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Extreme poverty and human rights

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on extreme poverty and human rights, Olivier De Schutter, in accordance with Human Rights Council resolution 44/13.

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Report of the Special Rapporteur on extreme poverty and human rights, Olivier De Schutter

The burnout economy: poverty and mental health

Summary

In the present report, the Special Rapporteur on extreme poverty and human rights, Olivier De Schutter, identifies the mechanisms that expose people in poverty to a heightened risk of mental health conditions, and he examines how, despite the extraordinary resilience of many people in poverty, mental health issues can perpetuate poverty. He calls upon States to move from a biomedical approach to mental health, which treats it as a problem of the individual, to an approach that addresses its social determinants. In order to combat the global tide of depression and anxiety, more should be done to fight poverty and inequality, and to address economic insecurity.

In addition to increasing investments in mental health care, the Special Rapporteur identifies addressing the psychosocial risks caused by the casualization of labour, strengthening social protection by providing an unconditional basic income, destigmatizing mental health conditions and facilitating access to green spaces in order to reconnect with nature, as priority interventions. The vicious cycles connecting poverty to mental health problems are the price we pay for the current focus on stimulating competition and performance. In a society obsessed with increasing total economic output, these cycles can be broken, provided we put well-being above the endless quest for economic growth.

I. Introduction

1. In his most recent report to the Human Rights Council, the Special Rapporteur on extreme poverty and human rights called for expanding the toolbox against poverty in order to identify how the eradication of poverty could be made less dependent on increasing economic output, measured as the gross domestic product (GDP). He noted that the obsessive quest for increasing GDP, what he described as "growthism", could become counterproductive. Beyond a certain point in the development process, or when economic growth is extractive and exploitative, its negative impacts outweigh its benefits: as societies become more affluent in general, environmental pressures increase and consumption patterns change, resulting in new forms of social exclusion and inequalities (A/HRC/56/61).

2. One of the reasons why growth can become "uneconomic" is that the focus on increasing material consumption and on competition threatens mental health.[1] In the present report, the Special Rapporteur explores the vicious cycles that exist between poverty and poor mental health. Poverty causes mental health conditions, which in turn constitutes an obstacle to escape from poverty. In order to understand how these cycles can be broken, we need to understand how they work.

3. The World Health Organization (WHO) defines mental health as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community".[2] WHO recalls that mental health is "a basic human right" that is "crucial to personal, community and socioeconomic development".[3] Today, however, 970 million people globally (11 per cent of the world's population) live with a mental health condition,[4] over 280 million people worldwide suffer from depression and 301 million people face anxiety.[5] Every year, 700,000 people commit suicide, which is the fourth leading cause of death in young people aged 15–29 years.[6] The prevalence of depression and anxiety increased by 25 per cent during the first year of the coronavirus disease (COVID-19) pandemic, moreover, due to increased social isolation and economic fears.[7] Climate change and related disruptions, as well as biodiversity loss and pollution, may further worsen mental health outcomes.[8]

4. The implications of the increase in mental health issues are huge both for individuals and for societies as a whole. Globally, mental health conditions cause losses of $1 trillion annually, with depression being the leading cause of ill-health and disability; the returns on investing in treating depression and anxiety would therefore be considerable.[9] In countries members of the Organisation for Economic Co-operation and Development (OECD), between one third and one half of all new disability benefit

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[1] 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); and Byung-Chul Han, *Burnout Society* (Stanford, Stanford University Press, 2015).

[2] World Health Organization (WHO), "Mental health", 17 June 2022.

[3] Ibid.

[4] See www.who.int/health-topics/mental-health#tab=tab_2.

[5] See www.who.int/observatories/global-observatory-on-health-research-and-development/analyses-and-syntheses/mental-health/global-strategic-direction.

[6] WHO, *Suicide Worldwide in 2019* (Geneva, 2021), pp. 4 and 7.

[7] WHO, "Mental health and COVID-19: early evidence of the pandemic's impact", 2 March 2022.

[8] United for Global Mental Health, "The impact of the triple planetary crisis on mental health in low and middle-income countries", 2024.

[9] See www.who.int/observatories/global-observatory-on-health-research-and-development/analyses-and-syntheses/mental-health/global-strategic-direction; and (for estimates), Dan Chisholm and others, "Scaling-up treatment of depression and anxiety: a global return on investment analysis", *The Lancet: Psychiatry*, vol. 3, No. 5 (May 2016).

claims are for mental health reasons, and among young adults it was estimated to go up to over 70 per cent.[10]

5. As a result, the prescription of psychiatric drugs has increased exponentially, as if the problem were only attributable to the chemical imbalances of the brain or limited to individual suffering. However, while it can help to reduce blame and serves pharmaceutical companies, this biomedical approach distracts from more systemic solutions.[11] Rather than to the functioning of neurotransmitters, such as serotonin and dopamine, the mental health pandemic is attributable to the increased pressures towards higher productivity and the constant quest for more.[12]

II. Mental health conditions and decision-making under scarcity

6. Since the present report addresses the links between poverty and mental health, the focus is different from the separate, but related, issue of the constraints in decision-making that people in poverty might encounter.

7. People facing scarcity find themselves in a paradoxical situation.[13] On the one hand, scarcity leads them to focus on what matters most to fulfil their needs, for instance paying attention to prices or to opportunities to reduce avoidable expenses; and to make more consistent choices aimed at paying less, they are, in that sense, "hyperrational" and skilled at comparing options. On the other hand, however, scarcity may operate as a "cognitive tax", making it more difficult for people facing scarcity to make the choices that would serve them best; and it may result in a tendency to neglect a wider range of options, to focus too much on the short-term, or to be excessively risk-averse, leading to decisions different from those more privileged people would take.

8. Strictly speaking, the impacts of scarcity on cognitive bandwidth and on the ability to make fully reasoned choices, that do not excessively discount long-term impacts, are separate from the mental health impacts of poverty. The argument of the authors having studied decision-making under scarcity is not that "poor people have less bandwidth", it is instead that "all people, if they were poor, would have less effective bandwidth".[14] This distinction matters. Not all failures to make the right decisions by people living in poverty can be attributed to the mental health impacts of poverty; some are attributable to poverty itself, which leads the person facing scarcity to a particular framing of the situation in which they find themselves.

9. At the same time, such failures in decision-making may fuel negative stereotypes against people in poverty (what the Special Rapporteur labelled "povertyism" in an earlier report (A/77/157)), which in turn can lead, at best, to paternalism, and, at worse, to discrimination. Moreover, the impacts of failed

[10] Organisation for Economic Co-operation and Development (OECD), *Sick on the Job? Myths and Realities about Mental Health and Work* (Paris, 2012).

[11] See A/HRC/44/48, para. 23; and Brett Deacon and Grayson L. Baird, "The chemical imbalance explanation of depression: reducing blame at what cost?", *Journal of Social and Clinical Psychology*, vol. 28, No. 4 (April 2009).

[12] See A/HRC/41/34, para. 81; A/HRC/44/48, para. 9; and James Davies, *Sedated: How Modern Capitalism Created Our Mental Health Crisis* (London, Atlantic Books, 2021).

