MENTAL HEALTH AS A MATTER OF RIGHTS

UHC POLICY BRIEF SERIES

UNITED FOR GLOBAL MENTAL HEALTH

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

The Constitution of the World Health Organisation

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EXECUTIVE SUMMARY

The concept of universal health coverage (UHC) originated in the WHO constitution of 1948[1]. It's based on the idea that everyone, everywhere should be able to access the health services they need without suffering financial hardship. The constitution defines health as a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity.

But the coverage gap in care for common mental health conditions, which is as wide as 90% in some low-income countries[2], underlines that we are failing to provide the right to the highest attainable standard of health as set out in the WHO constitution. All of society, including policy makers and civil society organisations, must acknowledge this inaction comes at a high cost - not just in terms of lack of services - but a failure to address human rights abuses of people living with mental health conditions, particularly children and caregivers.

To address these issues, a rights-based approach to integrating mental health into UHC must be taken[3]. Commitments have already been made, through instruments such as the United Nations Convention on Rights of Persons with Disabilities (CRPD) and the WHO Comprehensive Mental Health Action Plan 2013–2030, and at high-level meetings such as the UN High-Level Meeting on UHC in 2019. But the time has now come to implement those commitments.
This briefing paper provides policy makers, the mental health community and those working more broadly to achieve universal health coverage with recommendations on how to implement a rights-based approach to mental health while fully integrating mental health into UHC.

To implement the commitments already made, we propose the following actions:

1) **National mental health legislation, policy and planning must be brought in line with modern human rights conventions.**
2) **Mental health systems must be decentralised and transitioned to evidence-based and rights-based community mental health care.**
3) **Mental health community outreach and education programmes must be fully integrated into UHC systems.**
4) **People with lived experience of mental health conditions must be properly included in UHC policy and legislative dialogue and development.**
5) **Human rights relating to mental health within UHC systems must be monitored and governments held accountable for their commitments.**

THE STATUS QUO

The UN High-Level Meeting on Universal Health Coverage 2019 saw world leaders come together and re-affirm the right of every human being to the highest attainable standard of physical and mental health. For the first time, mental health was included alongside physical health in such a document on UHC, thanks to the advocacy efforts of the Global Mental Health Action Network. But delivery of this right has been slow, as documented in the WHO's Mental Health Atlas 2020 and in its reports on the impact of Covid-19 on mental health.

Legislation and policies

According to data collected in the WHO Mental Health Atlas, out of the 86% of the 170 WHO member states who have a standalone mental health law, only 39% reported alignment with international and regional human rights instruments, including the CRPD[4]. As the WHO Mental Health Atlas acknowledges, these self-reported results are likely to be much worse because publicly available information shows that policies, plans and laws do not fully align with international human rights standards. This means 120 countries are still to develop and/or implement rights-based mental health legislation. In terms of policy, while 75% of member states do have mental health policies in place, 49% are yet to align them with human rights instruments.

As a result, human rights abuses remain a threat to the welfare of those living with or at risk of mental health conditions. These abuses are occuring around the world, in homes, workplaces, psychiatric institutions and mental health services, hospitals and health care services, prisons, police interactions and the legal system, government and official services, and even in the education sector [5].

Stigma, discrimination and social determinants of mental health conditions

Some of the biggest barriers to accessing support come from the stigma and misconceptions surrounding mental health. Integrating mental health into UHC can help bridge affordability and accessibility gaps, but until stigma is addressed, services will often go unused. When people with mental health conditions are unfairly seen as unstable, violent or incapable, discrimination often follows, in access to employment and education, and in bringing into question their ability as caregivers.

"Sometimes I do feel like I'm treated like I'm a danger to society. People need to get to know us better and then they will relate to us in terms of how they judge us, perhaps."

Anonymous

"I have an intellectual disability. In the community, I feel very stigmatised. They look at you differently. As if you are not able to become independent. We are all human and we are all living in a world where we should be loved and accepted."

Shavonne Wagner (South Africa)

For example, stigma can lead to discrimination in the workplace. Unemployment rates among those with mental health conditions can be as high as 90%[6], due to a lack of trust among employers in the ability of those with mental and psychosocial disabilities to deliver work and handle pressure.

Discriminatory behaviour can start much earlier. Children and adolescents with mental health conditions are often denied admissions to schools, which are not equipped to handle their needs. These children are forced to go elsewhere, where the quality of education is worse, due to funding constraints[7]. This social exclusion makes it difficult for those with mental health conditions to compete for high-paying jobs or work in technical sectors[8]. Additionally, in contrast to physical illnesses, stigma often results in parents and caregivers being blamed for the societal struggles and mental health problems of their children.

