

DISCUSSION PAPER

A RIGHTS-BASED APPROACH TO DISABILITY IN THE CONTEXT OF MENTAL HEALTH

*This discussion paper is a supplement to the
MHPSS Technical Note (2019)*



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A girl was set up to be married by her father. At only 15 years of age, her father wanted her to move in with a man, a common practice in Pokot culture (Uganda). To escape this fate, she ran away from home with six other girls and sought refuge at Amudat District police station. She was rescued and rehabilitated with UNICEF support and is back in school. The girls are currently staying at Kalas Girls Primary School in Amudat District and continue to receive counselling and psychosocial support from the district probation office with UNICEF support.

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A youth from Aceh, Indonesia poses with a sign that is part of a campaign to raise awareness of Mental Health Day, 10 October 2020.

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70-year-old Rosalie with Mariette (18) and Boris (17) at her home in Ouagadougou, Burkina Faso. Rosalie has taken care of Mariette and Boris since they were babies. Now retired, she has taken care of more than 150 vulnerable children. Vulnerable children are received in a transit centre before being sent into foster care. UNICEF supports the training of foster families and seeks sustainable solutions for the reintegration of children.

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After participating in activities at the UNICEF-supported early childhood centre of San Luis Jilotepeque, Jalapa, Guatemala, Emily Samantha Agustín López (12) and Joel Eduardo Agustín López (8) play at home with their brother, Luis Francisco Agustín López (6), who has a disability. Luis is loved by his siblings who protect him, play with him and teach him.

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DISCUSSION PAPER

A RIGHTS-BASED APPROACH TO DISABILITY IN THE CONTEXT OF MENTAL HEALTH

*This discussion paper is a supplement to the
MHPSS Technical Note (2019)*

This discussion paper proposes a framework to ensure a rights-based approach to programming related to disability in mental health and psychosocial support (MHPSS) at UNICEF. It presents standards and lessons learned from the implementation of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and it explores how they impact mental health and psychosocial well-being. Accordingly, it intends to stimulate a dialogue and common understanding of the existing opportunities and challenges related to persons with psychosocial disabilities within the UNICEF programmatic and operational agenda.

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This discussion paper was prepared for **UNICEF's New York Headquarters Disability Section** by **Alberto Vásquez**, a Peruvian disability rights expert. He is a human rights lawyer and holds an LL.M in Disability Law and Policy from the National University of Ireland, Galway. He has worked as a consultant to a number of United Nations agencies and as Research Coordinator in the Office of the United Nations Special Rapporteur on the rights of persons with disabilities. In Peru, he worked in the Peruvian Ombudsman Office and in the Peruvian Congress on mental health and disability-related issues.

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PART 1

INTRODUCTION



1.1

RATIONALE AND OBJECTIVES

Attention to mental health is gaining momentum. Important voices are increasingly calling for the expansion of mental health services, especially in low- and middle-income countries, in order to reduce and close the existing ‘treatment gap’ in mental health provision. In addition, the impact of mental health on development and its role in achieving health, educational, social and economic outcomes, particularly in the case of children and adolescents, is greatly understated. As a result, mental health and substance abuse have been included as health priorities in the Sustainable Development Agenda and further global efforts are taking place to reduce the ‘global burden’ of mental health problems.

At the same time, the awareness of human rights challenges associated with the provision of mental health services is increasing. As the United Nations Human Rights Council has pointed out, users of mental health services continue to be subjected to, “*inter alia*, widespread discrimination, stigma, prejudice, violence, abuse, social exclusion and segregation, unlawful or arbitrary institutionalization, overmedicalization and treatment practices that fail to respect their autonomy, will and preferences”¹. This improved awareness is due in large part to the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which questions mental health law, policy and practice as long as they continue to give rise to human rights violations. Hence, alongside the notorious calls to expand mental health coverage, many key stakeholders, including several human rights mechanisms, have raised concerns about the approaches and strategies proposed to

address mental health issues at the global and national levels. They are calling for a paradigm shift in mental health provision in order to avoid reproducing the same poor outcomes and dissatisfaction witnessed in high-income countries.

Against this background, the present discussion paper aims to contribute to UNICEF’s efforts to mainstream mental health and psychosocial support across its sectors by providing a general overview of how to ensure a rights-based approach to disability in the context of mental health. This document also provides a general review of different topics related to the rights of persons with psychosocial disabilities, including:

- Definitions, terminology and demographics;
- International and regional instruments and standards;
- Mental health and psychosocial support both in development and in humanitarian action;
- Gaps and types of approaches to be considered;
- Human rights violations; and
- Programmatic implications and interventions across UNICEF.

This discussion paper also puts forward a theory of change based on the international human rights framework and existing literature and theory, in order to promote a rights-based approach to disability in mental health policies across countries and territories.

¹ Resolution adopted by the United Nations General Assembly, Human Rights Council, ‘Mental health and human rights’, A/HRC/RES/36/13, 28 September 2017.

