



HANDOVER DIALOGUES

UN Special Rapporteur on the Right to Health

A discussion paper on

Global mental health and human rights: history and the need for change

A discussion paper on global mental health from a movement perspective

1. 2020-2021: Psychosocial health and wellbeing sharpens as a global issue

The year 2020 brought an acute and urgent awareness about mental health worldwide. Globally, mental health policy makers and health care advisors made calls to “fill the mental health care gap” as health services, community development facilities, and allied social and economic services were stretched up to and beyond capacity by COVID-19. The pandemic greatly impacted people’s lives, mobility, connections, and aspirations, and especially those living in communities already experiencing poverty or marginalization. Countries faced political, social, and economic uncertainty, and governance and social systems were strained everywhere. Lockdowns had devastating effects across the lifespan, on families, livelihoods, work and employment, access to leisure, outdoor spaces, sports, grooming, social and cultural activities. People experienced an extraordinary sense of stress, loneliness, malaise, loss, grief, and social isolation.

However, community support and social networks were resilient and rose to the challenge. As much as possible they helped meet basic needs, provided social and emotional support, volunteering, supporting local community initiatives, resource pooling (for example, food), sharing and spreading useful information and creating safety nets for vulnerable people.

Older persons, those in poor health, people with disabilities, and others requiring healthcare services during the pandemic lived with the stress of having to use already overburdened health care environments that now exposed them to greater risk of being exposed to the new corona virus. Throughout the world many older persons, those with disabilities, or people in poor health, stayed isolated in their homes for months with absolutely no social contact.

Those living in conditions of poverty with few resources, especially children, faced escalating risks of malnutrition and poor health, and had little access to emergency services, public health information or social and financial support systems. Disability organisations around the world reported serious rights violations of persons with disabilities, especially those living inside care homes and institutions, and have made recommendations on how to prevent such violations.¹ The pandemic has highlighted the urgency of taking seriously the human rights imperative to deconstruct the institutional model of care—something highlighted by the former Special Rapporteur on the right to health in his final report to the General Assembly.

For persons with mental health issues, or mental, multiple, and psychosocial disabilities, their networks of care, peer and social support systems were minimized or cut off. Family life often became more challenging as resources and available care dwindled. Violence within households increased, especially for women and girls with psychosocial disabilities. Essential services became less available, which was especially daunting for people who were hearing voices, or homeless, or unable to participate in their normal communities. There were also challenges for those who use specific mental health services, such as medications, diagnostics, social workers, peer support, support groups or therapies, as well as losing access to general health services. There were serious compromises for persons with psychosocial disabilities on receiving information about COVID-19, lock down protocols, and safety measures. In resource poor settings, gaining or maintaining access to phones or other digital devices and internet access was challenging. In many situations the only available phone in a family is kept by the household head, often a man. Persons with psychosocial disabilities within the household had their privacy and dignity put at risk in such circumstances.

2. Global mental health and its detractors

Medical professionals started writing about an ‘alarming rise’ in ‘mental disorders’² at the beginning of the millennium. As this momentum gathered within public health worldwide, a Movement for Global Mental Health (MGMH) emerged, prioritizing the scaling of health care services and advocating treatment of mental disorders as a high priority. Even though MGMH was initially the predominant voice for escalating health care services for mental disorders, several other streams of global mental health emerged, involving a variety of service providers, family groups, international non government organizations (INGOs), and various stakeholders. Global mental health was often presented and understood from the perspective of health care services, using a narrow, biomedical view of the ‘right to health’ as limited to the “right to healthcare”.

Global mental health actors did acknowledge the importance of social determinants, including gender based violence. However, service provider actions or solutions based on those determinants were undermined or understated. For example, it was widely acknowledged that poverty and psychosocial health were correlated,³ but integrated efforts to reduce poverty, improve livelihoods, or provide social protection were not considered as ways of enhancing psychosocial health and wellbeing. Limiting the significance of social, economic, and other dimensions on mental health and wellbeing, led to some unacceptable positions within the MGMH, for example, that, when left ‘untreated’, mental disorders can bring about the collapse of national economies and make city streets unsafe.⁴

Around the same time (2007), the United Nations adopted the Convention on the Rights of Persons with Disabilities (CRPD).⁵ It is interesting that while MGMH strongly advocated for the right to mental healthcare, the CRPD gave guidance on the realization of all human rights for all persons with disabilities, without making any exceptions. The right to health is specifically mentioned in Article 25 as an entitlement for all persons with disabilities. The World Network of Users and Survivors of Psychiatry represented persons with psychosocial disabilities during the drafting of the CRPD. As all human rights are indivisible and inter dependent, international human rights law does not allow the prioritization of one human right over another, or for any specific disability constituency.⁶ Therefore, the CRPD guarantees not only health rights but all other human rights for all people with disabilities of any type.