People with mental health conditions can also have their ability as caregivers questioned, sometimes denied the right to marry or to the legal guardianship of their children. Mental health can often be given as grounds for divorce, or can be a barrier to seeking divorce.

Health professionals at times carry the same stigma[9], which translates into the kind of care they give. In a survey held in Switzerland, it was found that psychiatrists held more negative stereotypes of people with mental illness than the general population[10]. These stereotypes can lead to controlling and restrictive behaviour, dishonesty in approach to treatment, avoidance and rejection of difficult-to-treat patients, and low expectations from patients in terms of ability to recover or self-actualize[11].

Lack of access to basic mental health services

Some low- and middle-income countries (LMICs) either do not have mental health services at the community level or they are inaccessible and unaffordable[12]. Mental health support is not always available in rural areas, and people in LMICs may struggle to afford travel to urban centres[13]. It is often those who are most marginalised in other areas of their lives, due to their mental health, who are further marginalised by health systems.

In the case of children, service accessibility issues are often due to the inability of caregivers to identify indicators of mental ill health, due to inadequate training. The WHO, in its 2005 Child and Adolescent Mental Health Policies and Plans guidance package[14], highlighted that children are seldom empowered to seek out mental health services and more easily accept negative, misapplied labels. These labels, combined with communication gaps between children and caregivers, make it difficult for them to access support.

It is not enough to simply make 'availability of services' part of UHC. There is also a need to bridge the gap between availability and accessibility.

Abusive treatment

A common form of support comes from psychiatric institutions and tertiary-level treatment facilities, where human rights abuses are a significant risk. Inhumane treatment at such facilities includes unsanitary living conditions, physical, mental and sexual abuse, lack of food and proper clothing, isolation, and prison-like regimens[15]. Arbitrary detentions and coercive practices are common.

Children and adolescents with disabilities are particularly vulnerable to violence and abuse. A 2021 Unicef policy brief explains that coercive practices, such as forced treatment, involuntary sterilisation, seclusion and restraint, hinder recovery and have a lasting impact on children's mental health and well-being.[16] Outside of institutional treatment methods, shackling[17], chaining and beating are also considered curative methods[18] in some rural settings in LMICs. A Human Rights Watch report found evidence of shackling in at least 60 countries around the world. People in these countries were arbitrarily detained against their will in homes, state-run or private institutions, and traditional and religious healing centres[19].

