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Right of everyone to the enjoyment of the highest attainable standard of physical and mental health

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

Summary

In the present report, submitted pursuant to Human Rights Council resolution 42/16, the Special Rapporteur elaborates on the elements that are needed to set a rights-based global agenda for advancing the right to mental health.

The Special Rapporteur welcomes international recognition that there is no health without mental health and appreciates the different worldwide initiatives to advance all elements of global mental health: promotion, prevention, treatment, rehabilitation and recovery. However, he also emphasizes that despite promising trends, there remains a global failure of the status quo to address human rights violations in mental health-care systems. This frozen status quo reinforces a vicious cycle of discrimination, disempowerment, coercion, social exclusion and injustice. To end the cycle, distress, treatment and support must be seen more broadly and move far beyond a biomedical understanding of mental health. Global, regional and national conversations are needed to discuss how to understand and respond to mental health conditions. Those discussions and actions must be rights-based, holistic and rooted in the lived experience of those left furthest behind by harmful sociopolitical systems, institutions and practices.

The Special Rapporteur makes a number of recommendations for States, for organizations representing the psychiatric profession and for the World Health Organization.

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I. Introduction

1. There is no health without mental health. The rich links between mind, body and the environment have been well-documented for decades. As the third decade of the millennium begins, nowhere in the world has achieved parity between mental and physical health and this remains a significant human development challenge. An important message within that collective failure is that without addressing human rights seriously, any investment in mental health will not be effective. Attacks on universal human rights principles threaten the physical, political, social and economic environment, and actively undermine the struggle for positive mental health and well-being.

2. The global message is clear: there can be no good mental health without human rights. More than 70 years ago, the Charter of the United Nations established the three founding pillars of the United Nations system: human rights, peace and security, and development. These equally weighted elements are a framework for shared responsibility across the spectrum of multilateral activity, including mental health. Conversely, the promotion and protection of the mental health and well-being of everyone, starting from early childhood, is critical to supporting all three pillars. That indicates the significance of how stakeholders invest in mental health so that a transformative paradigm is developed to help the global community prepare for a radically different, just and more peaceful future.

3. Throughout his term, the Special Rapporteur has sought to amplify the importance of mental health within the right to health and to elevate the unique and interdependent relationship between mental health and the full enjoyment of all human rights. Since his report to the Human Rights Council in 2017 (A/HRC/35/21), mental health has continued to grow in prominence on the global stage. While that international recognition is welcome, much more is needed in the global, regional and national conversations around how to understand and respond to mental health. Those discussions and related actions must be rights-based, holistic and rooted in the lived experience of those left furthest behind by harmful sociopolitical systems, institutions and practices. In his final report to the Human Rights Council, the Special Rapporteur reflects on the progress made in the global movement towards a rights-based mental health praxis.

II. Global health: progress, challenges, common ground and a fractured consensus

4. Global mental health refers to both a specific movement, the Movement for Global Mental Health, which aims to scale up access to mental health services, and to a wider more disparate field of advocacy, activism and research, including critical perspectives. How global mental health is and has been framed is of vital importance to the construction of global priorities for how global mental health is defined and delivered, and subsequently how human rights can be promoted or undermined.[1]

A. Contextual entry points and priorities

5. Differences within and between low-, middle- and high-income countries provide very different entry points to understanding the meanings of, and advocacy around, mental health and related disabilities. Context is essential. Some countries have an entrenched colonial psychiatric system, while others have no formalized psychiatric system at all. Many countries have experienced colonialism, and its links to psychiatry, very differently.

6. Political and social systems provide different narratives of how good mental health can be structurally undermined by the environment upstream that political choices create. The Special Rapporteur has previously emphasized how the underlying and social determinants of health can be detrimental to the mental health of individuals and societies within and beyond mental health-care systems. Those harms can arise from systemic

[1] See Alison Howell, China Mills and Simon Rushton, "The (mis)appropriation of HIV/AIDS advocacy strategies in global mental health: towards a more nuanced approach", *Globalization and Health*, vol. 13, No. 44 (2017).

violations of economic and social rights, such as neoliberal policies and austerity measures. Harms to mental health can equally arise from systemic violations of civil and political rights that lead to structural discrimination and violence against different communities, as well as restricting the space of civil society.

7. In many high-income countries, there has been a mainstream focus on the improvement of existing mental health systems, alongside campaigns to resist and reduce over-medicalization. In many low- and middle-income countries, there has been a policy shift towards developing or increasing access to mental health services similar to those in high-income countries, alongside simultaneous grassroots activism focused on developing community-owned and peer-led support systems.[2] Globally, almost all contexts share the need for a paradigm shift in mental health, although what that shift looks like in practice is a matter of much debate.

8. Contextual entry points are important to ensure that advocacy strategies are not uncritically exported from global North to South. Some experts view less established mental health infrastructures, especially in low-income countries, as a hindrance to the realization of the right to mental health and the rights enshrined in the Convention on the Rights of Persons with Disabilities. They argue that what is required under the Convention is unrealistic and even counterproductive to the promotion and protection of human rights settings with such scarce resources. Others see less-established mental health infrastructures as an opportunity for transformation and creative innovation. Recognition of these contextual nuances and the wider sociopolitical factors that shape them means that while a dominant global status quo in mental health exists, it is fracturing under the pressure of these divergent and powerful movements and experiences.

9. Mental health systems worldwide are dominated by a reductionist biomedical model that uses medicalization to justify coercion as a systemic practice and qualifies the diverse human responses to harmful underlying and social determinants (such as inequalities, discrimination and violence) as "disorders" that need treatment. In such a context, the main principles of the Convention on the Rights of Persons with Disabilities are actively undermined and neglected. This approach ignores evidence that effective investments should target populations, relationships and other determinants, rather than individuals and their brains.

10. How that dominance is overcome requires transformative human rights action. However, action that focuses only on strengthening failing mental health-care systems and institutions is not compliant with the right to health. The locus of the action must be recalibrated to strengthen communities and expand evidence-based practice that reflects a diversity of experiences. Such community-led recalibration enables the necessary social integration and connection required to more effectively and humanely promote mental health and well-being.[3]

11. Globally, there is insufficient allocation of adequate resources for mental health, including for advocacy, support and research led by persons with disabilities. There is a lack of investment in capacity-building for civil society, including organizations of persons with disabilities, human rights advocates and academia, on the Convention on the Rights of Persons with Disabilities and its conceptual connections with other human rights treaties, specifically those that enshrine the right to health. As such, very little literature and scholarship has been developed on what a rights-based approach to mental health might look like in a range of practices and contexts. Rights-based frameworks are starting to emerge and can serve as essential building blocks for future communities of practices to expand and develop within and beyond existing mental health systems.[4]

[2] See TCI Asia, "Turning the tables: the imperative to reframe the debate towards full and effective participation and inclusion of persons with psycho-social disabilities. Excerpts from 'Galway-Trieste' conversations – part IV", 28 October 2019.