Numerous concluding observations from the CRPD monitoring committee have also directed states parties under review to ensure CRPD compliance, including by dismantling guardianship, repealing non-compliant mental health laws, and stopping mandatory treatments.⁷ Other UN agencies changed practices following adoption of the CRPD, for example, the World Health Organization withdrew publicly available resources about mental health legislation. The Convention on the Elimination of Discrimination Against Women monitoring committee, the Office of the High Commissioner of Human Rights, the Human Rights Council, and the Convention Against Torture committees each showed paradigm shifts in their various guidance on the

forced detention of persons with disabilities, especially women and girls. As Special Rapporteur on the right to health, Dr. Darius Pūras delivered several reports which expanded the normative understanding of the right to mental health to include the right to underlying social and psycho-social determinants of health and called for the right to health to be understood within the rapidly evolving normative context ushered in by the CRPD. This work concluded with a report to the Human Rights Council that established a vision of rights-based approaches to mental health (A/HRC/44/4). This continues a decade-long tradition of policy advice and jurisprudence against guardianship and involuntary commitment, as accepted by the CRPD monitoring committee and other UN agencies.

In the immediate years following the Convention, there were heated professional conversations as mental health workers and legal professionals debated and challenged the applicability of the social model of care and the CRPD in the field of mental health. Of particular concern in the debates were the CRPD provisions for full legal capacity (Article 12) and the prohibition against deprivation of liberty on the basis of disability (forced incarceration).⁸ Professional bodies of psychiatrists, such as the World Psychiatric Association⁹, in its challenge to the CRPD, claimed that involuntary commitment was at times unavoidable, and that it was not prudent to totally abolish guardianship and institutional care. Some reformative solutions for more conducive institutional programs were proposed as compromises, for example, training institutional staff in human rights and harm reduction within institutions. These proposals did not propose dismantling these institutions or overturning the legal disqualifications of capacity.

At the same time, again following the adoption of the CRPD, worldwide movements of persons with psychosocial disabilities, mad identities, users and survivors of psychiatry, and others with intersectional identities and neuro-diversities were forming national, regional, and global alliances. They challenged the universal and simplistic way of framing mental health as the 'right to healthcare'. Importantly, with the support of the international cross disability movement, they strongly resisted advocacy by some sectors to introduce an SDG goal on 'treatment of mental disorders'.¹⁰ Focussing only on the 'right to healthcare' and 'closing the treatment gap', within a care system that had a distinctive power imbalance¹¹, was seen as a denial of all other human rights enshrined in the CRPD, which were hard won victories for the movement. Also, the global mental health agendas and mental health services were not addressing the elephant in the room: the widely prevalent practice of forced incarceration and treatment of people diagnosed with 'mental disorders' and the disempowering regime of legal guardianship, for such persons.¹² Often working at the core of the national and regional cross disability movements, the psychosocial disability movements asked for 'full CRPD compliance' — the realization of all human rights, no less.

For decades, the ex-patients liberation movements¹³, users and survivors of psychiatry and persons with psychosocial disabilities and neuro-diversities (in the post CRPD period), have been exposing the human rights violations happening within the mental health care sector. In the past decade, the Pan African Network of Persons with Psychosocial Disabilities issued a 'Cape Town Declaration'¹⁴ (2011); Transforming Communities for Inclusion Asia Pacific (TCI), issued a 'Bali Declaration' (2018)¹⁵; and the Lima Declaration¹⁶ of Redesfera Latinoamericana de la Diversidad Psicosocial, from Latin America (2019). The European Network of Users and Survivors of Psychiatry, along with the European Disability Forum (EDF) are also campaigning against the Oviedo Protocol¹⁷. Worldwide, movements of persons with disabilities, supported by the cross disability movements, are nearly all making the same demands: end coercion in psychiatry and ensure the full range of human rights are available to all. The colonial origins of social control and incarceration have also been prominent in the literature, especially that emerging from the global south where old colonial asylums still dot the landscape.¹⁸

3. Amelioration, reformative practice, or transformation?

From within professional circles, attempts were made to redefine and bring a more honest, person-centric perspective to global mental health. Psychiatrists themselves debated the dubious value of psychiatric diagnosis and the diagnostic framework¹⁹, the cultural impropriety of transferring models developed in the West to other cultures, and the racist and colonial nature of coercive and custodial practices.²⁰ Practitioners emphasized the need to engage more with grassroots communities on validating their cultural competency²¹, ending coercion, and bringing development solutions to reduce the burden of mental disorders.²² There were calls to medical professionals to be more egalitarian in cooperation with other non-medical mental health service providers and to acknowledge the usefulness of non-medical 'alternative' approaches.