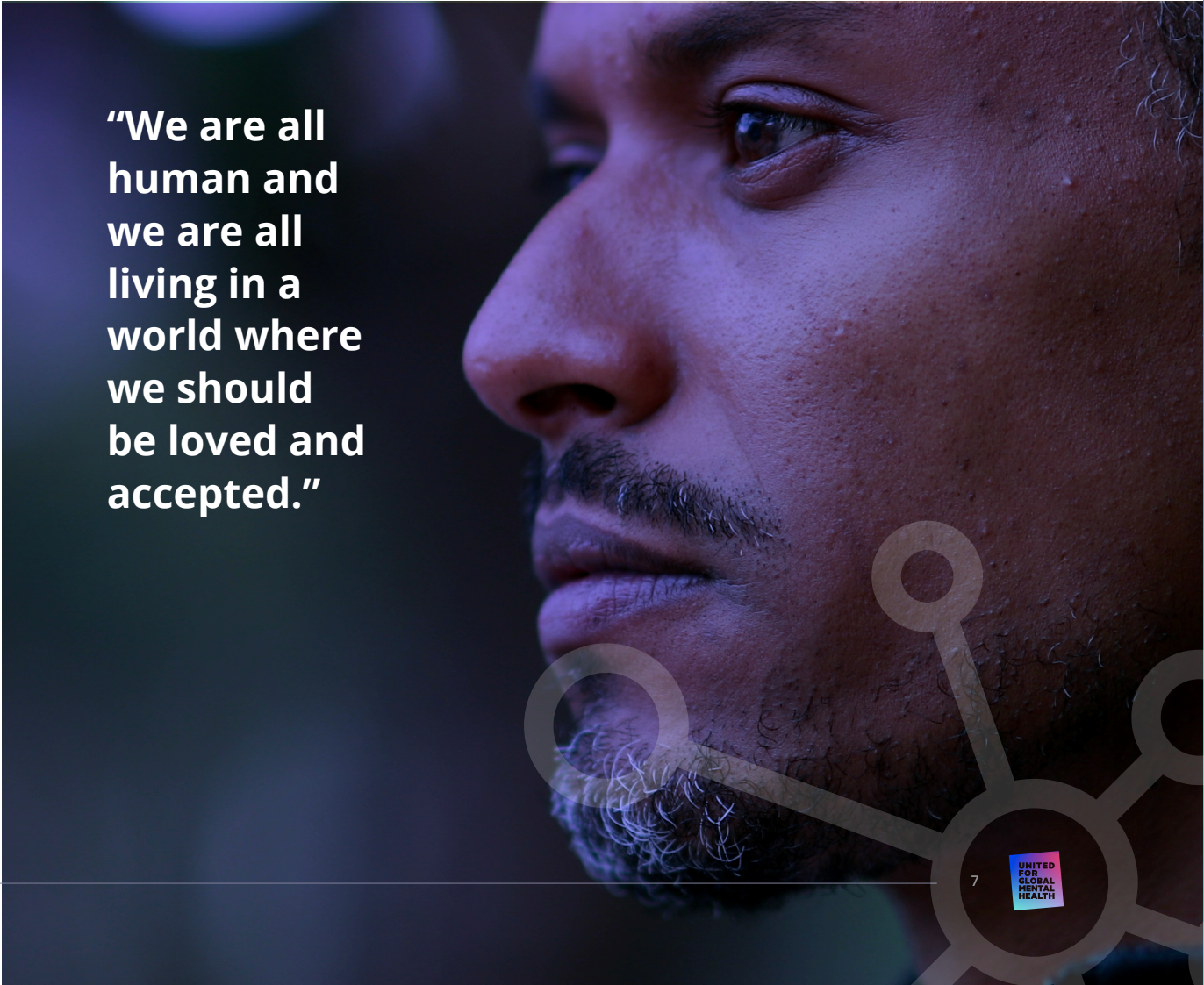## Legal capacity issues of people with mental health conditions

The right to legal capacity is enshrined in the Convention on the Rights of Persons with Disabilities. It means that people with mental health conditions have the same right as anyone else to make their own decisions or have access to supported decision making. It is up to society to enable them to exercise those rights, rather than ignore them on the basis of prejudice. If people with mental health conditions experience difficulties in understanding their treatment options or in any other form of decision making, they should have access to trusted supporters, of their choosing, who can assist them.

In many countries, however, the law precludes people with severe mental health conditions from having any say in their treatment. This leaves open the possibility of designated guardians willfully neglecting them, leading to conditions being left untreated for years.
This issue is compounded when it comes to children and young people. Their capacity to make decisions or evaluate treatment methods is often questioned[20], and the law often precludes them from any role in decision making.

This lack of capacity extends beyond treatment. Family members, government officials and even local service providers often have complete autonomy over decisions as to where a person should live and with whom, and even how their money, property and personal affairs should be managed. This leaves already vulnerable individuals even more exposed during treatments in which they're arbitrarily detained and socially excluded[21].

Looking deeper, it's clear that these issues stem from a lack of legislative protections. Exclusion is caused by an institutionalised, outdated and paternalistic approach to mental health support, combined with unaffordable and inaccessible mental health services, and misinformation at a community level. The affectees and beneficiaries of mental health services need to be involved in the conversation, to properly determine the best approach for their needs.

"We are all human and we are all living in a world where we should be loved and accepted."

COMMITMENTS TO MAKING A RIGHTS BASED CHANGE

The problems identified above are long standing despite global leaders having already made significant commitments to adopting a rights based approach to address them, through various international conventions and covenants and multilateral instruments. The United Nations Convention on Rights of Persons with Disabilities (CRPD) is particularly worth highlighting as it tasks member states with safeguarding all persons with disabilities from discrimination of any kind, enjoyment of legal capacity on an equal basis with others and prefers the person to either make their own decision or have access to supported-decision making over involuntary treatment.

The abusive treatment methods mentioned earlier are strictly prohibited and rejected by both the United Nations Convention against Torture and other Cruel, Inhuman and Degrading Treatment and the Covenant on Civil and Political Rights. Meanwhile, commitments to UHC and providing accessible health care for all, including mental health care have been made time and again through the Sustainable Development Goals, the WHO Comprehensive Mental Health Action Plan 2013-2030, at the UN High Level Meeting on UHC in 2019 and in the Convention on the Rights of Child (CRC) in the context of children, but the time has now come to implement those commitments.