[3] See Bhargavi V. Davar, "Globalizing psychiatry and the case of 'vanishing' alternatives in a neo-colonial state", *Disability and the Global South*, vol. 1, No. 2 (2014).

[4] See Peter Stastny and others, "Critical elements of rights-based community supports for individuals experiencing significant emotional distress: foundations and practices", *Health and Human Rights Journal* (forthcoming, June 2020); Faraaz Mahomed, "Establishing good practice in rights-based

12. The Bali Declaration of August 2018, issued by Transforming Communities for Inclusion-Asia Pacific, was composed by persons with psychosocial disabilities and cross-disability supporters from 21 countries of the Asia-Pacific region. They affirmed the need for a paradigm shift in mental health towards inclusion and away from a focus dominated by the medical model. Instead of focusing efforts on reform systems that violate rights, the focus should be on developing and strengthening existing movements for the non-violent, peer-led, trauma-informed, community-led programmes, healing and cultural practices preferred by local groups of persons with psychosocial disabilities, attentive to the movement of non-medical alternatives and progressive community support worldwide. Similar approaches are shared by organizations in other regions, such as Mental Health Europe. This advocacy direction is an important means to transform the global conversation and rebalance it away from the expansion and improvement of services as the main response to mental health and from the impetus in global mental health to scale up access to mental health for all, especially in low- and middle-income countries.[5]

B. Participation and power: a global perspective

13. The participation of persons with mental health conditions, including persons with disabilities, in the planning, monitoring and evaluation of services, in system strengthening and in research, is now more widely recognized as a way to improve the quality, accessibility and availability of services and the strengthening of mental health systems.[6] Promising evidence and guidelines in this area exist in high-income countries:[7] the Special Rapporteur has observed promising practices in "medication-free" treatment wards in Norway and in a rights-based pilot project in Sweden, where the use of peers has been employed to confront power asymmetries and support dialogical, non-coercive approaches. There is little evidence available to show where and how this has been done in low- and middle-income countries, particularly at the systems or policy level.

14. While empowerment is often referred to, power has been a neglected topic in global mental health. Recently, some attention has been paid to the need to rebalance power towards local actors to mitigate the "inappropriate application of ideas not well-suited to local needs".[8] In that context, equalizing global power dynamics is a promising pathway towards rights-based transformation across all resource settings. All States, regardless of income level, remain embryonic in their status of development towards integrating new normative frameworks and practices that can liberate the field of mental health from discriminatory and other outdated attitudes and practices.

15. However, discussions about power in global mental health decision-making, agenda-setting and knowledge production remain largely absent. In addition, the global literature is less prominent in engaging with the research and literature conducted and written by those who identify as service users or psychiatric survivors, or as persons with psychosocial disabilities. Much of that research and literature originates in the global North, which means that participation does not necessarily extend to persons with disabilities living in low- and middle-income countries.[9]

16. Emerging power dynamics within the psychiatric profession have traditionally reinforced the status quo dominated by the biomedical paradigm. However, psychiatry is not a monolith and many members of the psychiatric community across all regions are

approaches to mental health in Kenya", doctoral dissertation, Harvard T.H. Chan School of Public Health (May 2019).

[5] See Lancet Global Mental Health Group, "Scale up services for mental disorders: a call for action", *The Lancet*, vol. 370, No. 9594 (October 2007).

[6] See Angela Sweeney and Jan Wallcraft, "Quality assurance/monitoring of mental health services by service users and carers", WHO Regional Office for Europe; and Graham Thornicroft and Michele Tansella, "Growing recognition of the importance of service user involvement in mental health service planning and evaluation", *Epidemiology and Psychiatric Sciences*, vol. 14, No. 1 (March 2005).

[7] National Survival User Network, "4Pi national involvement standards" (2013).

[8] See Julian Eaton, "Rebalancing power in global mental health", *International Journal of Mental Health*, vol. 48, No. 4 (2019).

[9] See Pan-African Network of People with Psychosocial Disabilities, "Voices from the field. The Cape Town Declaration (16 October 2011), *Disability and the Global South*, vol. 1, No. 2 (2014).

breaking with the status quo in support of a rights-based paradigm shift. That shift must be welcomed as necessary for the future credibility of the profession. It is troubling to see such voices dismissed by the conventional (and dominant) psychiatric profession and its leadership.[10] Those who speak against coercion and support the view that alternatives are safe are not unethical, negligent or derelict in their duty of care, neither do they represent "anti-psychiatry". On the contrary, the Special Rapporteur has reviewed alternatives that have applied a harm reduction lens for decades and have diligently ensured risk minimization.

17. The combination of a dominant biomedical model, power asymmetries and the wide use of coercive practices together keep not only people with mental health conditions, but also the entire field of mental health, hostage to outdated and ineffective systems. States and other stakeholders, specifically the professional group of psychiatry, should critically reflect on this situation and join forces already on the way towards abandoning the legacy of systems based on discrimination, exclusion and coercion.

C. Standardization and practice-based evidence

18. Many global mental health tools and technologies, including the WHO mental health gap action programme intervention guide (mhGAP-IG), are designed to be universal, meaning they are often standardized. While standardization is important for global work, it also overlooks understanding and practices that resist standardization owing to complexity or locality.[11] The design and implementation of such guidelines are never neutral and involve ethical and political work. Guidelines and protocols are shaped by the assumptions and life experiences of those who design and use them, by available evidence and by the local health infrastructure.[12]

19. Global guidelines in mental health, such as the WHO intervention guide, are evidence-based, with recommendations for interventions based on systematic reviews of randomized controlled trials. Locating guidelines in evidence-based medicine is important for political buy-in, but reliance on randomized controlled trials, which are mainly carried out on pharmacological interventions and are often funded by the pharmaceutical industry, may skew treatment recommendations towards drugs. Furthermore, far more randomized evidence is generated in specialized provider settings in high-income countries, which has questionable application in primary care settings in low- and middle-income countries.

20. A rights-based pathway to achieving more local relevance in global mental health might be to move away from evidence-based practice to practice-based evidence, which takes as its starting point local realities, possibilities and understanding of care. Research shows that mental health system reform in fragile and conflict-affected areas emerges through creative practices, experimentation, adaptation and the application of knowledge, as people deal with uncertainty and complexity in contexts where fundamental resources are sometimes lacking.[13]

[10] See Niall Maclaren, "Ready, fire, aim: mainstream psychiatry reacts to the UN Special Rapporteur", Mad in America, 26 January 2020.

[11] See Sara Cooper, "Prising open the 'black box': an epistemological critique of discursive constructions of scaling up the provision of mental health care in Africa", *Health*, vol. 19, No. 5 (September 2015).

[12] See China Mills and Kimberley Lacroix, "Reflections on doing training for the World Health Organization's mental health gap action program intervention guide (mhGAP-IG)", *International Journal of Mental Health*, vol. 48, No. 4 (2019).

[13] See Hanna Kienzler, "Mental health system reform in contexts of humanitarian emergencies: toward a theory of 'practice-based evidence'", *Culture, Medicine and Psychiatry*, vol. 43, No. 4 (December 2019).