[13] Sendhil Mullainathan and Eldar Shafir, *Scarcity: The New Science of Having Less and How It Defines Our Lives* (New York, Times Books, 2013). See also, Anandi Mani and others, "Poverty impedes cognitive function", *Science*, vol. 341, No. 6149 (August 2013); and Ernst-Jan de Bruijn and Gerrit Antonides, "Poverty and economic decision-making: a review of scarcity theory", *Theory and Decision*, vol. 92 (2022).

[14] Mullainathan and Shafir, *Scarcity* (2013), p. 66.

decision-making may be similar, whether they stem from the more restricted cognitive bandwidth of people facing scarcity or whether they have their source in mental health issues, such as depression or anxiety. Finally, some policy recommendations included in this report that address the vicious cycles linking poverty to mental health are also relevant to improving the ability for people in poverty to make the right choices, despite the "cognitive tax" scarcity imposes on them.

III. How poverty and inequality cause mental health conditions

10. In 2012, when it endorsed the Guiding Principles on Extreme Poverty and Human Rights in its resolution 21/11, the Human Rights Council identified as "a clear example of the vicious circle of poverty" the mechanisms through which "persons experiencing ill health are more likely to become poor, while persons living in poverty are more vulnerable to accidents, diseases and disability".[15] Below, the Special Rapporteur describes these links, before examining how they can be addressed.

A. Proven correlations

11. The link between poverty and mental health is well-documented. A 2011 study with 35,000 adults in the United States of America found that mental conditions were more common among those making less than $40,000 per year than among those making more than $70,000.[16] Transition into poverty causes more than 6 per cent of common mental health conditions among the working-age population in the United Kingdom of Great Britain and Northern Ireland.[17] And the relationship is also strong in low- and middle-income countries.[18]

12. The reasons for this link are obvious. People living on low incomes generally contact psychiatric services later than those from higher income households, both because of limited access to such services and because they may be less well-informed about whatever services are available and affordable.[19] Yet, the economic insecurity they experience is a permanent source of stress, detrimental to mental well-being: the WHO comprehensive mental health action plan 2013–2030, updated in 2021, identifies households living in poverty among the vulnerable groups most likely to experience mental health problems.[20] Moreover, there is a correlation between education levels and income and better education generally translates into better physical and mental health.[21]

13. More than absolute poverty or material deprivation as such, however, it is relative poverty or inequality, as well as economic insecurity, that cause mental

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[15] Guiding Principles on Extreme Poverty and Human Rights, para. 81.

[16] Jitander Sareen, Tracie O. Afifi and Katherine A. McMillan, "Relationship between household income and mental disorders: findings from a population-based longitudinal study", *Archives in General Psychiatry*, vol. 68, No. 4 (April 2011).

[17] Rachel M. Thomson and others, "Effects of poverty on mental health in the UK working-age population: causal analyses of the UK Household Longitudinal Study", *International Journal of Epidemiology*, vol. 52, No. 2 (April 2023).

[18] Crick Lund and others, "Poverty and common mental disorders in low and middle income countries: a systematic review", *Social Science and Medicine*, vol. 71, No. 3 (August 2010).

[19] Vijaya Murali and Femi Oyebode, "Poverty, social inequality and mental health", *Advances in Psychiatric Treatment*, vol. 10, No. 3 (2004).

[20] See para. 10 of the action plan.

[21] Clive R. Belfield and Henry M. Levin, *The Price We Pay: Economic and Social Consequences of Inadequate Education* (Washington, D.C., Brookings Institute Press, 2007).

conditions.[22] A sample of 43,824 respondents collected by the European Social Survey 2006–2007 in 23 European countries found that individuals in countries with greater income inequalities reported more symptoms of depression, although this could be mitigated by coping resources, such as social support, self-esteem and optimism.[23] In 2009, depression was found to be the main cause of loss of healthy years of life in Mexico (affecting 6.4 per cent of the population), a phenomenon researchers related to high inequality and to the feelings of despair, fear and impotence that result from economic insecurity.[24] In the Brazilian city of São Paulo, living in areas with medium and high income inequality increases the risk of depression, relative to low-inequality areas.[25] Similarly, a study covering 26 countries from 1975 to 2011 showed a statistically significant correlation between incidence rates for schizophrenia and income inequality, leading researchers to suggest that chronic stress associated with living in highly disparate societies places individuals at risk of schizophrenia because of the impacts of income inequality on social cohesion and on the erosion of social capital.[26] Another cross-country comparison covering 50 countries and 249,217 individuals showed that various forms of psychoses (leading to hallucinations, delusions of thought control and delusional mood) are correlated with income inequality, controlling for average income per capita.[27]

14. Various explanations have been proposed to link income inequality to mental conditions in general, and to depression in particular. Based on data from the European Quality of Life Survey containing information from 30 countries and over 35,000 individuals, researchers concluded that the chief reason for this link is that social capital (what binds people together) is higher in more equal countries.[28] Indeed, social capital provides a more supportive environment to individuals, thus allowing them to cope better with stress. It allows communities to resort to collective action in order to hold governments accountable and, as a result, to improve the provision of health-care services. Social capital may also help to reduce risky behaviours, such as addictions.[29] Another reason for inequality being linked to mental conditions is because it may increase status anxiety, the fear of falling behind, and, therefore, levels of stress.[30] In 2007, a cross-national survey of more than 34,000 individuals carried

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[22] Richard G. Wilkinson and Kate Pickett, *The Spirit Level: Why More Equal Societies Almost Always do Better* (London, Penguin Books, 2009); Wagner Silva Ribeiro and others, "Income inequality and mental illness-related morbidity and resilience: a systematic review and meta-analysis", *The Lancet: Psychiatry*, vol. 4, No. 7 (2017); and A/HRC/41/34, para. 41.

[23] Ioana van Deurzen, Erik van Ingen and Wim J.H. van Oorschot, "Income inequality and depression: the role of social comparisons and coping resources", *European Sociological Review*, vol. 31, No. 4 (August 2015).

[24] Shoshana Berenzon, Hector Sentíes and Elena Medina-Mora, "Mental health services in Mexico", *International Psychiatry*, vol. 6, No. 4 (October 2009).

[25] Alexander Dias Porto Chiavegatto Filho and others, "Does income inequality get under the skin? A multilevel analysis of depression, anxiety and mental disorders in Sao Paulo, Brazil", *Journal of Epidemiology and Community Health*, vol. 67, No. 11 (2013).

[26] Jonathan K. Burns, Andrew Tomita and Amy S. Kapadia, "Income inequality and schizophrenia: increased schizophrenia incidence in countries with high levels of income inequality", *International Journal of Social Psychiatry*, vol. 60, No. 2 (March 2014).

[27] Sheri L. Johnson, Erol Wibbels and Richard Wilkinson, "Economic inequality is related to cross-national prevalence of psychotic symptoms", *Social Psychiatry and Psychiatric Epidemiology*, vol. 50 (2015).