1.2

DEFINITIONS AND TERMINOLOGY

Mental health is defined in a number of ways. The most widely used definition is the one developed by the World Health Organization (WHO), which describes **mental health** as:

“

“a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”²

”

In the case of children and adolescents, mental health has been defined as the ability “to achieve and maintain optimal psychological and social functioning and well-being.”³ This includes “a sense of identity and self-worth, sound family and peer relationships, an ability to be productive and to learn, and a capacity to tackle developmental challenges and use cultural resources to maximize growth.”⁴

Many terms are used to refer to mental health conditions and experiences, including ‘mental illness’, ‘mental disorders’ and ‘mental health problems’. Those experiencing such conditions and situations are thus often referred to as ‘people with mental illness’, ‘people with mental disorders’ and ‘people with mental health conditions’, or are directly named after

their diagnosis (for example, ‘people with schizophrenia’). Many people find these terms to be stigmatizing and pathologizing, and so self-identify in other ways, as ‘persons with lived experience’, ‘users and consumers of mental health services’, ‘people who experience mood swings, fear, voices or visions’, ‘Mad people’ or ‘survivors of psychiatry’.

‘Persons with psychosocial disabilities’ is the preferred term used by international human rights mechanisms and agencies, as well as by representative organizations of person with disabilities. It encompasses all “persons who, regardless of self-identification or diagnosis of a mental health condition, face restrictions in the exercise of their rights and barriers to participation on the basis of an actual or perceived impairment.”⁵ This term aims to reflect a social rather than a medical approach to mental health conditions and experiences, placing the focus on the attitudinal and environmental barriers that restrict their equal participation in society.

There is no clear-cut line between mental health conditions and psychosocial disability. Many people experiencing mental distress or mental health conditions may face no or few restrictions or barriers to their full participation in society; at the same time, however, having a mental health diagnosis may lead to discrimination (e.g., in employment or health insurance). Some persons with psychosocial disabilities may also consider that their differences are not an actual mental health condition or impairment, but a label imposed due

² World Health Organization, *Promoting Mental Health: Concepts, Emerging Evidence, Practice. Summary Report*, WHO, Geneva, 2004, p. 12.

³ World Health Organization, *Mental Health Policy and Service Guidance Package: Child and Adolescent Mental Health Policies and Plans*, WHO, Geneva, 2005, p. 2.

⁴ Ibid.

⁵ Office of the High Commissioner for Human Rights, *Mental health and human rights*, Report of the United Nations High Commissioner for Human Rights, A/HRC/34/32, OHCHR, Geneva, 2017, para. 5.

to their behaviour or deviance from the norm.⁶ All people with mental health conditions are protected by the CRPD, whether they consider themselves persons with psychosocial disabilities or not.

Persons with intellectual disabilities and autistic persons⁷ are also usually overrepresented in mental health services, particularly children and adolescents.

This overrepresentation is mainly due to the existence of dual diagnosis and the demand for behavioural management, but also to the existence of an outdated understanding of the way to address and respond to those conditions. For many years, the term ‘persons with mental disabilities’ was used to group all people with psychosocial and intellectual disabilities and autistic people together.

UNICEF Lebanon Representative Yukie Mokuo with 10-year-old Hayat, in Karantina municipal garden, where UNICEF partners provide psychosocial support to children affected by the explosions. More than 7,200 children, parents and primary caregivers received mental health and psychosocial support through child-friendly spaces established in affected areas. © UNICEF/UN0360084/Choufany



⁶ United Nations Human Rights Office of the High Commissioner, Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP) and the Campaign to Support CRPD Absolute Prohibition of Commitment and Forced Treatment (Absolute Prohibition Campaign), ‘Response to draft General Comment 7 on Article 4.3, paragraph 14(a) and (d) and transversal’, Preliminary version, 2018, <www.ohchr.org/EN/HRBodies/CRPD/Pages/SubmissionsDraftGC7.aspx>, accessed 10 November 2020.

⁷ The autism spectrum includes a wide range of people, from those with an intellectual disability to those who are gifted. In the autism community, many self-advocates prefer the term ‘autistic person’ as they understand autism as an inherent part of an individual’s identity.



1.3 CONTEXT

Over the last decade, mental health has become an important part of international discussions on global development.

The 2030 Agenda for Sustainable Development (General Assembly resolution 70/1) and its 17 Sustainable Development Goals (SDGs) contain specific references to mental health and substance abuse. The 2030 Agenda affirms that universal health coverage and access to quality health care are necessary to promote mental health and well-being.⁸ Moreover, most of the 17 goals have a link with mental health, and many address important social determinants of health, such as poverty, gender inequality, violence, climate change and displacement (*see section 3.4, Social determinants of mental health*).

The inclusion of mental health in the SDGs has led to several high-level political processes. In October 2018, the United Kingdom and the Organisation for Economic Co-operation and Development (OECD) held the first Global Ministerial Mental Health Summit, which brought together political leaders, policymakers, practitioners, persons with psychosocial disabilities and civil society representatives, aiming to build momentum on global mental health issues and share good practices in mental health and psychosocial support.⁹

The summit also hosted the launch of a new Lancet Commission on Global Mental Health and Sustainable Development, which outlined a blueprint for action on mental health to help achieve the SDGs.¹⁰

The United Nations Secretary-General has also reiterated the United Nations commitment to mental health in the context of the SDGs' implementation¹¹ and launched a new United Nations system-wide strategy on mental health called 'Workplace Mental Health and Well-Being', which aims to provide a road map for improving the mental health and well-being of its personnel.¹² The WHO's comprehensive mental health action plan 2013–2020 was extended until 2030 to ensure its alignment with the 2030 Agenda for Sustainable Development, and mental health has risen on the agenda of World Economic Forum Annual Meetings.¹³

The Movement for Global Mental Health (MGMH) has been the leading stakeholder to position access to mental health care as a global priority. In its initial call for action, published in the first Lancet series on global mental health in 2007, this network of individuals and organizations called on the global health community, governments, donors, multilateral agencies and other mental health stakeholders to 'scale up' the coverage

⁸ Goal 3 ("Ensure healthy lives and promote well-being for all at all ages") includes two targets directly related to mental health and substance abuse: target 3.4 aims to "reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being"; and target 3.5 aims to "strengthen the prevention and treatment of substance abuse".