D. Determinants of health and measurement

21. Critiqued for its individualizing disease focus, the Movement for Global Mental Health has started to take the determinants of health more seriously.[14] For example, a systematic review of epidemiological research in low- and middle-income countries found a very strong relationship between indicators of poverty and common mental health conditions,[15] and the Cape Vulnerability index evidences the relationships between geopolitical factors, foreign aid and mental health.[16] Other findings from Global Mental Health show that health determinants do not act uniformly and many factors, including local context, are important.[17]

22. Much global mental health research about the relationship between poverty and mental health focuses on pre-existing mental health conditions diagnosed through the international statistical classification of diseases and related health problems that contribute to poverty. It is not focused on how poverty and social injustice can produce mental distress. The focus has been on the burden and cost of mental health disorders. That is not consistent with a human rights-based approach and has been shown to be methodologically flawed.

23. That approach is rooted in economic arguments instead of being centred on human rights. The focus remains on individual rather than systemic change as a means of tackling poverty and oppression. By positioning mental distress as a barrier to economic development, mental health is recast as a problem of individual brains. That, in particular, enables psychiatric and psychological expertise to be mobilized in relation to persons in situations of poverty, contributing to the "psychologization" and "psychiatrization" of poverty. In that context, the "world-first" well-being budget adopted by New Zealand is an initiative that goes in the right direction by prioritizing mental health and well-being over gross domestic product.

24. Measurement is key to evidencing relationships between disability, mental health and the determinants of health, and in making mental health count as a global priority area. However, the measurement of health determinants often relies on psychiatric-diagnostic criteria translated into easy-to-administer checklists. Not only are the criteria and checklists deeply problematic but they have been critiqued for individualizing distress, raising problems with using them as tools to map the mental health effects of health determinants.[18] Measurement systems should move away from individualized, causal models of health determinants and address structural conditions and root causes, meaningfully involving service users and persons with disabilities in decision-making about what counts in mental health. They should also develop indicators for actions on the determinants of mental health and include rights-based indicators to measure progress, as suggested by the Human Rights Council in its resolution 40/12.

25. As the determinants of health continue to attract important political attention, particularly within Global Mental Health, there is a risk that this attention remains rhetorical and not meaningfully integrated into the structural reforms required within mental health systems, particularly within the practice of psychiatry.[19] In his report on the education of the health-care workforce, the Special Rapporteur highlighted a range of pedagogical shifts that offer much promise in integrating this knowledge into practice (A/74/174).

[14] See Vikram Patel and others, "The Lancet Commission on global mental health and sustainable development", *The Lancet*, vol. 392, No. 10157 (October 2018).

[15] See Crick Lund and others, "Poverty and mental disorders: breaking the cycle in low- and middle-income countries", *The Lancet*, vol. 378, No. 9801 (October 2011).

[16] See Albert Persaud and others, "Geopolitical factors and mental health I", *International Journal of Social Psychiatry*, vol. 64, No. 8 (December 2018).

[17] Vikram Patel and Paul E. Farmer, "The moral case for global mental health delivery", *The Lancet*, vol. 395, No. 10218 (January 2020).

[18] See China Mills, "From 'invisible problem' to global priority: the inclusion of mental health in the sustainable development goals", *Development and Change*, vol. 49, No. 3 (2018).

[19] See Lisa Cosgrove and others, "A critical review of the Lancet Commission on global mental health and sustainable development: time for a paradigm change", *Critical Public Health* (September 2019).

26. The right to mental health is best enabled through the convergence of human rights and health determinants, where research and action on the structural, political and social determinants of distress, including poverty, inequality, discrimination and violence, are considered vital.[20] There is thus a need for more nuanced research in the field and a resource shift from the dominance of a biomedical paradigm towards the social sciences, emphasizing interdisciplinarity, intersectionality and the role of contextual factors. The biomedical approach to mental health conditions still has an important role to play, but it must be understood as one of many complex pieces in the rights-based transformation ahead.

III. Over-medicalization and threats to human rights

A. Context: from "bad" to "mad". Medical power and social control

27. Many people from traditionally marginalized groups in society, such as people living in poverty, people who use drugs and persons with psychosocial disabilities, have been entangled by a holy trinity of labels: (a) Bad people/criminals, (b) Sick or mad people or patients, or (c) A combination of the two. Those labels have left such communities vulnerable to excessive punishment, treatment and/or therapeutic "justice" for conditions or behaviours deemed socially unacceptable. The result is an exclusionary, discriminatory and often racist pipeline from schools, streets and underserved communities into prisons, hospitals and private treatment facilities, or into communities under treatment orders, where human rights violations may be systemic, widespread and often intergenerational. The global mental health discourse remains reliant on this "mad or bad" approach and on laws, practices and the attitudes of stakeholders excessively dependent on the idea that mental health care is mostly about preventing behaviours that might be dangerous or require interventions based on medical (therapeutic) necessity. Those advocating rights-based approaches infused by modern public health principles and scientific evidence challenge the "mad or bad" dichotomy as outdated, discriminatory and ineffective.

28. The many global efforts towards decarceration and decriminalization are welcome, but attention should be paid to the attendant politics and policy shifts towards the phenomenon of over-medicalization, which raises significant human rights concerns. Whether confined or coerced on public safety or medical grounds, the shared experience of exclusion exposes a common narrative of deep disadvantage, discrimination, violence and hopelessness.

29. This pernicious form of medicalization presents challenges to the promotion and protection of the right to health. Medicalization occurs when a diversity of behaviours, feelings, conditions or health problems are "defined in medical terms, described using medical language, understood through the adoption of a medical framework, or treated through medical intervention".[21] The process of medicalization is often associated with social control as it serves to enforce boundaries around normal or acceptable behaviours and experiences. Medicalization can mask the ability to locate one's self and experiences within a social context, fuelling misrecognition of legitimate sources of distress (health determinants, collective trauma) and producing alienation. In practice, when experiences and problems are seen as medical rather than social, political or existential, responses are centred around individual-level interventions that aim to return an individual to a level of functioning within a social system rather than addressing the legacies of suffering and the change required to counter that suffering at the social level. Moreover, medicalization risks legitimizing coercive practices that violate human rights and may further entrench discrimination against groups already in a marginalized situation throughout their lifetimes and across generations.

[20] See Dainius Puras and Piers Gooding, "Mental health and human rights in the 21st century", *World Psychiatry*, vol. 18, No. 1 (February 2019).

[21] See Peter Conrad and Joseph W. Schneider, *Deviance and Medicalization: from Badness to Sickness* (Philadelphia, Pennsylvania, Temple University Press, 2010).

30. There is a concerning tendency to use medicine as a means to diagnose and subsequently dismiss an individual's dignity and autonomy within a range of social policy areas, many of which are viewed as popular reforms to outdated forms of punishment and incarceration. Medicalization deflects from the complexity of the context as humans in society, implying that there exists a concrete, mechanistic (and often paternalistic) solution. That reflects the unwillingness of the global community to confront human suffering meaningfully and embeds an intolerance towards the normal negative emotions everyone experiences in life. How "treatment" or "medical necessity" is used to justify discrimination and social injustice is troubling.