[28] Richard Layte, "The association between income inequality and mental health: testing status anxiety, social capital, and neo-materialist explanations", *European Sociological Review*, vol. 28, No. 4 (August 2012).**Error! Hyperlink reference not valid.**

[29] Ichiro Kawachi and Lisa F. Berkman, "Social capital, social cohesion, and health", in *Social Epidemiology*, Lisa F. Berkman, Ichiro Kawachi and M. Maria Glymour, eds. (Oxford, Oxford University Press, 2000).

[30] Richard G. Wilkinson, "Health, hierarchy, and social anxiety", *Annals of the New York Academy of Sciences*, vol. 896, No. 1 (December 1999).

out in 31 European countries showed that status anxiety was highest in the more unequal countries at all points on the income rank curve.[31]

15. In sum, while GDP growth per capita increases life satisfaction in low-income countries, beyond a certain level of average affluence it is income inequality that matters the most. Indeed, the richer the country is on average, the more distribution of income across population groups explains mental health outcomes. It then operates like a "virus", affecting all the population negatively (as it is associated with more mental conditions and drug use), and not only the lowest income groups.[32]

16. The respective roles of extreme deprivation (absolute poverty) and high inequality (relative poverty) in explaining mental health issues will vary from country to country, not least because how inequalities are perceived and whether they are seen as a failure of the individual or instead as a challenge for society as a whole may be a major explanatory factor.[33] In addition, these two explanations are not mutually exclusive: while inequality increases the risks of mental health conditions across all groups of society, people in poverty may be the most vulnerable, because of their more limited access to health care and because they may have fewer supportive networks, as poverty can increase social isolation.

B. Manufacturing insecurity: employment and social protection

17. Changes in the world of employment and in the organization of social security play a major role in the increase of mental health conditions, particularly affecting people living on low incomes.

18. What these factors have in common is that they are associated with the quest for competitiveness and, in the name of innovation, a form of acceleration of life which results in an insecure environment.[34] Individuals are recruited into a fearful competition against each other, and the most politically disempowered and economically disenfranchised face the heaviest "allostatic loads", i.e. bodily reactions to the stress of having to cope with insecurity.[35]

19. People literally age faster as a result of the stress from uncertainty, conflict and competition, lack of control and lack of information.[36] These impacts are measurable: during the financial crisis of 2009–2011, young adults in Greece faced significantly higher levels of depression and anxiety than young adults in Sweden, to the point that hair samples showed that the protective response to stress (the production of cortisol) was debilitated among the former group.[37] Stress-hormone levels among children

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[31] Richard Layte and Christopher T. Whelan, "Who feels inferior? A test of the status anxiety hypothesis of social inequalities in health", *European Sociological Review*, vol. 30, No. 4 (August 2014).

[32] Leandre Bouffard and Micheline Dubé, "Mental income inequality: a 'virus' which affects health and happiness", *Santé mentale au Québec*, vol. 38, No. 2 (Autumn 2013).

[33] In South Africa, cross-district comparisons did not show a correlation between depression and inequality levels, although this may be because inequality is rather high in all districts. See Kafui Adjaye-Gbewonyo and others, "Income inequality and depressive symptoms in South Africa: a longitudinal analysis of the National Income Dynamics Study", *Health and Place*, vol. 42 (November 2016).

[34] David Stuckler and others, "The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis", *The Lancet*, vol. 374, No. 9686 (July 2009).

[35] Gabor Maté and Daniel Maté, *The Myth of Normal: Illness, Health and Healing in a Toxic Culture* (London, Penguin Books, 2022), p. 276.

[36] E. Ronald De Kloet, "Corticosteroids, stress, and aging", *Annals of the New York Academy of Sciences*, vol. 663, No. 1 (November 1992).

[37] Åshild Faresjö and others, "Higher perceived stress but lower cortisol levels found among young Greek adults living in a stressful social environment in comparison with Swedish young adults", *PLoS One*, vol. 8, No. 9 (2013).

from low-income households in Canada were found to be much higher than average, a sign that parental stress from economic insecurity has biological impacts on children.[38]

1. The new world of work

Economic insecurity

20. Economic shocks have a major impact on the rates of depression and suicide. In India, for temperatures above 20°C, a 1°C rise causes about 70 additional suicides per day, in particular during the agricultural growing season, since such climate shocks lead to a loss of harvests.[39] In Indonesia, reduced agricultural output and income as a result of extreme rainfall caused increased rates of depression and suicide among farmers; cash transfers could mitigate such impacts.[40]

21. In more advanced economies, economic insecurity caused by globalization and economic restructuring is a major cause of psychological distress, affecting disproportionately people in poverty or those who are most at risk of falling into poverty: those facing such insecurity seek comfort in the use of drugs or alcohol and they run a higher risk of committing suicide – they are the "deaths of despair" described by Anne Case and Angus Deaton, who note how working-class white men without a college degree are especially affected.[41] A study on plant closures in Austria between 1999 and 2001 showed that men significantly increased expenditures on antidepressants and related drugs, as well as for hospitalizations owing to mental health problems.[42] Similarly, researchers who assessed the impacts of increased global competition on the counties in the United States most exposed (where the risks of closures of industrial plants was higher) reported higher rates of suicide and related causes of death, especially in white males, from that change.[43]

Unemployment and underemployment

22. Mental health conditions are also strongly associated with unemployment. As far back as 60 years ago, it was shown that unemployment in Great Britain almost quadrupled the likelihood of substance abuse and drug dependence (even after controlling for other sociodemographic variables), and more than doubled the odds of depression, anxiety and obsessive-compulsive disorder.[44] More recent studies confirm this association,[45] especially since unemployment is often associated with

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[38] Sonia J. Lupien and others, "Child's stress hormone levels correlate with mother's socioeconomic status and depressive state", *Biological Psychiatry*, vol. 48, No. 10 (November 2000).

[39] Tamma A. Carleton, "Crop-damaging temperatures increase suicide rates in India", *Proceedings of the National Academy of Sciences*, vol. 114, No. 33 (2017).

[40] Cornelius Christian, Lukas Hensel and Christopher Roth, "Income shocks and suicides: causal evidence from Indonesia", *The Review of Economics and Statistics*, vol. 101, No. 5 (December 2019).

[41] Anne Case and Angus Deaton, *Deaths of Despair and the Future of Capitalism* (Princeton University Press, 2020).

[42] Andreas Kuhn, Rafael Lalive and Josef Zweimüller, "The public health costs of job loss", *Journal of Health Economics*, vol. 28, No. 6 (December 2009).

[43] Justin R. Pierce and Peter K. Schott, "Trade liberalization and mortality: evidence from US counties", *American Economic Review: Insights*, vol. 2, No. (1) (March 2020). Specifically, the research assessed the impacts of the granting of Permanent Normal Trade Relations (PNTR) to China in October 2000, a change that differentially exposed U.S. counties to increased international competition via their industry structure.

[44] Howard Meltzer, Nicola Singleton and Alison Lee, *Psychiatric morbidity among adults living in private households, 2000: technical report*. Her Majesty's Stationery Office (2002).