⁹ See United Kingdom [website] gov.uk, 'Global ministerial mental health summit 2018', <www.gov.uk/government/collections/global-ministerial-mental-health-summit-2018>, accessed 13 November 2020.

¹⁰ See the Lancet Commission on Global Mental Health, 'The Lancet Commission on Global Mental Health and Sustainable Development', <<https://globalmentalhealthcommission.org>>, accessed 10 November 2020.

¹¹ United Nations, Meetings Coverage and Press Releases, United Nations Secretary-General, Message for World Mental Health Day, 10 October 2018, 'One in Five Youth Face Mental Health Problems, Secretary-General Says, Calling for Attitude Change to End Stigma, in Message for International Observance', 8 October 2018, <www.un.org/press/en/2018/sgsm19283.doc.htm>, accessed 10 November 2020.

¹² United Nations, *A healthy workforce for a better world: United Nations System Mental Health and Well-Being Strategy*, 2018, <www.unsystem.org/CEBPublicFiles/mental_health_well_being_strategy_final_2018_may_25th_english.pdf>, accessed 12 November 2020.

¹³ Parker, Ceri, 'Davos CEOs open up on mental health – and the toxic toll of our connected lives', World Economic Forum, Geneva, 24 January 2019, <<https://www.weforum.org/agenda/2019/01/davos-ceos-open-up-on-mental-health-and-the-toxic-toll-of-our-connected-lives>>, accessed 13 November 2020.

of “services for mental disorders in all countries, but especially in low-income and middle-income countries”.¹⁴ The MGMH has had significant success positioning the narrative of the ‘treatment gap’ within the WHO and other leading development agencies.¹⁵ A new global campaign, endorsed by the MGMH, to raise funding and political will for global mental health care was launched in 2018.¹⁶

Concerns have been raised about some of the foundations, approaches and human rights implications of the global mental health agenda. It has been suggested that this agenda responds to a narrow biomedical approach, overmedicalizing individual and social suffering, reducing the attention to treatment alternatives and to the social determinants of mental health, and widening the power asymmetry between psychiatry and users.¹⁷ In addition, there is growing concern that these developments are not taking into account human rights concerns or the voice of persons with psychosocial disabilities.¹⁸ For example, the new Lancet Commission has been criticized for failing to understand the potential of the CRPD to reframe,

transform and enhance the global response to mental health in light of the rights of persons with disabilities.¹⁹

Indeed, the CRPD, adopted in 2006, has served as a catalyst for this new impetus for rethinking mental health from a human rights perspective. Different United Nations bodies and mechanisms have pointed out the need to ensure that mental health systems embrace a human rights-based approach.²⁰ The Human Rights Council has issued three resolutions on mental health and human rights in which its members express their deep concern on the widespread human rights violations experienced by mental health users and persons with psychosocial disabilities.²¹ The Human Rights Council has urged States to “take active steps to fully integrate a human rights perspective into mental health and community services” and to “develop community-based, people-centred services and supports that do not lead to overmedicalization and inappropriate treatments.”

The Committee on the Rights of Persons with Disabilities (CRPD Committee), the monitoring body of the implementation of the CRPD, has emphasized that

¹⁴ Prince, Martin, et al., ‘No health without mental health’, *The Lancet*, vol. 370, no. 9590, 8 September 2007, pp. 859–877.

¹⁵ See, for example, World Health Organization, WHO Mental Health Gap Action Programme (mhGAP), <www.who.int/mental_health/mhgap/en>, accessed 10 November 2020.

¹⁶ United for Global Mental Health, ‘Move Together’, <<https://unitedgmh.org>>, accessed 10 November 2020.

¹⁷ Mills, China, ‘From “Invisible Problem” to Global Priority: The Inclusion of Mental Health in the Sustainable Development Goals’, *Development and Change*, vol. 49, no. 3, 6 March 2018, pp. 843–866; Whitley, Rob, ‘Global Mental Health: Concepts, conflicts and controversies’, *Epidemiology and Psychiatric Sciences*, vol. 24, no. 4, August 2015, pp. 285–291; Priebe, Stefan, Tom Burns and Tom K. J. Craig, ‘The future of academic psychiatry may be social’, *British Journal of Psychiatry*, vol. 202, no. 5, May 2013, pp. 319–320.

¹⁸ Devandas, Catalina, ‘Comment Piece’, Lancet Commission on Global Mental Health, <<https://globalmentalhealthcommission.org/commentaries/special-rapporteur-on-the-rights-of-persons-with-disabilities>>, accessed 10 November 2020.

¹⁹ See Patel, Vikram, et al., ‘The Lancet Commission on global mental health and sustainable development’, *The Lancet*, vol. 392, no. 10157, 27 October 2018, pp. 1553–1598.