31. A dominant biomedical approach has led to States justifying their authority to intervene in ways that limit the rights of individuals. For example, medical rationales should never be used as a defence or justification for policies and practices that violate the dignity and rights of people who use drugs. While efforts to move responses to drug use away from criminalized models towards health-based ones are welcome in principle, it is important to raise a caution about the risk of medicalization further entrenching rights abuses against people who use drugs. Medicalized responses to address addiction (particularly when framed as a disease) can reflect parallel coercive practices, detention, stigmatization and the lack of consent found in criminalized approaches. Without human rights safeguards, these practices can flourish and can often disproportionately affect individuals who face social, economic or racial marginalization.

32. Forced interventions in mental health settings have been justified because of determinations of "dangerousness" or "medical necessity". Those determinations are established by someone other than the individual in question. Because they are subjective, they require greater scrutiny from a human rights perspective. While people worldwide are fighting for the unshackling of people with serious emotional distress, the physical chains and locks are being replaced by chemical restraints and active surveillance. The gaze of the State and the investment of resources remain too narrowly focused on controlling the individual with "medical necessity", commonly invoked as grounds to justify such control.

33. Despite the absence of biological markers for any mental health condition,[22] psychiatry has reinforced biomedical and acontextual understanding of emotional distress. Because of the lack of a comprehensive understanding of the aetiology of, and treatment for, mental health conditions, there is a growing trend that urges a transition away from medicalization.[23] There are growing calls within psychiatry for a "fundamental rethinking of psychiatric knowledge creation and training" and a renewed emphasis on the importance of relational care and the interdependence of mental and social health.[24] The Special Rapporteur concurs but calls on organized psychiatry and its leaders to firmly establish human rights as core values when prioritizing mental health interventions.

34. When considering initiating treatment, the principle of *primum non nocere*, or "first do no harm", must be the guiding one. Unfortunately, the burdensome side effects resulting from medical interventions are often overlooked, the harms associated with numerous psychotropic drugs have been downplayed and their benefits exaggerated in the published literature.[25] The potential for overdiagnosis and overtreatment must therefore be considered as a potential iatrogenic effect of current global efforts to scale up access to treatment. Additionally, the broader human rights and social harms produced by medicalization, such as social exclusion, forced treatment, loss of custody of children and loss of autonomy, warrant greater attention. Medicalization affects every aspect of the lives of persons with psychosocial disabilities; it undermines their ability to vote, work, rent a home and be full citizens who participate in their communities.

[22] See James Phillips and others, "The six most essential questions in psychiatric diagnosis: a pluralogue part 1: conceptual and definitional issues in psychiatric diagnosis", *Philosophy, Ethics and Humanities in Medicine*, vol. 7, No. 3 (January 2012).

[23] See Vincenzo Di Nicola. "'A person is a person through other persons': a social psychiatry manifesto for the 21st century", *World Social Psychiatry*, vol. 1, No. 1 (2019).

[24] See Caleb Gardner and Arthur Kleinman, "Medicine and the mind - the consequences of psychiatry's identity crisis", *The New England Journal of Medicine*, vol. 381, No. 18 (October 2019).

[25] See Joanna Le Noury and others, "Restoring Study 329: efficacy and harms of paroxetine and imipramine in treatment of major depression in adolescence", *The BMJ*, vol. 351 (September 2015).

35. It is now widely recognized that the mass incarceration of individuals from groups in marginalized situations is a pressing human rights issue. In order to prevent mass medicalization, it is essential to embed a human rights framework in the conceptualization of, and policies for, mental health. The importance of critical thinking (for example, learning about the strengths and weaknesses of a biomedical model) and knowledge of the importance of a human rights-based approach and the determinants of health must be a central part of medical education.

B. World Health Organization essential medicines list and mental health

36. Essential medicines defined by WHO, "are those that satisfy the priority healthcare needs of the population … [they] are selected with due regard to disease prevalence and public health relevance, evidence of clinical efficacy and safety, and comparative costs and cost-effectiveness … For the past 30 years the Model List has led to a global acceptance of the concept of essential medicines as a powerful means to promote health equity."[26]

37. In keeping with the position of WHO that the concept of the model list is a "forward-looking" mechanism to promote health equity and should be regularly reviewed and updated to "reflect new therapeutic options and … to ensure drug quality", the Special Rapporteur stresses the following points.

38. Unlike other physical health conditions (for example, bacterial meningitis), for which there are essential medicines (for example, antibiotics), the pathophysiology of mental health conditions and the specific mechanisms by which psychotropic drugs may be effective are unknown. Although much progress has been made in terms of understanding the pharmacokinetics and pharmacodynamics of antidepressants and antipsychotic medications, their effectiveness is not comparable to amoxicillin for a bacterial infection.

39. WHO has identified a list of essential medicines for mental conditions but, however well-intentioned, it should reconsider the inclusion of 12 medications for the treatment of psychotic "disorders" (24.1 on the list), mood "disorders" (24.2), anxiety "disorders" (24.3) and obsessive-compulsive "disorders" (24.4).

40. A number of reanalyses of the randomized clinical trial data upon which the drugs were based and meta-analyses suggest that a re-evaluation of their risk-benefit ratios is needed.[27] It is now recognized that in general, response to initial treatment with antidepressant medication is in the range of 40–50 per cent and thus many individuals do not achieve a full response or remission from antidepressants.[28] There is growing concern about "treatment-resistant depression" and that anti-depressants on the list may actually be causing an iatrogenic effect.[29] There is a clear burden of side effects of antipsychotic medications. These facts in combination point to an important question: is having such medications listed as "essential" undermining a stepped, evidence-based approach to the care and support of people with mental health conditions, including persons with disabilities? The overemphasis on medication for addressing mental health issues has already been identified by the Special Rapporteur as no longer compliant with the right to health.

41. While debates continue over the evidence base for psychotropic medications, their inclusion on the essential medications list may raise other issues. For instance, their inclusion may reify contested disease categories and suggest that these mental conditions are primarily biomedical in nature, which further reinforces medicalization. Additionally, the list may inadvertently reinforce coercive practices because it is grounded in an

[26] WHO, "Essential medicines and health products", available from www.who.int/medicines/services/essmedicines_def/en/.

[27] See Joanna Le Noury and others, "Restoring Study 329: efficacy and harms of paroxetine and imipramine in treatment of major depression in adolescence".

[28] See Claire D. Advokat, Joseph E. Comaty and Robert M. Julien, *Julien's Primer of Drug Action*, 14th ed. (New York, Worth Publishers, 2019).

[29] See Ziad A. Ali, Sharon Nuss and Rif S. El-Mallakh, "Antidepressant discontinuation in treatment resistant depression", *Contemporary Clinical Trials Communications*, vol. 15 (September 2019).

assumption that individuals diagnosed with mental health conditions require medication as a first-choice treatment, undermining their own insight into their distress.