[45] Paula Acevedo, Ana I. Mora-Urda and Pilar Montero, "Social inequalities in health: duration of unemployment unevenly effects on the health of men and women", *European Journal of Public Health*, vol. 30, No. 2 (April 2020).

reduced social participation.[46] Indeed, a study covering 3,170 respondents in New Haven, Connecticut, United States, showed that the effects of poverty were substantially reduced when controlling for degree of isolation from friends and family. This suggests that rather than the loss of income alone associated with unemployment, it is the resulting social isolation that explains the relationship between social and physical statuses and major depression.[47]

23. Whether or not unemployment increases the risk of depression significantly depends, however, on the nature of the compensation provided. Whereas the risk does not increase significantly when the unemployed receives unemployment compensation or benefits from other entitlement programmes based on social insurance (deriving from prior earnings and work history), the index of depression is much higher among unemployed persons receiving welfare benefits or no benefits.[48] A study on 4,842 participants (between 18 and 65 years old) from Germany from 2011 to 2014 showed unemployment to be a risk factor for impaired mental health where the unemployed receive means-tested social benefits, even adjusting for differences in sociodemographic factors, net personal income and risk of social isolation.[49] This may be owing to the stigmatizing impacts of social assistance, which is associated with images of laziness, dependency and unwillingness to work, whereas entitlement-based benefits in social insurance programmes are considered to be an "earned" right.[50] This should be seen as a warning sign, since recent welfare State reforms in developed countries have included the increased use of welfare-to-work-policies, reduced population coverage of unemployment benefits, stricter entitlement criteria and more obligations for fulfilling unemployment benefits.

24. Underemployment, being forced to work part-time because of a lack of full-time jobs, also increases the likelihood of psychological distress. A British Household Panel Survey covering more than 8,000 individuals over a period of 18 years showed that transitioning from full-time employment to underemployment leads to an increase in distress levels, only 10 per cent of which could be explained by job earnings and perceptions of job security: the key explanatory factor was instead the individuals' feeling that their contribution to society was not sufficiently valued.[51]

Mental health risks at work

25. Employment itself entails a range of psychosocial risks. Such risks are magnified by the post-Fordist organization of work. High workload and pressures to improve productivity at work, as well as a lack of control over task performance, are associated with increased stress and ill-health.[52] Indeed, some studies suggest that

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[46] Lars Kunze and Nikolai Suppa, "Bowling alone or bowling at all? The effect of unemployment on social participation", *Journal of Economic Behavior and Organization*, vol. 133 (January 2017).

[47] M. L. Bruce and R. A. Hoff, "Social and physical health risk factors for first-onset major depressive disorder in a community sample", *Social Psychiatry and Psychiatric Epidemiology*, vol. 29, No. 4 (1994).

[48] E. Rodriguez, K. Lasch and J. P. Mead, "The potential role of unemployment benefits in shaping the mental health impact of unemployment", *International Journal of Health Services: Planning, Administration, Evaluation*, vol. 27, No. 4 (1997).

[49] Andrea E. Zuelke and others, "The association between unemployment and depression – results from the population-based LIFE-adult-study", *Journal of Affective Disorders*, vol. 235 (August 2018).

[50] Clare Bambra, "Yesterday once more? Unemployment and health in the 21st century", *Journal of Epidemiology and Community Health*, vol. 64, No. 3 (March 2010).

[51] Victoria Mousteri, Michael Daly and Liam Delaney, "Underemployment and psychological distress: propensity score and fixed effects estimates from two large UK samples", *Social Science and Medicine*, vol. 244, No. 112641 (January 2020).

[52] Ted Schrecker and Clare Bambra, *How Politics Makes Us Sick: Neoliberal Epidemics* (Springer, 2015), p. 53.

having a poor-quality job (with limited levels of control, high demands and complexity, job insecurity and unfair pay) leads to even worse mental health outcomes than being unemployed.[53]

26. The 2022 WHO guidelines on mental health at work identified such risks, which may result from how work is designed (fragmented or meaningless work, and work in which skills are underused, increase the risks), workload and time pressures, work schedules, lack of control in the work organization, poor environmental conditions of work, organizational culture, interpersonal relationships at work (including social or physical isolation, bullying, harassment or microagressions), how roles are defined at work, career development, or a limited ability to combine work and personal life or to have dual careers.

27. While all these psychosocial risks should be considered, work scheduling in particular stood out in the consultations led by the Special Rapporteur in preparation of this report. In an increasingly tertiary economy operating on a 24/7 basis, in which precarious work and the "just-in-time" organization of the production process become the norm, and in which work schedules are determined by workforce management algorithms to closely align staffing with demand, schedules are increasingly unstable and unpredictable, with variable work hours, short advance notice of weekly schedules, and frequent last-minute changes to shift timings. In 2014, 54 per cent of workers paid by the hour in the United States received less than two weeks' advance notice of their work schedule, and 41 per cent received less than one week's notice.[54]

28. This unpredictability increases household economic insecurity. It also leads to more work-life conflicts,[55] to diminished sleep quality and to increased psychological distress. A survey of 27,792 retail and food service workers employed at 80 large companies across the United States in 2016–2017 showed a strong relationship between variable work schedules or rotating schedules and psychological distress. Workers with fewer than three days' notice and workers with just three to six days' notice fared significantly worse than those with more than two weeks' advance notice of their schedules, especially where workers have no control over the working schedules. Similarly, the survey respondents who worked a variable schedule expressed reduced life satisfaction compared with those who worked a regular day shift, and those with zero or just a few days of advance notice were significantly less happy than those with at least one week's notice. Remarkably, the impacts of variable and unpredictable work schedules on psychological distress, sleep quality and happiness were even more significant than the impacts of low incomes. Although part of the mental health impacts of variable and unpredictable work schedules are attributable to greater household economic insecurity (as weekly and monthly incomes will vary depending on the number of hours worked), the main explanation for these impacts is the difficulties such work scheduling practices have on the worker's ability to combine work and private life – i.e. to be present for the family, to adequately deal with family or personal problems, or to handle family needs.[56]

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[53] P. Butterworth and others, "The psychosocial quality of work determines whether employment has benefits for mental health: results from a longitudinal national household panel survey", *Occupational and Environmental Medicine*, vol. 68, No. 11 (November 2011).

[54] Susan J. Lambert, Peter J. Fugiel and Julia R. Henly, "Precarious work schedules among early-career employees in the US: a national snapshot", research brief issued by Employment Instability, Family Well-being, and Social Policy Network at the University of Chicago, 27 August 2014.

[55] Julia R. Henly and Susan J. Lambert, "Unpredictable work timing in retail jobs: implications for employee work-life conflict", *ILR Review*, vol. 67, No. 3 (July 2014).

[56] Daniel Schneider and Kristen Harknett, "Consequences of routine work-schedule instability for worker health and well-being", *American Sociological Review*, vol. 84, No. 1 (February 2019).

29. These various factors, unemployment and underemployment and the psychosocial risks at work linked to post-Fordist work restructuring, affect low-income workers the most.[57] As such, they result in a double injustice: low-waged workers not only face difficulties paying their bills, they also are at a higher risk of mental health conditions.