THE CRUCIAL ROLE OF UHC FOR RIGHTS-BASED MENTAL HEALTH

"The world is accepting the concept of universal health coverage. Mental health must be an integral part of UHC. Nobody should be denied access to mental health care because she or he is poor or lives in a remote place."

Dr Tedros Adhanom Ghebreyesus, Director-General WHO[22]

In their political declaration stemming from the United Nations High-Level Meeting on UHC in September 2019, heads of state and governments reaffirmed the right of every human being to the enjoyment of the highest attainable standard of both physical and mental health.[23] Despite this, physical and mental health are still viewed differently in practice.

Inclusion of mental health in UHC ensures that the concept of indivisibility of physical and mental health is operationalised.[24] Now, given the emphasis on UHC in response to the Covid-19 pandemic, there is an opportunity to give greater spotlight to mental health issues and provision for them. It's crucial this opportunity is taken. Failing to integrate mental health into UHC would mean that UHC could not claim to be equitable, as a substantial number of people[25] would not gain access to the healthcare and support they need, which is their right.

UHC emphasises primary health care and delivery of services as well as promotion and prevention strategies at the community level.[26] This dovetails with the need for mental health care to be deinstitutionalised and destigmatised, to reduce human rights abuses and safeguard the rights of people with mental health conditions. As rights-based mental health service delivery will require upskilling of physical health care workers, there is also an excellent opportunity for training to include prevention of rights abuses. Moreover, prevention strategies focused on improving lay people's understanding of mental health would not only promote greater use of UHC systems but also help to tackle abusive treatment methods like shackling and chaining.

Lastly, UHC reforms will bring with them monitoring and accountability mechanisms, which assess both the quality and accessibility of services. By integrating mental health into UHC, governments can bridge the data gap between mental and physical health (as evidenced by the WHO Mental Health Atlas's figure of only 31% of member states hold mental health-specific data) [27]. Not only that, but people with mental health conditions would benefit from the additional scrutiny of services that monitoring would bring, and rights abuses prevalent in current treatment methods could be unveiled and documented for.

RECOMMENDATIONS FOR ADOPTING A RIGHTS-BASED APPROACH

Systemic rights violations and the non-realisation of rights of people with mental health conditions require a response that is strong, inclusive, evidence-based and integrated into existing strategies involving UHC. A lot of work has already gone into what such an approach might look like, in documents such as the WHO Quality Rights core training and guidance tools,[28] the Mental Health Gap Action Programme[29] and the Comprehensive Mental Health Action Plan 2013–2030. The following recommendations are based on this work.

1)   **National mental health legislation, policy and planning must be brought in line with modern human rights conventions**

"Develop, strengthen, keep up-to-date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including protective monitoring mechanisms and codes of practice, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments."

WHO Comprehensive Mental Health Action Plan 2013–2030

Legislation, policy and planning that is truly rights-based and acknowledges the key tenets behind UHC would primarily seek to improve everyone's mental health through progessive and non-coercive approaches. These would move away from involuntary treatment or confinement, instead empowering individuals with the capacity to determine their own treatment. If free and informed consent is a requirement for treatment of physical health, there should not be any difference in the approach to mental health.

In the case of children, the Committee on the Rights of the Child recognised that children's evolving capacities should be taken into consideration in health-related decision making. Children and adolescents therefore have the right to consent to treatment, including admission to a mental health facility, in accordance with their age and maturity. Caregivers can play a vital role in helping them understand their situation through supported decision making,[30] rather than being the sole decision maker.

UHC systems must also incorporate safeguards against abuses in treatment, whether in government facilities or in private settings, and provide safe and easy recourse to people (particularly children) who may have difficulty coming forward. Health systems must also protect those with mental health conditions from scenarios where their caregivers fail to uphold human rights.[31]

Similarly, legislation, policy and planning can pave the way for promotion of UHC and access to quality care through community based mental health services, and encouraging the integration of mental health into primary care and general hospitals. This would in effect make it mandatory for policy makers to address the issue of inequity and lack of quality services. It would also encourage the development of a regulatory framework to tackle unchecked service delivery. Lastly, it's crucial that laws and policies recognise people with mental health conditions as having the same rights and value as everyone else in society; able to freely make decisions on where they live, how they live and who their supporters are.