²⁰ Resolution adopted by the United Nations General Assembly, Human Rights Council, A/HRC/RES/36/13, 28 September 2017; Committee on the Rights of Persons with Disabilities, General Comment No. 1, April 2014, para. 41, and Guidelines on article 14 of the CRPD, 2015; Office of the High Commissioner for Human Rights, *Mental health and human rights*, OHCHR, Geneva, 2017; Puras, Dainius, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/HRC/35/21, 2017; Méndez, Juan, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, A/HRC/22/53, 2013; and Devandas, Catalina, *Report of the Special Rapporteur on the rights of persons with disabilities*, A/73/161, 2018.

²¹ Resolutions adopted by the United Nations General Assembly, Human Rights Council, A/HRC/RES/32/18, 1 July 2016, A/HRC/RES/36/13, 28 September 2017, and A/HRC/RES/43/13, 19 June 2020.

forced institutionalization and forced treatment in the context of mental health are discriminatory and must be abolished.²² Moreover, the Committee has upheld that the CRPD imposes an absolute ban on the deprivation of liberty on the basis of actual or perceived impairment (Guidelines on article 14). The Special Rapporteur on the rights of persons with disabilities, Catalina Devandas, has supported and expanded the views of the Committee in her reports on legal capacity, rights-based support, health and deprivation of liberty.²³

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Puras, has also publicly questioned the status quo on mental health. In his groundbreaking report on mental health, published in March 2017,²⁴ he calls for a shift in the paradigm based on the recurrence of human rights violations in mental health settings. Puras questions the current 'burden of disease' approach, the dominance of the biomedical model in mental health, the asymmetric power of psychiatry and the pharmaceutical industry, and the biased use of evidence in mental health.

Following these calls for action, the Human Rights Council in May 2018 held a one-day-and-a-half open consultation on mental health and human rights focused on identifying strategies to promote human rights in mental health.²⁵ The consultation benefited

from practitioners from all regions who presented their practices and shared their experiences on how they are moving towards a human rights-based approach to mental health. The outcome report calls, *inter alia*, to move away from biomedical approaches to mental health, to abolish all forms of coercion, to ensure the adequate provision of rights-based support to individuals, and to ensure the effective and meaningful participation of users and persons with psychosocial disabilities in policymaking.²⁶ A new consultation will be organized in 2021 to discuss the best ways to harmonize national laws, policies and practices relating to mental health with the CRPD.²⁷

The COVID-19 crisis, which occurred after the completion of this paper, has once again put mental health in the spotlight, prompting calls for action from the United Nations system and governments.²⁸ The health, social and economic impacts of COVID-19 will undoubtedly contribute to widespread emotional distress, and initial evidence shows an increasing demand for mental health and psychosocial support. Children with disabilities placed in institutions are also particularly vulnerable, given the widespread restrictive measures adopted by governments.²⁹ As Puras has stressed, this situation further urges us to ensure a human rights-based approach in mental health.³⁰

22 Committee on the Rights of Persons with Disabilities, General Comment No. 1, 2014, para. 42; and General Comment No. 6, April 2018, para. 30.

23 See United Nations Human Rights Office of the High Commissioner, Annual thematic reports of the Special Rapporteur on the rights of persons with disabilities, <www.ohchr.org/EN/Issues/Disability/SRDisabilities/Pages/Reports.aspx>, accessed 10 November 2020.

24 Puras, Dainius, A/HRC/35/21.

25 For more information, see United Nations Human Rights Office of the High Commissioner, 'Consultation on Human Rights and mental health: "Identifying strategies to promote human rights in mental health"', 14–15 May 2018, Palais des Nations, Geneva, Switzerland, <www.ohchr.org/EN/Issues/Pages/MentalHealth.aspx>, accessed 10 November 2020.

26 Office of the High Commissioner for Human Rights, *Mental health and human rights*, Report of the United Nations High Commissioner for Human Rights, A/HRC/39/36, OHCHR, Geneva, 2018, paras. 40–53.

27 Resolution adopted by the United Nations General Assembly, Human Rights Council, A/HRC/RES/43/13, 19 June 2020.

28 See, for example, United Nations, 'Policy Brief: COVID-19 and the Need for Action on Mental Health', 13 May 2020, <<https://unsdg.un.org/sites/default/files/2020-05/UN-Policy-Brief-COVID-19-and-mental-health.pdf>>, accessed 12 November 2020.

29 United Nations Human Rights Office of the High Commissioner, UN Treaty Body Database, 'Committee on the Rights of the Child warns of the grave physical, emotional and psychological effect of the COVID-19 pandemic on children and calls on States to protect the rights of children', 8 April 2020, <https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT/CRC/STA/9095>, accessed 10 November 2020.

30 Puras, Dainius, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/75/163, 2020, para. 83.

Maxim (17) from Kostyantynivka, Ukraine lost a hand and an eye in an incident caused by an exploded ordnance. UNICEF and partners provide psychosocial support and mine risk education in eastern Ukraine to hundreds of thousands of children, youth and caregivers, and in 2018 introduced a small-scale mine victim assistance project. © UNICEF/UNI288581/Filippov



PART 2

**A RIGHTS-BASED
APPROACH TO
DISABILITY IN
THE CONTEXT OF
MENTAL HEALTH**

2.1

THE HUMAN RIGHTS MODEL OF DISABILITY

The CRPD represents the highest standard of protection of the rights of persons with disabilities.