2. Changing social protection

30. Improving income security is essential for the prevention of mental health conditions. Some studies suggest that, even more than poverty itself, such conditions can result for changed life circumstances, such as an illness or a family separation, against which the individual is not protected.[58] There is also strong evidence that the worries and uncertainty created by economic shocks, leading to increased income volatility, or even the mere anticipation of such shocks, are a major source of depression.[59] This highlights the importance of the right to social security and of rights-based social protection floors in preventing mental health challenges: a study covering 114 million beneficiaries of the Bolsa Familia cash transfer programme in Brazil between 2004 and 2012 showed, for example, the impact of Bolsa Familia in lowering suicide rates.[60]

31. Since the 1990s, however, the pressures from globalization, the ageing of societies, in particular, in affluent countries, the destandardization of employment relations and the emergence of new social risks (primarily attributable to the acceleration of skills depletion in the face of rapid technological change) have led to significant transformations of welfare in even the most advanced economies.[61] We have witnessed a gradual merger between social assistance and unemployment assistance, as the former was made increasingly conditional upon the beneficiary actively seeking work or undergoing training for work, and as the levels and the duration of unemployment benefits were drastically lowered. There has been a "contractualization" of the relationship between job-seekers and public employment agencies, with a view to "responsibilizing" both, and the imposition of a duty to accept "suitable" employment, with a generally broadened definition of what is suitable employment, based on the idea that the job-seeker should be "flexible" and encouraged to adapt to the exigencies of the employment market. This has created insecurity in the provision of social security itself: social protection is combined with monitoring the behaviour of the beneficiary and no longer operates as a fully reliable safety net against destitution.

32. In an earlier report, the Special Rapporteur noted that excessive targeting and the imposition of strict conditionalities to receive social security benefits could result in higher rates of non-take-up, thus reducing the effectiveness of social protection in poverty reduction (A/HRC/50/38). In addition, these transformations create more insecurity, increasing the risk of mental health impacts on beneficiaries. This is illustrated, for example, by the phased introduction in the United Kingdom, between 2013 and 2018, of Universal Credit. The Universal Credit brought together six earlier schemes covering housing and living costs for people facing adversity, such as

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[57] Guy Standing, *The Politics of Time. Gaining Control in the Age of Uncertainty* (Pelican Books, 2023), p. 193.

[58] Jishnu Das and others, "Mental health and poverty in developing countries: revisiting the relationship", *Social Science and Medicine*, vol. 65, No. 3 (August 2007).

[59] Matthew Ridley and others, "Poverty, depression, and anxiety: causal evidence and mechanisms", *Science*, vol. 370, No. 6522 (December 2020).

[60] Daiane Borges Machado and others, "Relationship between the Bolsa Família national cash transfer programme and suicide incidence in Brazil: a quasi-experimental study", *PLoS Medicine*, vol. 19, No. 5 (2022).

[61] Anton Hemerijck, *Changing Welfare States* (Oxford, Oxford University Press, 2013).

unemployment, disabilities, and low-paid employment, thus rationalizing social support. It also introduced strict conditions backed up by sanctions, ostensibly to provide greater incentives for claimants to enter employment and to ensure that the receipt of benefits "maximizes claimants' responsibility and self-sufficiency".[62] Following his visit to the country in November 2018, the former Special Rapporteur expressed his fear that the Universal Credit would worsen mental health outcomes for the beneficiaries (A/HRC/41/39/Add.1, para. 47). This fear appears to now be corroborated by research: a study showed that the introduction of Universal Credit, while having no measurable effect in pushing individuals into employment, led to an increase of 6.57 percentage points of the rate of psychological distress among unemployed individuals affected by the policy.[63]

C. Nature-deficit disorders

33. A further factor putting people in poverty at higher risk of mental health issues are the barriers they may face to have frequent contacts with nature (A/HRC/41/34, para. 81).

34. In urban settings, children from low-income backgrounds generally have reduced access to green areas. This may be owing to the fact that they live in impoverished urban environments, which lack green areas, or where existing parks lack amenities, such as restrooms, are less aesthetically pleasing, are unsafe, or do not include wooded areas. It may also be owing to financial obstacles: leisure activities conducted in the natural world may be unaffordable for children in low-income households.

35. Yet, the proximity of gardens and public parks and more frequent contact with nature results in improved cognitive functioning of adolescents, including improved attention, memory, cognitive performance, and cognitive development, reducing stress, anxiety, and symptoms of depression.[64] as well as behaviour and social problems, such as attention deficit and hyperactivity disorder.[65] Thus, improving access to green spaces – one element of creating more equigenic environment – may benefit children's prosocial behaviours, with particularly important effects among lower-income children.[66]

IV. How mental health conditions push people into poverty

36. Some of the ways in which mental health conditions may lead to and entrench poverty are obvious enough. Discriminatory attitudes in the workplace and a failure to provide reasonable accommodation, put people with mental health conditions at a higher risk of unemployment. In OECD countries, people with a severe mental health

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[62] United Kingdom of Great Britain and Northern Ireland, National Audit Office, *Rolling out Universal Credit* (London, 2018).

[63] Sophie Wickham and others, "Effects on mental health of a UK welfare reform, universal credit: a longitudinal controlled study", *The Lancet: Public Health*, vol. 5, No. 3 (March 2020).

[64] Michelle C. Kondo and others, "A greening theory of change: how neighborhood greening impacts adolescent health disparities", *American Journal of Community Psychology*, vol. 73, Nos. 3–4 (June 2024).

[65] Richard Louv, *Last Child in the Woods: Saving our Children from Nature-Deficit Disorder* (Algonquin Press, 2005); and Katherine D. Arbuthnott, "Nature exposure and social health: prosocial behavior, social cohesion, and effect pathways", *Journal of Environmental Psychology*, vol. 90 (September 2023).

[66] Paul McCrorie and others, "Neighborhood natural space and the narrowing of socioeconomic inequality in children's social, emotional, and behavioural well-being", *Well-Being, Space and Society*, vol. 2 (2021).

condition are 6 to 7 times more likely to be unemployed than people without a severe mental health condition, and those with a common mental health condition 2 to 3 times.[67] In Finland, a nationwide cohort study covering more than 2 million individuals during the period from 1988 to 2015 showed that being diagnosed with a mental health condition between the ages of 15 and 25 was a strong predictor of not being employed and not having any secondary or higher education between the ages of 25 and 52, as well as a predictor of having lower earnings.[68] Depression among the unemployed is also associated with lower rates of re-employment, especially as such depressive states lead to a loss of social connections.[69]

37. People with mental health conditions are also routinely excluded from the mainstream education system.[70] They are disproportionately at risk of being homeless or of being incarcerated. In sum, they face a range of human rights violations, despite the protection afforded to them by the Convention on the Rights of Persons with Disabilities.

38. There is also a self-reinforcing loop between mental health, physical health and unemployability. Depression, for example, predisposes people to myocardial infarction and diabetes, both of which increase the likelihood of depression, making it more difficult for the people affected to find work,[71] while at the same time exposing them to financial distress owing to the costs of treatment. People in poverty are also more likely to adopt risky behaviours, including addictions, as a way to cope and seek relief from stressful lives.[72] Such behaviours can, in turn, cause physical health problems which lower work productivity and diminish life expectancy.