42. The Special Rapporteur has repeatedly made calls for a more expansive understanding of mental health, which aligns with the Constitution of WHO extending beyond individual factors and interventions. The essential medications list may imply that making such drugs available is equivalent to providing the appropriate standard of care for the treatment of mental health conditions, which is not the case. The list is insufficient for assessing compliance with the right to health. Relying predominantly on the essential medicines list is misleading and presents a challenge to the right to health. Any suggestion that psychotropic medications are the most important method of managing mental health conditions, including those of persons with disabilities, contravenes the provisions of the Convention on the Rights of Persons with Disabilities, which establishes a shift away from the medical model. Furthermore, placing psychotropic medications on the list of essential medicines sends a misleading message to stakeholders (States, users and providers of mental health services) and undermines the fact that for the majority of mental health conditions, psychosocial and other social interventions should be viewed as the "essential" option for treatment.

43. In the light of new evidence, the enhanced understanding of how to support good mental health and the significant obstacles that overreliance on medications for mental health present to the realization of the right to health, WHO should review the current essential medicines list of mental health medications (Nos. 24.1–24.4), with a view to removing the ones for which there is no evidence of an adequate risk/benefit profile. In its place, the Special Rapporteur calls on WHO and other Global Mental Health actors to work towards developing a new, holistic list of essential psychosocial and population-based interventions, informed by evidence and supported and developed by rights-based principles, which can more appropriately guide States towards full compliance with the right to health. Until the crisis of the status quo is recognized and a more holistic list is developed, there remains a continued risk of systemic violations of human rights in the delivery of mental health-care services.

C. Across the life course: specific groups vulnerable to excessive medicalization

44. Throughout the life cycle, many individuals at the intersection of race, class and gender are at increased risk of the effects of excessive medicalization. Indeed, it is well documented that persons with intellectual, cognitive or psychosocial disabilities, particularly those who are poor and/or from groups in marginalized situations, are particularly vulnerable. In that way, medicalization can pathologize responses to social inequities and escalate social control and violations of rights in vulnerable populations. Scholarship on this issue details numerous examples where "the project of helping certain groups of people merged all too easily with the project of controlling them".[30] The Special Rapporteur highlights the experiences of several groups that are particularly vulnerable to excessive medicalization.

45. There is a general international trend towards increasing psychotropic prescription rates for children and adolescents (as well as for adults), although rates vary widely between countries.[31] A growing number of studies have documented a trend in long-term poly-pharmacy in children and adolescents for antipsychotics and other psychotropic classes.[32] Such drugs are increasingly used for behavioural and social control. Exposing children unnecessarily to psychotropic medications undermines the right to health.

[30] See Jonathan Metzl. *The Protest Psychosis: How Schizophrenia Became a Black Disease*, (Boston, Massachusetts, Beacon Press. 2010).

[31] See Hans-Christoph Steinhausen, "Recent international trends in psychotropic medication prescriptions for children and adolescents", *European Child & Adolescent Psychiatry*, vol. 24, No. 6 (June 2015).

[32] See Amanda R. Kreider and others, "Growth in the concurrent use of antipsychotics with other psychotropic medications in Medicaid-enrolled children", *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 53, No. 9 (September 2014).

Although it is not possible to identify precisely the reasons for the increase in diagnosed mental health conditions in children, and the resulting increase in the use of psychotropic medication and poly-pharmacy, widened diagnostic boundaries,[33] increased use of technology[34] and increased social isolation have been suggested. Inexplicably, this upward trend is happening at the same time as, and despite the fact that, an enormous body of evidence continues to emerge on the impact of adverse childhood experiences on mental health and well-being.

46. The tendency to medicalize children's distress can lead to an approach whereby multiple medications are prescribed for various symptoms, where some symptoms are iatrogenic effects of the medications, despite the lack of evidence for poly-pharmacy in children.[35] Children have a right to thrive, to develop in a holistic way to their full potential and enjoy good physical and mental health in a sustainable world. It is crucial that investments are made to provide the nutritional, educational and societal resources for healthy development, and that the effects of adverse childhood experiences are addressed.

47. The Special Rapporteur welcomes the attempts of organizations in the field of child and adolescent mental health to oppose excessive medicalization and to develop mental health-care services for children and adolescents that prevent coercive measures and excessive use of psychotropic medications.[36] It is important to train mental health professionals and educate broader society to understand that psychotropic medications are not effective first-choice treatment options in child and adolescent mental health care and that excessive use of psychotropic medications is not compliant with the right to health. A broad variety of other interventions, such as watchful waiting and other psychosocial interventions, must be available, accessible, acceptable and of sufficient quality.

48. Many care facilities for the aged routinely pathologize symptoms associated with ageing and use sedative and antipsychotic drugs on older persons as chemical restraints. There is a growing body of literature that suggests that the use of chemical restraints in older persons, particularly in care homes, is increasing.[37] Subjecting older persons with dementia to chemical restraints is inconsistent with a human rights approach and points to a clear need to increase resources to provide appropriate staffing and offer person-centred support. Most importantly, however, is the need to promote the conditions and social resources that foster healthy ageing and to develop policies and allocate resources that allow older persons to remain integrated in their communities.

49. Human rights-based approaches can help expose gaps in current policies and identify antiquated ideas that can undermine the conditions that are conducive to living a life with dignity. Without an interdisciplinary approach and genuine stakeholder involvement in the development of mental health policies, criminal justice reforms and clinical practice guidelines and education, it will be impossible to address the growing problem of medicalization and coercion that often follows. Responding effectively to this problem will require approaches that take into account how institutional thinking and practice and guild interests may impede the ability to genuinely make room for models of care that fall outside a medical model.[38]

[33] See Allen Frances and Laura Batstra, "Why so many epidemics of childhood mental disorder?", *Journal of Developmental & Behavioral Pediatrics*, vol. 34, No. 4 (May 2013).

[34] See Jean M. Twenge, "The sad state of happiness in the United States and the role of digital media" in *World Happiness Report 2019*, John F. Helliwell, Richard Layard and Jeffrey D. Sachs, eds. (New York, Sustainable Development Solutions Network, 2019).

[35] See Jon Jureidini, Anne Tonkin and Elsa Jureidini, "Combination pharmacotherapy for psychiatric disorders in children and adolescents: prevalence, efficacy, risks and research needs", *Pediatric Drugs*, vol. 15, No. 5 (October 2013).

[36] See Joseph M. Rey, Tolulope T. Bela-Awusah and Jing Liu, "Depression in children and adolescents" in *Textbook of Child and Adolescent Mental Health*, Joseph M. Rey, ed. (Geneva, International Association for Child and Adolescent Psychiatry and Allied Professions, 2015).

[37] See Human Rights Watch. "'Fading away': how aged care facilities in Australia chemically restrain older people with dementia" (2019).