Another perspective developed from those working in critical mental health, along with journalists, psychologists, alternative practitioners, consumers, and others who sought more evidence in global mental health to come from life affirming services; they opposed the dominance of the evidence in mental health being based on health costs and effects on the brain and human longevity of long term use of hazardous drugs.²³ These critical arguments and redefinitions of global mental health are well captured in the 2020 report by the Special Rapporteur on the right to health.²⁴

These global movements, advocacy, and UN reports have led to the acceptance now, within a much broader global mental health sector, that there are mental health solutions and approaches available which do not employ forced treatment. Instead psychosocial support, psychological treatments, various interpersonal therapies and group support, and trauma counselling have had their impact demonstrated in clinical trials. The Special Rapporteur's report on rights-based approaches to mental health support include programs such as Soteria and Open Dialogue.²⁵

MGMH has recently suggested that medical professionals do not want 'involuntary commitment' brought into the policy conversations, as it can have 'lethal consequences'.²⁶ In the Special Rapporteur's report to the Human Rights Council, Dr. Pūras encourages governments to create policy frameworks and budgets to embrace these new, legitimate initiatives, which would help mitigate the harms caused by mental health systems. The World Health Organization is also expected to release a 'good practice' guidance on mental health services which will discourage coercive approaches to mental health treatment.

There is a desperate need for psychosocial support systems at the community level and more robust psychosocial ecosystems that are peace building, just, psychosocially restorative in practice and egalitarian in value base. These reformative practices are therefore an important refining of 'global mental health'. They are welcomed by the movements of users and survivors of psychiatry, persons with psychosocial disabilities, mad, intersectional and neuro-diverse persons.

However, movements of persons with psychosocial disabilities, while seeking mental health care, are also equally clear that they are not in receipt of what they actually need. This is not a rare occurrence but a worldwide phenomenon which people in the movement have long endured. While co-operating with ameliorative solutions and reformative practices in mental health, the movement remains vocal about standards of practice which fall short of that promised by the CRPD: programs and service providers are yet to commit to a full prohibition on coercion. Policy commitment to 'zero coercion', creation of community support systems, and full and effective participation and inclusion of persons with disabilities within communities, is still much awaited by the movement worldwide.

Whether it is the challenge to the Oviedo protocol, or to the continuing attempts to impose mental health laws allowing coercion in the global south regions, or using underpaid, untrained staff to work as peer support, advocacy work is still necessary at many levels.

Linking the issues of the human rights of persons with psychosocial disabilities with other movements, and widening the scope of global mental health includes taking action on the structural, political, and economic determinants of mental health locally and globally. The propensity to cause harm and impact mental health is frequently embedded in the state – for example, in harmful economic and corporate practices such as hazardous work conditions, structural racism, practices that entrench gender inequality, loss of home and security through austerity measures, providing psychosocial succour to agricultural disasters, etc. Global mental health must address the social and structural production of distress.



Chart by Julie Hannah, Fact Sheet on the Right to Mental Health Promotion (A/HRC/41/34)

4. Resizing global mental health and going beyond mental health

The Special Rapporteur's report of 2020 provides a new vision for service providers: they can act to make global mental health the best it can be, for example, by serving people's own priorities and preferences. By placing the person receiving care at the center of all decisions and processes, service providers are able to respect the individual's choice and not impose treatments upon them. At its best, global mental health and its practitioners can provide excellent support services. Several initiatives from around the world, including those led by persons with psychosocial disabilities, have played an important role in bringing a new face to mental health service provision and to reclaiming global mental health as a domain within care systems. The search for and documentation of various zero coercion models from around the world will further strengthen global mental health agendas.

However, movements of persons with psychosocial disabilities ("movement") aspire for life and not just care. The vision of the CRPD is one of engagement with actors and service providers well beyond mental health. The movement, in collaboration with the cross disability movements worldwide, is using the CRPD to de-colonize, de-economize, and de-psychiatrize their lives by creating excellent opportunities for participation in integrated communities. A vision for inclusion, rather than 'good treatment' has emerged. Although global movements of persons with psychosocial disabilities will continue to co-operate on the reform of mental health care as a harm reduction measure, their aspiration lies elsewhere: where global mental health has no role to play – in housing, employment, sports, grooming, self care, relationships, leisure, family, and more. Resizing global mental health, so there are no medical barriers to the enjoyment of life, is a critical segment of this aspiration.

References

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- 6 Notably, the World Network of Users and Survivors of Psychiatry, a global organization representing the voices of persons with psychosocial disabilities, was the forefront of the CRPD drafting, ensuring inclusion from the very beginning.
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