39. The stigma associated with a mental health condition makes things worse. A Lancet Commission report involving 50 experts and co-produced with people with lived experience of public health conditions identified four different forms through which stigma operates: (a) self-stigma, which occurs when people with mental health conditions become aware of the negative stereotypes of others and turn them against themselves; (b) stigma by association, which directs stigma against family members or carers; (c) public and interpersonal stigma, which refer to the negative stereotypes and adverse treatment by members of society towards people with mental health conditions; and, (d) institutional stigma, which refers to policies and practices that work to the disadvantage of people with mental health conditions.[73]

40. These various forms of stigma have an impact on all aspects of life. They affect self-esteem and the ability to develop social relationships. They limit access to employment and housing. They discourage individuals from seeking help, because of the fear of being labelled as having a mental health condition.[74] Moreover, negative

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[67] OECD, Sick on the Job?, p. 39.

[68] Christian Hakulinen and others, “Mental disorders and long-term labour market outcomes: nationwide cohort study of 2 055 720 individuals”, *Acta Psychiatrica Scandinavica*, vol. 140, No. 4 (October 2019).

[69] Natalia Wege, Peter Angerer and Jian Li, “Effects of lifetime unemployment experience and job insecurity on two-year risk of physician-diagnosed incident depression in the German working population”, *International Journal of Environmental Research and Public Health*, vol. 14, No. 8 (2017).

[70] On the right to quality inclusive education, see article 24(1) of the Convention on the Rights of Persons with Disabilities; and on the right to inclusive education adopted by the Committee on the Rights of Persons with Disabilities, see general comment No. 4 (2016).

[71] See para. 12 of the WHO comprehensive mental health action plan 2013–2030.

[72] Vijaya Murali and Femi Oyebode, “Poverty, social inequality and mental health”, *Advances in Psychiatric Treatment*, vol. 10, No. 3 (May 2004).

[73] Graham Thornicroft and others, “The Lancet Commission on ending stigma and discrimination in mental health”, *The Lancet*, vol. 400, No. 10361 (October 2022).

[74] Matthias C. Angermeyer and H. Matschinger, “The stigma of mental illness: effects of labelling on public attitudes towards people with mental disorder”, *Acta Psychiatrica Scandinavia*, vol. 108, No. 4 (October 2003); and Patrick W. Corrigan, “How clinical diagnosis might exacerbate the stigma of mental illness”, *Social Work*, vol. 52, No. 1 (January 2007).

stereotypes against people with a mental health condition can explain the unwillingness of public policymakers to invest in mental health.

41. People in poverty thus face a triple threat: they are economically disadvantaged; as a result of the financial stress they face, they are disproportionately affected by mental health conditions, with limited access to preventive and curative care; and they also suffer the stigma associated with the condition.

V. Breaking the vicious cycles

42. We have encouraged growth-obsessed societies, pressuring individuals to compete and to improve their performance, thus manufacturing status anxiety and pushing people into depression when they can't meet unrealistic expectations of what it means to live a productive life. We should instead move to designing care-obsessed societies, that provide economic security and help all individuals gain a sense of self-esteem and worthiness. The Special Rapporteur identifies four priority actions in this regard.

A. Investing in mental health care

43. Increasing investment in mental health care should be a first step. While not a substitute for poverty alleviation, such investment can have major effects on mental, neurological and substance misuse conditions, with significantly improved economic outcomes.[75] In other terms, mental health care is a major tool for human development. Investing in mental health may seem costly, but the costs of inaction are much higher in lost productivity at work and in anti-depressants.

44. The budget allocations going to mental healthcare remain grossly insufficient. On average, States dedicate only 2.1 per cent of their health expenditures to mental health, and the percentage is even lower in low- and middle-income countries. While globally the median number of mental health workers is 13 per 100,000 population, this figure varies enormously, from below two workers per 100,000 population in low-income countries to over 60 in high-income countries. And whereas there are only 0.11 community-based mental facilities for every 100,000 inhabitants in low-income countries, there are 5.1 such facilities for every 100,000 inhabitants in high-income countries.[76] According to WHO, 76 to 85 per cent of people with severe mental health conditions receive no treatment for their condition in low-income and middle-income countries, while this is the case for 35 to 50 per cent of people in high-income countries. Spending on mental health is not only too low (the global annual average is less than $2 per person and it is less than $0.25 per person in low-income countries), it is also allocated to the wrong things: 67 per cent of the resources go to stand-alone mental hospitals, despite this being widely recognized as an ineffective way to address the problem.[77]

45. While the WHO comprehensive mental health action plan 2013–2030 sets a number of targets for countries, these targets will for the most part not be met,[78] and the objective of universal health as set out under target 3.8 of the Sustainable Development Goals remains a distant dream. When the Sustainable Development Goals were adopted, only one in five people in high-income countries and one in 27

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

[76] WHO, *Mental Health Atlas 2020* (Geneva, 2021).

[77] See para. 14 of the action plan; see also A/HRC/41/34, para. 21.

[78] WHO, *World Mental Health Report: Transforming Mental Health for All* (Geneva, 2022).

in countries in low- and lower-middle-income countries received at least minimally adequate treatment for major depressive conditions.[79] It is against this background that WHO launched a special initiative for mental health in 2019, in order to close the gap.[80] Yet, despite these pledges and initiatives such as the WHO mental health gap action programme, in most low-income countries, three out of four people do not have access to the treatment they need.[81]

46. In part, low spending on mental health care is a collateral victim of underinvestment in healthcare in general. While the overall spending on health care increased in 2021 as a reaction to the COVID-19 pandemic, reaching 10.3 per cent of GDP or $ 9.8 trillion on health that year, the budget constraints facing low-income countries actually forced them to reduce expenditures on public health-care services, and the gaps between countries widened further: 11 per cent of the world's population live in countries which spend less than $50 per year per person on health care (compared to an average of $4,000 in high-income countries), and low-income countries, which host 8 per cent of the world's population, represent just 0.24 per cent of global health-care expenditure.[82] Moreover, although the public financing of health care through taxation or public health-care schemes is more cost-effective and equitable[83], 40 per cent of health-care funding is still based on private insurance schemes, which means that it is less affordable for the poor who are often left uninsured or face catastrophic health-care expenditures.[84]

47. In addition, while health care is underfunded in general, preventive health-care services fare even worse: in 2021, only 3 per cent of total health expenditure in high-income countries and 13 per cent in low-income countries related to prevention.[85]

48. Against this general pattern of underfunding of health care, mental health-care services are even more neglected: because of the stigma attached to mental health conditions, because people facing mental distress are poorly organized to claim their rights, and because governments fail to recognize the importance of investing in mental health-care services.

B. Reducing insecurity

49. Important as it is to invest more in mental health services, whether preventive or remedial, this should not be seen as a substitute for addressing the background factors that cause depression and anxiety in the first place: poverty, social isolation and inequalities leading to status anxiety.