[38] See Roberto Mezzina and others, "The practice of freedom: human rights and the global mental health agenda" in *Advances in Psychiatry*, Afzal Javed and Kostas N. Fountoulakis, eds. (Cham, Switzerland, World Psychiatric Association/Springer Publishing, 2019).

IV. Rights-based approaches to alternatives: defining features, foundational principles and the application of a normative framework

50. The Special Rapporteur has frequently been approached by mainstream service providers, lawyers, judicial officials and policymakers about how practically to promote the rights of those in the most vulnerable situations without coercion. "What is the alternative?" is a familiar question in these exchanges. What seems largely absent from global and national discussions is the promise of many alternatives in place around the world, often operating on the fringes of health systems or entirely outside them, which have for decades been transforming lives without coercion and within the community.

51. The Special Rapporteur has visited many of these "alternatives", meeting inspiring innovators working tirelessly and often against insurmountable systemic obstacles. These peer workers, health professionals (including progressive psychiatrists), social workers and human rights defenders are to be commended for their conviction in plotting a course away from coercive medicalization towards humane, compassionate and rights-based support for those experiencing serious psychic distress. The Special Rapporteur expresses his solidarity with and gratitude and admiration for the many individuals working worldwide who contribute every day to moving the global community towards the elimination of discriminatory practices in mental health care.

A. Scaling up alternatives as a core obligation under the right to health

52. The right to health contains the core obligation to ensure the "right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups".[39] While many people have found support and healing from traditional mental health services, there are many who have not. Those who have been failed or harmed by mental health systems (including people struggling with serious psychosocial difficulties, often at the intersection of trauma, abuse, being young, being from an ethnic or racial minority, or in situations of poverty) must be viewed as belonging to a vulnerable or marginalized group. They are left furthest behind by absent or inappropriate, biomedically dominant, mental health systems in different resource settings. States, therefore, have an immediate obligation under the right to health to take action to ensure the availability of appropriate and acceptable services and rights-based support. That requires the immediate scaling-up of rights-based, non-coercive alternatives.

53. Prioritization around so-called mild (common) mental health conditions, which has been advanced by international financial institutions and global health actors, is insufficient for meeting core obligations on the right to health. The starting point for a rights-based transformation must be to address the crisis of those left languishing in coercive health systems and those entering mental health systems with intellectual, cognitive or psychosocial disabilities and unable to access community-based support because the alternatives remain woefully underinvested and unavailable.

B. Alternatives models of mental health services as human rights in practice: key concepts and principles of rights-based support

54. Such alternative practices with transformative potential have been in existence for decades, with many shown to be effective. They take many shapes and forms, from the commendable global work of WHO with its QualityRights initiative on improving the quality of mental health care and services, to systems-level community health reforms in Brazil and Italy, to highly localized innovations in different resource settings around the world, such as Soteria House, Open Dialogue, peer-respite centres, medication-free wards,

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

recovery communities and community development models.[40] A quiet revolution has been occurring in neighbourhoods and communities worldwide. At the root of these alternatives is a deep commitment to human rights, dignity and non-coercive practices, all of which remain an elusive challenge in traditional mental health systems too heavily reliant on a biomedical paradigm.

55. By labelling these innovations as "alternatives", it paradoxically renders them easier to ignore as not a part of mainstream efforts to transform mental health. However, such alternatives are essential to the transformation required to support the right to mental health globally. As such, there is a need to shift the language around alternatives and replace it with "rights-based supports".

56. The Special Rapporteur welcomes the efforts of WHO to undertake a scoping study to gather information on promising practices that step outside the traditional biomedical framework. Attention should also be drawn to growing international networks, scholarship and platforms that serve as important outlets to disperse learning and experiences to a broader community.[41] It is vital to have more stories and experiences that highlight such innovations (and their struggles) in progress. That expands understanding beyond standard medicalized solutions to human problems. While many understand their challenges through a medical lens, many do not. It is crucial to build space for a diversity of creative approaches and experiences within and outside existing mental health systems.

57. As these innovations emerge, it is essential to establish a baseline to both guide and assess compliance with the right to health, particularly in the light of the Convention on the Rights of Persons with Disabilities. There is still far too little literature dedicated to this operational area of rights-based implementation and the Special Rapporteur calls on the international donor community to support further human rights research, which is essential to guide global, regional and national efforts to scale up rights-based support and facilitate a radical shift away from coercion. The key principles set out below are grounded in the right to health and infused by the principles of the Convention. They should be viewed as a minor contribution to rights-based frameworks aimed at furthering efforts that will guide transformative rights-based practices within existing mental health systems and beyond.

C. Key principles

Dignity and autonomy

58. At the centre of rights-based support are the dignity and well-being of those accessing and using services. People must be empowered, through adequate support if needed, to make independent and informed decisions about their lives, including their mental health care.

Social inclusion

59. Securing interpersonal, community and broader connections with society is an essential psychosocial determinant of mental health and vital to the promotion and protection of the right to mental health, including at the intervention level. Social exclusion is a universal experience for persons with intellectual, cognitive or psychosocial disabilities, which symbolizes a core obstacle to recovery and the full enjoyment of their right to mental health. Exclusion emerges from discriminatory structural factors, including harmful mental health legislation, cultures of institutional and segregated care and inherent power asymmetries in policy and clinical practice that actively undermine users of services as passive recipients of care instead of the active rights holders they are.

[40] Piers Gooding and others, *Alternatives to Coercion in Mental Health Settings: a Literature Review*, Melbourne Social Equity Institute, University of Melbourne (2018); Peter Stastny and Peter Lehmann, eds., *Alternatives Beyond Psychiatry* (Berlin, Peter Lehmann Publishing, 2007).

[41] See, for example, International Network towards Alternatives and Recovery, Mad in America, Bapu Trust Seher community mental health and inclusion program and Shaping Our Lives: a national network of service users and disabled people.

Participation

60. All people are entitled to active and informed participation in issues relating to their mental health, including at the level of care and support services. Meaningful peer involvement to support individuals accessing services is a critical component of rights-based support. For many, being "heard" is pivotal to healing in crisis and requires rights-based support that ensures that diverse, multifaceted communication methods and networks are developed and available.

Equality and non-discrimination

61. Everyone, regardless of their diagnosis, the voices they hear, the substances they use, their race, nationality, gender, sexual orientation or gender identity, or other status, is guaranteed the right to non-discrimination in accessing care and support for their mental health. However, 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.

62. Respecting the broad diversity of how human beings process and experience life, including their mental distress, is critical to ending discrimination and facilitating equity in mental health provision. The obligation to respect diversity requires establishing a diverse package of options for people seeking care and support. "One size fits all" care models (in the absence of alternatives), particularly those which favour a rigid biomedical narrative of psychosocial distress, are not considered compliant with the right to health. Peer-led initiatives, harm-reduction approaches, and co-produced models of care and support offer much promise in facilitating flexible, non-discriminatory and respectful therapeutic alternatives.

Diversity of care: acceptable and quality responses

63. In addition to the obligation that rights-based alternatives be available in sufficient numbers and accessible, they must also be acceptable and of sufficient quality.