The CRPD calls for the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability.

The CRPD outlines specific steps to be taken by States parties to ensure the enjoyment of these rights and to promote awareness of the capabilities and contributions of persons with disabilities. Its general principles (article 3) reflect CRPD adherence to the universal human rights principles and values.³¹

The human rights model of disability, underpinned by the CRPD, challenges the so-called medical model to disability.³² From the medical model perspective, the problem is believed to be with the person and the ultimate aim is to cure or 'fix' the person. Under the human rights model of disability, the problem are the social barriers preventing people with disabilities from participating in society on an equal basis with others. The human rights model of disability recognizes that disability is a social construct and impairments must

not be taken as a legitimate ground for the denial or restriction of human rights.³³ Diversity is to be valued and embraced.

It is important to understand that the human rights model of disability does not deny the role of medical interventions in people's lives but questions societal responses reducing people with disabilities to mere recipients of treatment, shelter and welfare. People with disabilities may need and want medical interventions, but that is not the only way that people's life can be enhanced.³⁴ **People with disabilities need to be considered as a whole, including in their interactions with their environment.** While abandoning the medical model of disability does not mean rejecting the practice of medicine, medicine cannot be the gatekeeper for people with disabilities' rights.

The human rights model of disability also moves beyond anti-discrimination approaches, upholding a complex substantive model of equality, which seeks to address structural and indirect discrimination, values different layers of identity and acknowledges intersectional discrimination.³⁵ Furthermore, reaffirming the social nature of humanity and the importance of inclusion, this model introduces a dimension of participation in decision making. Persons with disabilities, including children, must be consulted and actively involved in all public decisions affecting them (echoed in the motto 'nothing about us without us').³⁶

³¹ The principles set out in article 3 of the CRPD are: (a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons; (b) Non-discrimination; (c) Full and effective participation and inclusion in society; (d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; (e) Equality of opportunity; (f) Accessibility; (g) Equality between men and women; (h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

³² The social model of disability as developed in disability studies heavily influenced the theoretical background of the CRPD.

³³ Committee on the Rights of Persons with Disabilities, General Comment No. 6, 2018, para. 9.

³⁴ World Health Organization, QualityRights, *Promoting human rights in mental health*, WHO/MSD/MHP/172, WHO, Geneva, 2017, pp. 26–28.

³⁵ Degener, Theresia, 'Disability in a Human Rights Context', *Laws*, vol. 5, no. 3, 25 August 2016, p. 35.

³⁶ Committee on the Rights of Persons with Disabilities, General Comment No. 7, 2018, para. 4.

While the CRPD and its human rights-based model of disability have had a powerful influence over international, regional and national law and policy, the medical model is still prevalent in societal responses to the needs of persons with psychosocial disabilities. For example, while it would be rare to reduce the rights of people with physical impairment simply to the access of physical rehabilitation services, the rights of people with psychosocial disabilities are constantly equated with the right to access mental health services. Moreover, even within that framework, most of the policy responses are framed in terms of prevention, treatment and rehabilitation, and the imbalance of power is significant between mental health practitioners and people with psychosocial disabilities.³⁷

Against this background, the notion of psychosocial disability needs to be understood as a social construct resulting from the interaction between persons with actual or perceived mental conditions and attitudinal and environmental barriers. Persons with psychosocial disabilities must be recognized as equal members of a diverse humanity, with the same rights as everybody else. Accordingly, mental health systems need to appropriately integrate the human rights-based model to disability into their practice and move away from practices of pathologization and segregation.³⁸

Persons with psychosocial disabilities have the right to the highest attainable standard of health without discrimination, and must thus be protected by the same general framework of the right to health as everybody else.

In Kampong Speu, Cambodia, Honr Chansy provides home assistance to four-year-old Kosal Socheat, who has autism. In the midst of school closures due to COVID-19, Honr Chansy visits her students every two weeks to check on their progress and to monitor their parents' level of engagement.

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³⁷ Office of the High Commissioner for Human Rights, *Mental health and human rights*, Report of the United Nations High Commissioner for Human Rights, A/HRC/39/36, OHCHR, Geneva, 2018, para. 45.

³⁸ Goering, Sara, 'Rethinking disability: the social model of disability and chronic disease', *Current Reviews in Musculoskeletal Medicine*, vol. 8, no. 2, 11 April 2015, pp. 134–138.

2.2

THE RIGHT TO HEALTH FRAMEWORK

The right to the highest attainable standard of health is a fundamental human right recognized in various international and regional human rights instruments, including the Convention on the Rights of the Child (CRC) (article 24) and the CRPD (article 25).

The right to health covers physical, mental and social well-being. As Puras has pointed out, the arbitrary division between physical and mental health has contributed to an untenable situation of unmet needs and human rights violations in the context of mental health.³⁹

There can be no health without mental health.