50. The Special Rapporteur therefore reiterates his call to place the fight against income and wealth inequalities at the heart of the search for a new eco-social contract, which he already identified as essential for a just transition, as well as his call for a shift to a post-growth development model that prioritizes well-being above GDP (see

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[79] Graham Thornicroft and others, "Undertreatment of people with major depressive disorder in 21 countries", *British Journal of Psychiatry*, vol. 210, No. 2 (February 2017).

[80] WHO, "The WHO special initiative for mental health (2019–2023): universal health coverage for mental health", 2019.

[81] See www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme.

[82] WHO, *Global Spending on Health: Coping with the Pandemic* (Geneva, 2023).

[83] Jomo Kwame Sundaram, "Finance healthcare, not insurance premia", Inter Press Service, 26 June 2024.

[84] WHO and World Bank, *Tracking Universal Health Coverage: 2023 Global Monitoring Report* (Geneva, 2023).

[85] "Financing Universal Social Protection and Health Coverage", Background paper in preparation for the Fourth International Conference on Financing for Development workstream on Financing Social Protection and Health Services in Developing Countries (unpublished, 20 June 2024), p. 9.

A/75/181, paras. 44–48 and A/HRC/56/61, paras. 32–37). Combating inequalities, but also combating the tendency towards the precarization of work and the contractualization of social protection (through the introduction of conditionalities and the monitoring of beneficiaries), should be central to combating the global pandemic of depression and anxiety. Eradicating poverty, guaranteeing income security and realizing the right to mental health are complementary and mutually supportive.

1. Preventing psychosocial risks at work

51. In a 2012 OECD report, it was acknowledged that workers across OECD countries have been exposed to changes in working conditions as a result of structural adjustments in the past decades and that poor-quality jobs or a psychologically unhealthy work climate can erode mental health, and in turn influence the position of individuals in the labour market.[86] Surprisingly, the Recommendation on Integrated Mental Health, Skills and Work Policy, which was adopted by the OECD Council on 14 December 2015, barely alludes to this structural dimension, simply insisting that member States "promote and enforce psychosocial risk assessment and risk prevention in the workplace".[87]

52. We should go beyond this attitude of denial. Higher demands on the job, low job control (i.e. limited ability to make decisions about work) and unclear roles can all exacerbate work-related stress and heighten the risk of exhaustion, burnout, anxiety and depression.[88] In previous reports, the Special Rapporteur addressed some of the implications of the post-Fordist reorganization of work, including how wages are set and working conditions determined (A/78/175 and A/HRC/53/33). These changes also increase psychosocial risks at work. Under the Occupational Safety and Health Convention, 1981 (No. 155) and the Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187) of the International Labour Organization, both of which were declared fundamental conventions in 2022 (implying that they should be complied with even by States having not ratified them) – States are expected to address such risks. Yet, by 2019, only 35 per cent of States had a national programme in place to address work-related mental health issues.[89]

53. While the 2022 WHO guidelines on mental health at work list a number of psychosocial risks to mental health at work, it is perhaps in the area of work schedules that the regulatory gap is clearest. Work scheduling regulations should help to mitigate the mental health impacts of unpredictable working schedules. Such regulations could require advanced notice of work schedules, and in cases where shift timing is changed with less notice, employees could be provided compensation, just as they are compensated for overtime work. On-call shifts should be discouraged, for instance by guaranteeing at least partial pay for workers who are on-call. Minimum rest periods between two shifts could be imposed. "Access to hours" rules could be introduced, ensuring that part-time workers working on call are guaranteed a minimum number of hours of work per week or per month, thus improving their economic security.[90]

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[86] OECD, Sick on the Job?, p. 40.

[87] OECD, document OECD/LEGAL/0420.

[88] WHO and International Labour Organization (ILO), *Mental Health at Work: Policy Brief* (Geneva, 2022), p. 4; and Michael Quinlan, "The effects of non-standard forms of employment on worker health and safety", Conditions of Work and Employment Series, No. 67 (Geneva, ILO, 2016).

[89] WHO, *Mental Health Atlas 2020*.

[90] Schneider and Harknett, "Consequences of routine work-schedule instability".

2. Providing an unconditional basic income

54. Economic shocks are a major cause of depression and economic insecurity is a major cause of anxiety. In order to reduce both, social protection could be strengthened in order to make it more universal and to remove the conditionalities that exercise a permanent pressure on beneficiaries. In 2008, the provision of subsidized health insurance (worth $550–$750 per year) to low-income individuals in Oregon was shown to reduce rates of depression by about a quarter within a few months. This randomized control trial shows that the main contribution of social protection schemes to preventing mental health challenges is in the sense of security they provide, rather than in the increased levels of income they provide.[91] The provision of rights-based and unconditional schemes can thus create a sense of security and entitlement, with significant positive mental health impacts.

55. This is why the Special Rapporteur recommends implementing social protection schemes to the fullest extent possible, without excessive targeting, and without introducing conditionalities that can discourage acceptance and create the very insecurity such schemes are meant to prevent. Unconditional basic incomes schemes provide the kind of security that can prevent mental health conditions linked to economic uncertainty. In an unconditional cash transfer experiment conducted in Malawi in 2008 and 2009, schoolgirls were around 38 per cent less likely to suffer psychological distress than the control group, while the same figure was 17 per cent if the cash transfers offers were made conditional on regular school attendance. Researchers analysing the survey results commented that "when the transfers become an important source of income for the entire family and depend on [the beneficiary schoolgirl's actions], they might turn into too heavy a burden for her to shoulder and become detrimental to her mental health".[92] The Mincome experiment, a guaranteed annual income field experiment carried out in Manitoba Province, Canada, between 1974 and 1979, showed a reduction of 8.5 per cent in the hospitalization rate of the treatment group receiving a basic income, relative to the control group, for accidents and injuries and mental health, as well as reduced reliance of the treatment group's members on physicians, especially for mental health. Even a modest guaranteed income, researchers concluded, can lead to significant savings for the health-care system.[93] In Finland, 2,000 unemployed individuals received an unconditional basic income of 560 Euros a month for two years (in 2017 and 2018). The beneficiaries reported higher life satisfaction, better health, less mental distress and depression, and stronger cognitive capabilities regarding memory, ability to learn new things and the ability to concentrate, compared with the control group not receiving a basic income.[94]

56. These conclusions were confirmed by a meta-study covering 27 studies of nine basic income-like interventions providing unconditional payments to individuals or families, many were evaluated using randomized controlled trials or robust quasi-experimental methods. The findings showed strong positive effects on mental health outcomes.[95] Thus, unconditional cash transfer schemes can significantly help

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[91] Amy Finkelstein and others, "The Oregon health insurance experiment: evidence from the first year", *The Quarterly Journal of Economics*, vol. 127, No. 3 (August 2012).

[92] Sarah Baird, Jacobus de Hoop and Berk Özler, "Income shocks and adolescent mental health", Policy Research Working Paper, No. 5644 (World Bank, 2011), p. 19.

[93] Evelyn L. Forget, "The town with no poverty: the health effects of a Canadian guaranteed annual income field experiment", *Canadian Public Policy*, vol. 37, No. 3 (September 2011).

