabilities. Evidence from low and middle income countries", London School of Hygiene and Tropical Medicine (2015), part B, sect. 3.

[56] See John Hunsley Katherine Elliott and Zoé Therrien, "The efficacy and effectiveness of psychological treatments for mood, anxiety and related disorders", *Canadian Psychology*, vol. 55, No. 3 (August 2014).

[57] See Clair Le Boutillier and others, "Staff understanding of recovery-orientated mental health practice: a systematic review and narrative synthesis", *Implementation Science*, vol. 10 (June 2015).

[58] See Richard Warner, "Does the scientific evidence support the recovery model?", *The Psychiatrist*, vol. 34, No. 1 (January 2010).

83. Peer support, when not compromised, is an integral part of recovery-based services.[59] It provides hope and empowers people to learn from each other, 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.[60] Other non-coercive models include mental health crisis units, respite houses, community development models for social inclusion, personal ombudsmen, empowerment psychiatry and family support conferencing. The Soteria House project is a long-standing recovery-based model, which has been recreated in many countries.[61] The increasing availability of alternatives and education and training on the use of non-consensual measures are critical indicators for measuring overall progress towards compliance with the right to health.

VII. Conclusions and recommendations

A. Conclusions

84. **Mental health has often been neglected and when it does receive resources, it becomes dominated by ineffective and harmful models, attitudes and imbalances. That has led to the current situation of the grossly unmet need for rights-based mental health promotion and care. 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.**

85. **The failure of the status quo to address human rights violations in mental health-care systems is unacceptable. As mental health emerges as a policy priority, it is crucial now to assess the failure to chart a better way forward, reaching consensus on how to invest and how not to invest.**

86. **An assessment of the global burden of obstacles alarmingly suggests their burden may be heavier than any burden of "mental disorders". The crisis in mental health should be managed not as a crisis of individual conditions, but as a crisis of social obstacles which hinders individual rights. Mental health policies should address the "power imbalance" rather than "chemical imbalance".**

87. **The urgent need for a shift in approach should prioritize policy innovation at the population level, targeting social determinants and abandon the predominant medical model that seeks to cure individuals by targeting "disorders".**

88. **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. To reach parity between physical and mental health, mental health must be integrated in primary and general health care through the participation of all stakeholders in the development of public policies that address the underlying determinants. Effective psychosocial interventions in the community should be scaled up and the culture of coercion, isolation and excessive medicalization abandoned.**

89. **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**

[59] See Sarah Carr, "Social care for marginalised communities: balancing self-organisation, micro-provision and mainstream support", University of Birmingham, policy paper No. 18 (February 2014).

[60] See Jaako Seikkula and others, "Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: treatment principles, follow-up outcomes and two case studies", *Psychotherapy Research*, vol. 16, No. 2 (March 2006).

[61] See Tim Calton and others, "A systematic review of the Soteria paradigm for the treatment of people diagnosed with schizophrenia", *Schizophrenia Bulletin*, vol. 34, No. 1 (January 2008).

practices to take shape in communities is a powerful means to promote and advance the changes needed.

90. **The Special Rapporteur seeks to develop, through an inclusive and participatory process and open dialogue, guidelines on human rights and mental health to support all stakeholders in the implementation of rights-based mental health policies in their respective areas of work. He welcomes contributions and suggestions in this respect.**

B. Recommendations

91. **The Special Rapporteur calls for leadership to confront the global burden of obstacles and embed rights-based mental health innovation in public policy. That includes State champions in international policy efforts, the leadership of professional psychiatry in assessing constructively its approach to the necessity for change, managers of mental health services leading change by example and municipal officials championing grassroots innovation. These champions must work in partnership with their constituents, including persons with intellectual, cognitive and psychosocial disabilities and with autism.**

92. **To address the imbalance of the biomedical approach in mental health services, the Special Rapporteur recommends that:**

(a) **States take immediate measures to establish inclusive and meaningful participatory frameworks in the design of and decision-making around public policy, to include, inter alia, psychologists, social workers, nurses, users of services, civil society and those living in poverty and in the most vulnerable situations;**

(b) **States and other relevant stakeholders, including academic institutions, recalibrate mental health research priorities to promote independent, qualitative and participatory social science research and research platforms, exploring alternative service models that are non-coercive;**

(c) **States partner with academic institutions to address the knowledge gap in rights-based and evidence-based mental health within medical education.**

93. **To ensure that social and underlying determinants for the promotion of mental health for all are addressed, the Special Rapporteur recommends that States:**

(a) **Prioritize mental health promotion and prevention in public policy, scaling investments across the relevant ministries;**

(b) **Take immediate action to develop public policies which, in alignment with the Sustainable Development Goals, address mental health and holistic development in early childhood and adolescence, prioritizing promotion and psychosocial interventions;**

(c) **Take policy and legislative measures on the prevention of violence in all environments where people live, study and work;**

(d) **Take immediate action to address harmful gender stereotypes, gender-based violence and access to sexual and reproductive health;**

(e) **Take immediate steps to eliminate the corporal punishment of children and their institutionalization, including children with disabilities.**

94. **To ensure that international cooperation secures the right to mental health and the 2030 Agenda, States and multilateral and international institutions should:**

(a) **End all financial support for segregated residential mental health institutions, large psychiatric hospitals and other segregated facilities and services;**

(b) **Mainstream the right to mental health into health, poverty-reduction and development strategies and interventions, and explicitly include it in general and priority health policies and plans;**

(c) **Advance global mental health in all monitoring activities of the Sustainable Development Goals, including high-level political forums.**

95. **To ensure that health-care services guarantee the right to mental health for all, States should:**

(a) **Ensure that users are involved in the design, implementation, delivery and evaluation of mental health services, systems and policies;**

(b) **Stop directing investment to institutional care and redirect it to community-based services;**

(c) **Invest in psychosocial services, that are integrated into primary care and community services to empower users and respect their autonomy;**

(d) **Scale up investment in alternative mental health services and support models;**

(e) **Develop a basic package of appropriate, acceptable (including culturally) and high-quality psychosocial interventions as a core component of universal health coverage;**

(f) **Take targeted, concrete measures to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement;**

(g) **Seek technical assistance from the WHO QualityRights initiative to assess and improve the quality of mental health care.**