64. Acceptable and high-quality therapeutic relationships between providers and users of services must be based on mutual respect and trust. However, trends persist in modern mental health legislation and clinical practices worldwide that still allow the proliferation of non-consensual measures. Coercion erodes trust in mental health services and cannot be viewed as aligned with a rights-based approach.

65. Any rights-based support must be respectful of medical ethics, 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.[42] It must respect the principles of medical ethics (including "first, do no harm"), choice, control, autonomy, will, preference and dignity.[43] Overreliance on pharmacological interventions and the use of institutional care is inconsistent with quality care provision.

66. Quality, rights-based supports require the use of evidence-based practices for treatment and recovery, particularly through continuity of care. 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 over-prescription of psychotropic medications and the use of coercion and forced admissions, compromises the right to quality care.

Underlying social and psychosocial determinants of mental health

67. States must facilitate, provide and promote conditions in which mental health and well-being can be realized; that requires the provision of interventions that can protect populations from key risk factors for poor mental health. It requires action outside the traditional health sector in homes, schools, workplaces and communities. It also requires the therapeutic focus (alongside structural efforts by duty bearers) to extend beyond the individual to social healing, community strengthening and the promotion of a healthy

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

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

society. Rights-based support must embrace that ethos at the intervention level. It is critical to ensuring that immediate social, psychosocial and material needs become central components in supporting recovery.

D. Accountability for systems transformation

68. Accountability is a core normative principle for supporting rights-based implementation, but has thus far failed to deliver on its emancipatory and transformative potential in the area of mental health. Far from holding duty bearers to account for systemic failures, the work of many accountability mechanisms at the global and national levels, including monitoring mechanisms, national human rights institutions and treaty monitoring bodies, have served the cross-purpose of maintaining (albeit with improvements) existing mental health systems without significant attention paid to the egregious absence of alternatives. The Special Rapporteur calls on States, civil society and a range of accountability actors to work towards improving this paradoxical dilemma: how to ensure those within existing mental health services can live in humane conditions, while at the same time strongly asserting the legal case for large-scale systems reform and community transformation.

69. To make those key principles and concepts operational in practice, a set of critical, practical elements – essential rights-based ingredients – must be distilled at the intervention level. Attention should also be drawn to recent efforts to undertake this critical step, whereby key rights-based elements to crisis response have been developed as a foundational piece of work for local communities and stakeholders to build upon.[44]

V. Global threats and future trends

A. Mainstreaming the right to mental health in all global contexts

70. The global neglect of mental health sits entirely at odds with the right to the highest attainable standard of health, as well as the commitment in Sustainable Development Goal 3 to promote mental health and well-being. The gross neglect of mental health care and the inappropriate models of care that persist in many countries, based around segregated psychiatric institutions providing stigmatizing and human rights-unfriendly services, have rightly drawn criticism from the human rights community. However, broader contexts and social movements that are vital to mental health have often been neglected; without integrating a rights-based mental health agenda into such communities of activism, the right to health cannot be realized. Solidarity, collective activism and shared commitments to responding to global challenges are a powerful means of confronting helplessness and powerlessness, building resilience (and resistance) and promoting well-being. Having their collective voices heard is a potent antidote to power asymmetries and injustice. States must take all measures to ensure that this civic space is protected and flourishes as a key indicator for compliance with the right to health.

B. Climate change

71. As climate change intensifies, its destructive effects on the right to health, and on the environment and human rights more broadly, are being felt across the globe. Already groups in marginalized situations, including indigenous peoples, children, older persons, women, persons in situations of poverty, migrants and people with pre-existing health conditions are most at risk from climate change, which threatens to exacerbate inequalities within and between countries. Severe environmental changes have profound effects on the underlying social and environmental determinants of the right to health, such as clean air, safe drinking water, adequate housing and food, economic security, social relationships and community life.

[44] See Peter Stastny and others, “Critical elements of rights-based community supports for individuals experiencing significant emotional distress: foundations and practices”.

72. The physical health consequences of climate change have been well documented for some time. By contrast, the effects on the right to mental health have become better understood in recent years.[45] The emotional and existential realization of the magnitude of the climate problem and the often shockingly limited responses are increasingly experienced, particularly by children and young people. Mortality, owing to heat waves and climate change, disproportionately impacts people who are institutionalized.

73. The importance of the natural environment to social relationships and community life is enshrined in many national constitutions. The inextricable relationship of health and climate change is recognized in the United Nations Framework Convention on Climate Change. In the Paris Agreement, States were called upon to promote and consider the right to health in their actions to mitigate and adapt to climate change. Indeed, a rights-based approach, with mental health at its heart, can strengthen climate responses, fortify community relationships and citizen activism, and improve sustainability and well-being.

74. More work is needed to understand how threats to the environment and a lack of human engagement with the natural world may contribute to the subsequent breakdown of "human ecosystems" with the loss of social and cultural resources and damage to community life. Being able to live with concern for, and in relation to, the natural world fulfils psychological needs for "nature relatedness" and is associated with positive outcomes for attention, anger, fatigue and sadness, higher levels of well-being and lower levels of physiological stress.[46] Healthy, non-violent relationships include not only human relationships and their small and large groups, but also the relationship between humankind and nature. Climate change threatens that precious relationship and must be given more urgent attention.

75. Greater attention should also be paid to the right to mental health in the context of adaptation strategies. Where severe weather events occur, States must provide, individually and through the framework of international assistance and cooperation, timely access to high-quality, rights-based support, that is responsive to the particular needs of persons affected by severe weather events and integrated into existing primary, general health- and social care services. States must take urgent measures to restore and protect existing green spaces to support community connections with nature, explore the creative use of the environment as a way to build relationships, including with the natural world, and facilitate individual and community healing.[47] Such measures can catalyse community action for broader climate justice activism across generations, encouraging a broadening of alliances for the disability rights community and unifying movements through sustainability and resilience.

C. Digital surveillance

76. Advances in digital technology are transforming the capabilities of States, global tech giants, including Google, Facebook, Apple and Amazon, and private entities to carry out surveillance on entire populations to an unprecedented degree. By linking massive amounts of data collected from various sources, such as street cameras (with face recognition software), the administrative data of government agencies, banks, retailers, Internet searches and social media, detailed personal information can be captured and analysed without the individual's permission or awareness. That information can then be used to categorize an individual for commercial, political or additional surveillance purposes.

77. There are multiple ways in which that degree of non-transparent surveillance, carried out by either State or non-State actors, can be harmful to individual mental health and to the breakdown of trust in society and between people and the State. For example,

[45] See Katie Hayes and others, "Climate change and mental health: risks, impacts and priority actions", *International Journal of Mental Health Systems*, vol. 12, No. 28 (2018).

[46] See Daniel E. Baxter and Luc G. Pelletier, "Is nature relatedness a basic human psychological need? A critical examination of the extant literature", *Canadian Psychology*, vol. 60, No. 1 (February 2019).