The right to health is an inclusive right that contains both freedoms and entitlements. The freedoms include, *inter alia*, the right to non-discrimination, the right to control one's health and body, and the right to be free from non-consensual medical treatment and experimentation. The entitlements include, *inter alia*, the right to essential primary health care and the participation of the population in all health-related decision making. The right to health also extends to the underlying determinants of health, such as safe drinking water and adequate sanitation; safe food, nutrition and housing; healthy occupational and environmental conditions; and

access to health-related education and information.⁴⁰ The normative context around mental health involves the intimate connection between freedoms, entitlements and the underlying determinants of health.⁴¹

The right to health also encompasses four interrelated and essential elements: availability, accessibility, acceptability and quality.⁴² In the context of mental health, States have an obligation to ensure that mental health care goods, services and facilities are available in adequate quantity; financially and geographically accessible without discrimination, particularly for socially disadvantaged groups, such as children and persons with disabilities; respectful of medical ethics, culturally appropriate, and sensitive to gender and life-cycle requirements; and scientifically and medically appropriate and of good quality.⁴³ Overall, States "have an obligation to respect, protect and fulfil the right to mental health in national laws, regulations, policies, budgetary measures, programmes and other initiatives."⁴⁴

The right to health framework provides for both obligations of immediate effect and progressive realization in the context of mental health. The former include certain freedoms and core obligations, such as non-discriminatory access to services; freedom from non-consensual medical treatment and experimentation; access to food, basic shelter, housing and sanitation and safe and potable water; and the elaboration of a national public health strategy "with a road map leading away

³⁹ Puras, Dainius, A/HRC/35/21, para. 6.

⁴⁰ Committee on Economic, Social and Cultural Rights, General Comment No. 14, 2000, para. 4.

⁴¹ Puras, Dainius, A/HRC/35/21, para. 31.

⁴² Committee on Economic, Social and Cultural Rights, General Comment No. 14, 2000, para. 12.

⁴³ *Ibid.*

⁴⁴ Puras, Dainius, A/HRC/35/21, para. 35.

from coercive treatment and towards equal access to rights-based mental health services.”⁴⁵ The latter imposes an obligation on States to move as expeditiously and effectively as possible, making full use of their available resources, including those made available through international cooperation, towards the full realization of the right to health.⁴⁶

Accountability is another cornerstone of the right to health framework. States must ensure monitoring based on appropriate indicators and benchmarks; independent and non-independent review; and effective remedies and redress for those who have been victims of a violation of the right to health. Accountability should have as a goal and a result the empowerment of users and persons with psychosocial disabilities, thus reinforcing the principle of participation.⁴⁷

While persons with disabilities should benefit from the right to health framework on an equal basis with others, prior to the CRPD, the international human rights system

allowed for exceptional circumstances in which they could be restricted in the enjoyment of different elements of the right to health.⁴⁸ Significantly, the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles) established a lower standard of protection against human rights violations in mental health care settings.⁴⁹ The CRPD supersedes these and other previous international ‘soft law’ developments.⁵⁰

Furthermore, the CRPD reinforces the right to health framework, building on the universality, indivisibility and interdependence of human rights. Article 25 of the CRPD, on the right to health, reaffirms the right of all persons with disabilities, including children and adolescents, to the enjoyment of the highest attainable standard of health without discrimination. This includes all the elements of the right to health framework: *inter alia*, freedoms, entitlements, participation, monitoring and accountability. Therefore, mental health services must be respectful of all human rights of all persons with disabilities.

⁴⁵ Ibid., para. 37.

⁴⁶ Committee on Economic, Social and Cultural Rights, General Comment No. 14, 2000, para. 31.

⁴⁷ Office of the High Commissioner for Human Rights, A/HRC/34/32, para. 47.

⁴⁸ Ibid., para. 47.

⁴⁹ The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles) were adopted by the United Nations General Assembly in 1991 (A/RES/46/119).

⁵⁰ Puras, Dainius, A/HRC/35/21, para. 32; Devandas, Catalina, A/73/161, para. 12.

2.3

INTERSECTIONAL CONSIDERATIONS

The implementation of a rights-based approach to disability and the right to health framework demands an intersectional approach.

Persons with disabilities are not a homogenous group and have different layers of identity that comprise a wide range of impairments as well as identity markers, such as age, race, colour, sex, sexual orientation, gender identity, language, religion, national, ethnic, indigenous or social origin, and other status.

Persons with disabilities can experience discrimination on the basis of these multiple and intersecting identities. 'Multiple discrimination' refers to a situation in which a person experiences discrimination on two or more grounds, leading to discrimination that is compounded or aggravated.⁵¹ 'Intersectional discrimination' refers to a situation in which several grounds interact with each other at the same time in such a way as to be inseparable.⁵² Mental health

policies and programmes must respond to the heterogeneous needs of the disability community and seek to overcome the impact of the multiple, intersecting and aggravated forms of discrimination faced by persons with disabilities belonging to these groups in accessing mental health services.

Children with psychosocial disabilities are particularly vulnerable to multiple and intersectional forms of discrimination, especially in the context of mental health. They may experience discrimination and stigma from both peers and institutional settings, and are often victims of pervasive practices, such as overmedicalization and institutionalization.⁵³ Those in institutions are at particular risk of violence and abuse, including sexual exploitation and trafficking.⁵⁴ In addition, while children with disabilities and their families may require different types of disability and age-appropriate support services, the understanding of how to provide them from a rights-based perspective is limited. In fact, too often, they are perceived as mere recipients of 'special care' resulting in widespread segregation, institutionalization and neglect.

The CRPD is the first human rights treaty to explicitly acknowledge multiple and intersectional forms of discrimination. Furthermore, it addresses the rights of children with disabilities as a cross-cutting issue. They are referred to in its general principles (article 3 (h)), its

⁵¹ Committee on the Rights of Persons with Disabilities, General Comment No. 3, 2016, para. 4.