2)   **Mental health systems must be decentralised and transitioned to evidence-based and rights-based community mental health care**

UHC is premised on the right of all people to have access to health services, when and where they need them, without financial hardship. Achieving this for mental health means recognising that currently, within limited budgets, institutionalised care is prioritised. This form of care is not only expensive but also home to human rights abuses. Deinstitutionalisation requires up-front resources, but in the longer term, it is a more efficient use of funding.

UHC policies must prioritise care provided in community and non-specialised health settings, so that it is both affordable and accessible. This could include short-stay inpatient and outpatient care at general hospitals, basic health units, primary care, comprehensive mental health centres, peer support services, daycare centres and support at home. Evidence-based health care must also be promoted and primary health care providers should be trained as such. Adequate staffing of trained professionals would drive down the cost and increase the availability of care. This must be extended to both physical and mental health care professionals, as the former are often the primary point of contact and trust holders of the community.

"Developing mental health services of good quality requires the use of evidence-based protocols and practices, including early intervention, incorporation of human rights principles, respect for individual autonomy and the protection of people's dignity."
WHO Comprehensive Mental Health Action Plan 2013–2030

Civil society organisations (CSOs) can play a major role[32] in service delivery. They can be potential identifiers and first points of contact for people who are experiencing mental health issues and their caregivers, providing access to basic forms of care and offering a referral system to quickly transition those in need to appropriate mental health service providers. However, it is crucial that such initiatives are supported by governments, to ensure quality and sustainability.

3)   Mental health community outreach and education programmes must be fully integrated into UHC systems

While an increase in the availability of community-based care through UHC would be a big step forward, community-level outreach and education on the value of that care is equally important. Raising awareness of how to support the mental health of all people, particularly the most vulnerable, will be necessary in implementing a UHC approach. While these initiatives on health promotion and the prevention of mental ill health can be CSO led, the messaging needs to be vetted and backed by official health systems authorities. This will increase efficiency, enable consistency and help overcome stigma (by providing "official" approval).

Similarly, awareness raising can go some way towards tackling ill-informed and inhumane treatment practices. It has been found that humanising individuals living with mental health conditions, through education, is one of the most effective ways to combat stigma and increase the use of services.[33]

It is also important to promote support and information for caregivers and families of children with mental health conditions, to increase their understanding and skills through a rights-based approach and assist them in accessing UHC services without discrimination.

4)   People with lived experience of mental ill health must be properly included in UHC legislative and policy dialogue and development

As beneficiaries of UHC, people with lived experience of mental health conditions are essential to discussions on policy and legislation. A key example are caregivers who either experience mental health conditions themselves or care for children who do. These caregivers typically have frequent contact with health systems, in particular primary or community-level care. Their children must also be included. The Convention on the Rights of the Child mandates their inclusion in all conversations about their well-being, and it is important that policy-level discussions enable children to add their perspective.

> **"Lack of awareness about mental health conditions and poor access to mental health care can be important drivers of human rights abuses."**
>
> **WHO Mental Health Gap Action Programme (mhGAP)**

Evidence suggests that including people with lived experience not only leads to evaluations that are more relevant to their needs, but also leads to relevant outcome indicators and practical suggestions on how services can be improved.[34] By bringing lived experience advocates (both children and adults) and their caregivers into the conversation, the risk of developing mental health legislation that is discriminatory or restrictive is reduced.

5)   Human rights relating to mental health within UHC systems must be monitored and governments held accountable for their commitments

"Information, evidence and research are critical ingredients for appropriate mental health policy, planning and evaluation."

WHO Comprehensive Mental Health Action Plan 2013–2030

The Comprehensive Mental Health Action Plan 2013–2030 states that, to be in line with human rights instruments, countries need to update their laws, policies and plans in line with human rights instruments. Monitoring of services can not only identify where rights are not being upheld and hold policy makers to account, but also enable treatment to be more responsive to the needs of users.

It is critical that civil society and those with lived experience are included in the design and implementation of monitoring systems. This will ensure they are fit for purpose and have independent oversight, particularly with regards to human rights abuses. The Comprehensive Mental Health Action Plan 2013–2030 recommends:

"[accountability] mechanisms, using independent bodies, to monitor, prevent and respond to torture or cruel, inhuman and degrading treatment and other forms of ill-treatment and abuse; collect data on restrain and seclusion and involuntary treatments; and involve appropriate stakeholder groups in these mechanisms, for example, lawyers, people with mental disorders and psychosocial disabilities, children, their caregivers and other vulnerable groups in a manner consistent with international human rights instruments."