[47] See Jules Pretty and others, "Improving health and well-being independently of GDP: dividends of greener and prosocial economies", *International Journal of Environmental Health Research*, vol. 26, No. 1 (2016).

State-owned databases have been linked and used to categorize people as "at risk" of committing benefit fraud or becoming a criminal. Such systems can have a chilling effect across a whole community because of their lack of transparency, and the difficulty of achieving redress if errors of identification or supposition are made leaves everyone vulnerable to their determinations.

78. When multiple sources of data are combined to rank or score individuals in society[48] with unknown infrastructure and algorithms driving the scoring, people become increasingly fearful of participating in society, not knowing who is scoring them or how. As a result, their right to liberty may be curtailed, social relationships are disabled and they are powerless to challenge the scores attributed to them. That influence on civil rights necessarily has an impact on the access to and enjoyment of social rights. The consequences for mental health and well-being, particularly how they may affect the relationship of the global community with the State and with each other, are profound and urgently require investigation and research. States and non-State actors have human rights obligations to protect the right to health, including mental health, and omnipresent surveillance, enabled by big data, is a fundamental erosion of that right.

D. Coronavirus disease (COVID-19) and its effects on mental health

79. At the time of writing the present report, the world faces a new global threat to public health: the COVID-19 pandemic, which is being addressed through concerted efforts by States and other stakeholders. Measures to contain the spread of the virus have included numerous restrictions on certain rights and freedoms. The impact of the pandemic, its effects and measures are yet to be fully explored. However, important challenges and opportunities related to mental health are expected and these should be taken into account now.

VI. Conclusions and recommendations

80. **There is no health without mental health and there is no good mental health and well-being without embracing a human rights-based approach. There is an urgent need to invest more in mental health. However, money should not be what is valued most in discussions of global health broadly and in particular mental health. There is an inherent and universal value to supporting dignity and well-being; furthermore, it is a human rights imperative.**

81. **The first two decades of the new millennium brought many promising changes to the field of mental health. Promotion of good mental health was included in the 2030 Agenda for Sustainable Development and there have been impressive worldwide initiatives in advancing all the elements of global mental health: promotion, prevention, treatment, rehabilitation and recovery.**

82. **However, despite promising trends, there remains a global failure of the status quo to address human rights violations in mental health-care systems. This frozen status quo reinforces a vicious cycle of discrimination, disempowerment, coercion, social exclusion and injustice – it is unacceptable. There is a shifting tide worldwide in how distress, treatment and support more broadly are viewed, which moves far beyond a biomedical understanding of mental health. The global status quo, its institutions and gatekeepers are falling far behind as consensus continues to fracture on how to plot the transformation ahead. Business as usual is no longer politically viable, nor is it compliant with human rights.**

83. **The call to close the treatment gap focuses largely on the "global burden of mental disorders", which comes at the expense of human rights.**[49] **That systemic imbalance leads to ineffective incentives and harmful systemic effects, which also**

[48] See Rogier Creemers, "China's social credit system: an evolving practice of control", SSRN (22 May 2018).

[49] See WHO, "Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level", EB130/9 (1 December 2011).

undermines the ethical obligation to "do no harm". The main obstacle for the realization of the right to mental health does not rest with individuals and their global burden of mental disorders, but rather in the structural, political and global burden of obstacles being produced by archaic, broken mental health systems.

84. **Those obstacles, power asymmetries in mental health care, the dominance of the biomedical model and the biased use of knowledge, need to be addressed by changes in laws, policies and practices. In particular, the dominance of medicalization in both existing and even in some "progressive" policy reforms continues to mask broader social injustices that must be confronted and addressed by the global community. Movements of service users, of persons with psychosocial disabilities, of mad people, of people who hear voices, who are rights holders in all their diversity, must be at the forefront of efforts for rights-based change. Scaling up rights-based support within and outside existing mental health systems holds much promise for the changes that are needed.**

85. **There is a common cause in this rapidly changing world. Significant global changes are afoot and the crisis in global mental health has common connections in other areas of human rights activism. Authoritarianism, late-stage neoliberalism, climate change, paternalism and the rise of big data all present risks to the enjoyment of human rights and an opportunity for coming together in solidarity to rethink and reshape social, economic and political structures to ensure a sustainable, peaceful, just and inclusive future.**

86. **The Special Rapporteur recommends that States:**

(a) **Undertake the legislative, policy and other measures required to fully implement a human rights-based approach to mental health with the inclusive participation of those with lived experience;**

(b) **Invest in rights-based research in this area to support those measures and better conceptually integrate implementation and efforts on the ground for reform;**

(c) **Integrate public health evidence, lived experience and rights-based research to guide decision-making on global and national public policy strategies. That should include prioritizing a shift away from medicalization in the development of mental health, criminal justice and public welfare-related reforms;**

(d) **Take immediate steps to implement the recommendations in Human Rights Council resolutions 32/18 and 36/13 on mental health and human rights;**

(e) **Promote mental health by increasing financial support to sustainable, cross-cutting programmes that reduce poverty, inequalities, discrimination on all grounds and violence in all settings, so that the main determinants of mental health are effectively addressed;**

(f) **Invest in child- and adolescent-friendly mental health services that are family-focused and community-based, and prevent financial and other incentives that fuel institutionalization, social exclusion and the overuse of psychotropic medication;**

(g) **Promote the principles of healthy ageing and respect for the rights of older persons to live in the community, and put in place measures, including workforce strengthening, to end the overdiagnosis and overuse of psychotropic medication.**

87. **The Special Rapporteur recommends that organizations representing the psychiatric profession, including academic medicine and psychiatry:**

(a) **Firmly establish human rights and social justice as core values when promoting mental health interventions;**

(b) **Modernize medical education and integrate mental health and human rights into medical education and research, with a special focus on the need to radically reduce coercion, over-medicalization, institutionalization, all forms of discrimination against persons with mental health conditions and other human rights violations;**

(c) **End the dismissal of alternative, rights-based support initiatives that are non-coercive and engender more dialogue as to how they too can be part of the change.**

88. **The Special Rapporteur recommends that the World Health Organization work with States through international cooperation and assistance to prioritize the following package of rights-based strategies:**

(a) **Support the development of principles and best practices to implement a rights-based approach in mental health policies and services;**

(b) **Offer support for the reform of discriminatory mental health laws and practices, including through a scaled-up roll-out of the QualityRights initiative;**

(c) **Review the current essential medicines list of mental health medications (Nos. 24.1–24.4), with a view to removing the ones for which there is no evidence of an adequate risk/benefit profile;**

(d) **Support the development of a new, holistic list of essential psychosocial and population-based interventions that are informed by evidence, supported and developed by participatory, rights-based principles and can more appropriately guide States towards full compliance with the right to health;**

(e) **Commit to consistency in human rights action across the WHO broad portfolio of work to ensure that the principles and values of the Convention on the Rights of Persons with Disabilities and the right to health enshrined in the WHO Constitution underpin and guide all technical assistance work, including developing global standards, measurements and guidelines on mental health.**