⁵² Ibid.

⁵³ See World Health Organization and World Bank, *World Report on Disability*, WHO, Geneva, 2011; United Nations Children's Fund, *The State of the World's Children 2013: Children with Disabilities*, UNICEF, New York, 2013; Rau Barriga, Shantha, et al., 'Children with Disabilities: Deprivation of Liberty in the Name of Care and Treatment', in *Protecting Children against Torture in Detention: Global Solutions for a Global Problem*, Center for Human Rights & Humanitarian Law, Washington College of Law, Washington, D.C., 2017, pp. 285–302.

⁵⁴ United Nations Children's Fund/Terre des Hommes, 'Action to Prevent Child Trafficking in South Eastern Europe, A Preliminary Assessment', UNICEF Geneva and Terre des hommes, Le Mont sur Lausanne, 2006; Devandas, Catalina, *Report of the Special Rapporteur on the rights of persons with disabilities, A/72/133*, 2017, paras. 29–31.

two cross-cutting articles (articles 6 and 7), and several other substantive provisions. Article 7 on children with disabilities provides that States are obliged to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children. It also provides for the respect of the rights of children with disabilities in view of their best interests, which includes respecting their right to be heard and to participate in all matters affecting them, their views being given due weight in accordance with their age and maturity, and being provided with disability and age-appropriate assistance to realize that right. As

the Committee on the Rights of the Child has stressed, the child's best interests must be determined on a case-by-case basis and the assessment must include the hearing of the views of the child.⁵⁵

The human rights approach to disability, in conjunction with the child rights approach, calls for seeing children and adolescents with disabilities as rights holders, entitled to exercise their rights and to actively participate in all matters that affect them. This framework should guide the design, implementation, evaluation and monitoring of mental health policies and programmes.

A mother and her son, who has autism, pose for a picture outside Yerazi Tun (Dream House) Rehabilitation and Development Centre in Yerevan, Armenia. UNICEF supported the government's introduction of community-based rehabilitation, promoting early social inclusion for children with severe and moderate disabilities.
© UNICEF/UN0198825/Sokhin



55 Committee on the Rights of the Child, General Comment No. 14, paras. 32 and 43.

2.4

THE RIGHTS OF PERSONS WITH DISABILITIES IN THE CONTEXT OF MENTAL HEALTH

While all rights are interrelated and equally important, particular rights have historically been denied or restricted in the context of mental health, namely the right to equal recognition before the law, the right to personal liberty and security, and freedom from non-

consensual medical treatment and experimentation. As explained, all these human rights and freedoms are inextricably linked to the full and effective enjoyment of the right to the highest standard of health.

2.4.1 The right to legal capacity

The right to legal capacity is central to human rights. It entails holding rights and duties (legal standing) and exercising those rights and duties (legal agency).⁵⁶ Therefore, it is a precondition to the exercise of all human rights and fundamental freedoms.

However, many groups of persons with disabilities have historically been denied their legal capacity. Persons with psychosocial disabilities, persons with intellectual disabilities and autistic persons, for example, often have their legal capacity restricted on the basis of having a medical condition or impairment, having made a decision perceived as poor, or having deficient decision-making skills.⁵⁷ Once their legal capacity is restricted in one or more areas of life, a legal representative is appointed to make decisions on their behalf, or decisions will be made by designated medical personnel or by a court.

The CRPD challenges all these practices and introduces a paradigm shift in relation to the legal capacity of persons with disabilities. Its article 12 affirms the right of all persons with disabilities to equal recognition before the law, upholding their right to exercise legal capacity on an equal basis with others in all areas of life.

States parties must refrain from denying persons with disabilities their legal capacity and must, rather, provide persons with disabilities access to the support necessary to enable them to make decisions that have legal effect, including decisions about treatment or admission for treatment.

In the case of children and adolescents with disabilities, their right to legal capacity must be interpreted in light of the principle of the evolving capacities of the child. As the CRPD Committee has stressed, article 12 of the CRPD applies to all persons with disabilities regardless of age.⁵⁸ Children enjoy legal capacity in a manner consistent with their evolving capacities. The assessment of a child's best interests must include respect for the child's right to express his or her views freely and due weight given to said views in all matters affecting the child. Hence, States must ensure that the will and preferences of children with disabilities are respected on an equal basis with other children.⁵⁹ The Committee on the Rights of the Child has underscored that adolescents with disabilities should be provided with opportunities for supported decision making in order to facilitate their active participation in all matters concerning them.⁶⁰

⁵⁶ Committee on the Rights of Persons with Disabilities, General Comment No. 1, paras. 12–13.

⁵⁷ *Ibid.*, para. 15.

⁵⁸ *Ibid.*, para. 36.

⁵⁹ *Ibid.*

⁶⁰ Committee on the Rights of the Child, General Comment No. 20, para. 32.