National monitoring and accountability efforts can benefit from global data and international comparison. Mechanisms such as Countdown Global Mental Health 2030 can show where national mental health systems are failing in comparison to similar countries, highlight successes, and provide an advocacy tool through which civil societies can hold their governments to account.

FRANCIS PII: THE ABSENCE OF RIGHTS (GHANA)

"I didn't know I was having a mental problem. They removed my clothing, and then they locked me on the log. I thought I had nobody. I saw it that way." [35]
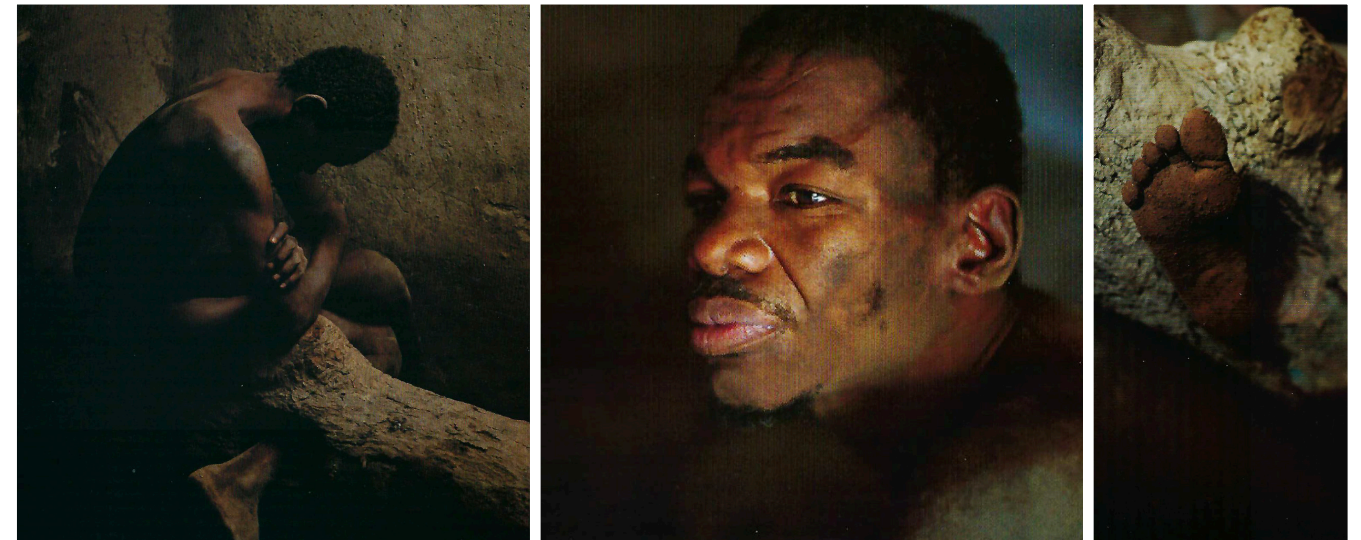
Francis Pii Kugbila never got to see a psychiatrist. A teacher at the Baptist primary school in Bolgatanga, he was struggling with a mental health condition as a result of using Indian hemp to cope with his worries. After neighbouring villagers complained of his supposedly aggressive behaviour, his brothers took him to a traditional healer. The healer forced his leg through a hole in a heavy length of tree trunk, pushing a metal rod through one half of the hole to trap Francis's leg. He was confined like this for almost two years: naked, in an empty room, on a bare concrete floor upon which he ate, slept and relieved himself. In November 2010, he was rescued by the BasicNeeds team in Ghana. They paid approximately US$5 for him to begin treatment with a community psychiatric nurse, and then supported the rest of his treatment with the help of the Talensi/Nabdam District Education Office. In addition to this care, Francis's friends offered social and psychological support. As a consequence, he is now happy, healthy and reunited with his family, and working again as a teacher in another district.[36]

For every person like Francis, there are countless others who remain undiscovered and without the support they desperately need. These people live in terrible conditions, their human rights consistently violated, because of lack of access to mental health services, lack of awareness and a lack of agency to decide their own treatment. To change this, it is essential that governments adopt a rights-based approach to integrating mental health into UHC.

CONCLUSION

The recommendations laid out above, if adopted and correctly implemented, allow for the development of inclusive health systems, where the rights of people with mental health issues are respected and safeguarded, health systems are not unnecessarily overburdened and holistic well-being is promoted.

If good health is truly the right of all under UHC, it is essential that a rights-based approach to mental health is integrated as a cross-cutting component of it.

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