[94] Miska Simanainen and Annamari Tuulio-Henriksson, "Subjective health, well-being, and cognitive capabilities", in *Experimenting with Unconditional Basic Income: Lessons from the Finnish BI Experiment 2017–2018* (Cheltenham, Edward Elgar Publishing, 2021).

[95] Marcia Gibson, Wendy Heaty and Peter Craig, "The public health effects of interventions similar to basic income: a scoping review", *The Lancet: Public Health*, vol. 5, No. 3 (March 2020).

to deal with the high burden of disease resulting from common mental health challenges, such as depression. These schemes (such as the Child Support Grant in South Africa)[96] therefore fulfil an important preventive function, reducing the costs of health care and the need for trained health staff and mental health treatment facilities.

57. Unconditional basic income-like schemes can also help address the cognitive bandwidth restrictions associated with scarcity. Conditionalities associated with cash transfer schemes and excessive targeting based on means-testing result in complex eligibility rules through which benefit recipients must manoeuvre under the threat of sanctions. Indeed, this is one explanation for high rates of rejection for certain social protection schemes, including minimum income schemes essential for people in poverty (see A/HRC/50/38, paras. 17 and 55). In contrast, an unconditional basic income ensures foreseeable income security and a regularity of payment which may minimize the interference with daily concerns of recipients, thus improving their cognitive abilities.[97]

C. Combating stigma and discrimination

58. The stigma associated with mental health conditions worsens the negative impacts of mental health problems on the ability for individuals to escape poverty.[98] In 2012, WHO launched the QualityRights Initiative to improve the quality of care, address stigma and discrimination and promote the human rights of people with mental health conditions.[99] In order to reduce stigma, specific schemes could be designed to help individuals reintegrate into employment. People with mental health conditions could be empowered to be able to choose services that best meet their needs. Anti-discrimination legislation could be better enforced, in particular by improving the information of people about their rights.[100] This is in line with the Convention on the Rights of Persons with Disabilities, and with objective 3 of the WHO comprehensive mental health action plan 2013–2030.[101]

59. In order to ensure that measures against stigma and discrimination are well informed and effective, people with lived experience of mental health conditions and people with lived experience of poverty should be involved in designing national action plans on mental health.

D. Designing equigenic urban environments

60. The former Special Rapporteur on the right to health recommended that States take 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” (A/HRC/44/48, para. 75). The urban landscape can be transformed to improve access to green spaces and parks, with benefits not only to

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[96] Julius Ohrnberger and others, “The effect of cash transfers on mental health: opening the black box – a study from South Africa”, *Social Science and Medicine*, vol. 260 (September 2020).

[97] Simanainen and Tuulio-Henriksson, “Subjective health”.

[98] Nicolas Ruesch, *The Stigma of Mental Illness: Strategies against Social Exclusion and Discrimination* (Elsevier, 2022).

[99] See www.who.int/activities/transforming-services-and-promoting-human-rights-in-mental-health-and-related-areas.

[100] For guidance, WHO and Office of the United Nations High Commissioner for Human Rights, *Mental Health, Human Rights, and Legislation: Guidance and Practice* (Geneva, 2023); and the tools developed under the WHO QualityRights Initiative.

[101] WHO, Comprehensive mental health action plan 2013–2030, p. 27.

mental health but also to social health, defined as "the ability to form and maintain relationships as well as experiencing a sense of connection, acceptance, and belonging". Prosocial behaviour and social connection are encouraged by facilitating contact with nature.[102]

61. Health-care initiatives can be taken in order to encourage people, especially children, to spend more time in nature.[103] While health-care professionals now recommend more frequent interactions with nature to patients, an even more promising approach is to organize group activities to involve people in activities with nature, in a way that allows them to become active agents rather than mere passive recipients, thus also providing an opportunity for building social relations.[104]

VI. Conclusions and recommendations

62. **The WHO comprehensive mental health action plan 2013–2030 outlines a vision for a world in which mental health is valued, promoted and protected, mental health conditions are prevented and persons affected by these conditions are able to exercise the full range of human rights and to access high-quality, culturally appropriate health care and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination.**[105]

63. **For this vision to be realized, we must move from a biomedical approach to a biopsychosocial approach to mental health challenges: from the psychiatrization of poverty to addressing the structural causes of depression and anxiety. This requires questioning the way the economy treats women and men (as resources to be exploited, and to be made productive as possible), and the priority given to the productive economy to the reproductive economy. Instead of GDP increase, the focus should be on improving well-being.**

64. **In order to address the social determinants of depression and anxiety, States should put the fight against poverty and inequality at the heart of national strategies to improve mental health, and they should combat the rise of income and wealth inequalities, the informalization and destandardization of work, the contractualization of welfare, and housing segregation in urban areas which leads to depriving children in low-income neighbourhoods from accessing green spaces.**

65. **Breaking the vicious cycles linking poverty to mental health issues also requires destigmatizing mental health conditions and investing more in preventing and treating such conditions, as noted under various General Assembly and Human Rights Council resolutions.**[106]

66. **The participation of people in poverty, including children,**[107] **in the design, implementation and evaluation of measures that seek to address the social**

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[102] Arbuthnott, "Nature exposure and social health".

[103] Jules Pretty and Jo Barton, "Nature-based interventions and mind-body interventions: saving public health costs whilst increasing life satisfaction and happiness", *International Journal of Environmental Research and Public Health*, vol. 17, No. 21 (November-1 2020).

[104] Wesley Tate and others, "Nature prescribing or nature programming? Complementary practices to increase time in nature to support mental health", *Ecopsychology* (2024).

[105] WHO comprehensive mental health action plan 2013–2030, para. 20.

[106] See General Assembly resolution 77/300, and Human Rights Council resolutions 32/18, 36/13, and 43/13.

[107] For a promising example, see the project "What do you think?" led by UNICEF in 2020–2022 to seek the views of 150 children from 6 to 17 years of age on their relationship to mental health interventions.

determinants of mental health issues affecting them is essential. Meaningful participation will ensure that policies are better informed and thus more effective – as building on the experiential knowledge of people in poverty allows to better identify the obstacles beneficiaries face and how to overcome them. It is also an end in itself. Consistent with the right to participation as a human right as reflected in particular in article 25 of the International Covenant on Civil and Political Rights and in article 38 of the Guiding Principles on Extreme Poverty and Human Rights, it is empowering. It allows people in poverty to co-construct policies, thus contributing to rights awareness and to building the confidence, social capital and knowledge of people in poverty.[108] **It is only through such participation that pathways towards building the human rights economy will be found.**

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[108] See A/HRC/23/36; and the Guidelines on the right to participate in public affairs (A/HRC/39/28). In cooperation with the International Movement ATD Fourth World, the Special Rapporteur has developed a methodology to ensure effective participation of people in poverty through the setting up of deliberative processes for the design and evaluation of policies. The Inclusive and Deliberative Elaboration and Evaluation of Policies (IDEEP) tool was presented in Washington, D.C., on 15 February 2024, at a conference hosted by the World Bank and the International Monetary Fund. It could guide, for instance, the development of national action plans on mental health, in order to ensure that the concerns and proposals of people in poverty are fully integrated.