2.4.2 The right to liberty and security

The right to liberty and security, as found in international human rights law, concerns freedom from confinement of the body, and freedom from injury to the body and the mind.⁶¹ While the right to liberty and security of a person is not an absolute right, it acts as a substantive guarantee that deprivation of liberty will not be unlawful or arbitrary.⁶² It is considered unlawful when it is not carried out with respect for the rule of law, whereas it is arbitrary when it is imposed in a manner that is inappropriate, unjust, disproportionate, unpredictable, discriminatory or without due process.⁶³

The CRC provides that no child shall be deprived of their liberty unlawfully or arbitrarily and that any arrest, detention or imprisonment must only be used as a last resort and for the shortest appropriate period of time (article 37(b)). Therefore, a child can be deprived of liberty as long as it is lawful and not arbitrary, and the best interests of the child are a primary consideration in every decision to initiate or continue a deprivation of liberty.

For too long, however, exceptions to the right to liberty and security of children, adolescents and adults with disabilities have been widely justified. In most countries, legislation authorizes the deprivation of liberty on the basis of impairment, or in combination with other factors, commonly when the individual presents an alleged 'risk to self or to others' or is in need of treatment or care. Mental health legislation has been one of the main vehicles for the introduction of such exceptions.⁶⁴

Again, the CRPD represents a paradigm shift in the regulation of the right to liberty and security of persons with disabilities. Recalling the universal nature of human rights, its article 14 stresses that persons with disabilities must enjoy the right to liberty and security on an equal basis with others and, therefore, cannot be deprived of their liberty unlawfully or arbitrarily. Moreover, article 14 clarifies that "the existence of a disability shall in no case justify a deprivation of liberty".

The CRPD Committee has stipulated that article 14 establishes an "absolute ban" on the deprivation of liberty on the basis of impairment.⁶⁵ Any deprivation of liberty on such grounds, including involuntary commitment to mental health facilities, would be discriminatory in nature and, consequently, both unlawful and arbitrary. The CRPD Committee has further explained that this absolute ban also applies when additional factors are used to justify the deprivation of liberty, for example being regarded as a 'danger to self or to others' or in need of treatment or care.⁶⁶ Different entities, treaty bodies and special procedures have endorsed these standards, including the Office of the United Nations High Commissioner for Human Rights (OHCHR), the WHO, the Committee on the Elimination of Discrimination against Women, the Working Group on Arbitrary Detention, as well as Puras and Devandas.⁶⁷

Nevertheless, the Human Rights Committee and the Subcommittee on the Prevention of Torture and Other

⁶¹ Human Rights Committee, General Comment No. 35, para. 3.

⁶² *Ibid.*, para. 10.

⁶³ *Ibid.*, para. 11.

⁶⁴ See Gooding, Piers, *A New Era for Mental Health Law and Policy: Supported Decision-Making and the United Nations Convention on the Rights of Persons with Disabilities*, Cambridge University Press, Cambridge, 2017.

⁶⁵ Committee on the Rights of Persons with Disabilities, Guidelines on article 14 of the CRPD, 2015, para. 6.

⁶⁶ *Ibid.*, paras. 6–7.

⁶⁷ Office of the High Commissioner for Human Rights, A/HRC/34/32, paras. 29–32; World Health Organization, QualityRights, *Mental health, disability and human rights: WHO QualityRights core training – for all services and all people*, WHO, Geneva, 2019; Committee on the Elimination of Discrimination against Women, CEDAW/C/IND/CO/4-5, para. 37; Working Group on Arbitrary Detention, 'Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of His or Her Liberty by Arrest or Detention to Bring Proceedings Before a Court', 2015, paras. 38 and 103; Puras, Dainius, A/HRC/35/21, para. 66; and Devandas, Catalina, A/73/161, paras. 14–15.

Cruel, Inhuman or Degrading Treatment or Punishment have challenged the views of the CRPD Committee regarding the absolute ban on deprivation of liberty on the basis of impairment.⁶⁸ Although they have discarded the possibility of depriving a person of their liberty on the basis of medical necessity or need of care, these mechanisms still uphold an exception in the case of 'risk to self or to others', which is intimately linked to the practice of involuntary commitment to mental health facilities.

As involuntary commitment involves the admission of a person into a mental health facility without their free and informed consent, the matter of consent to placement requires special consideration to evaluate deprivation of liberty in the case of children and adolescents with disabilities.

Atika (12), a girl with an intellectual disability, enjoys a moment with her mother and her teacher, Ika Setyawati, in front of her home in Ungaran, Central Java. Atika is a student at Madrasah Ibtidaiyah Keji (MI Keji) in Ungaran. In 2017, MI Keji became one of the pilot madrasas in Central Java that champions inclusive education under the '1 in 11' campaign, a collaboration between the Government of Indonesia, UNICEF and Lembaga Pendidikan Maarif Nahdlatul Ulama (LP Maarif NU), with support from Reach Out To Asia (ROTA) and the FC Barcelona Foundation. The school now welcomes 25 children with disabilities, including Atika. © UNICEF/UNI358764/ljazah



⁶⁸ Human Rights Committee, General Comment No. 35, para. 19; Subcommittee on the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, CAT/OP/27/2, 2016, paras. 5–11.

2.4.3 The right to free and informed consent

The right to free and informed consent to medical treatment and experimentation, including the right to refuse treatment, is widely recognized in international human rights law.

In the case of children, the CRC recognizes that children's evolving capacities should be taken into consideration in health-related decision making.⁶⁹ The CRC Committee has called on States to allow children to consent to certain medical treatments and interventions without the permission of a parent, caregiver or guardian, such as HIV testing and sexual and reproductive health services.⁷⁰ Furthermore, in the case of adolescents, the CRC Committee has stressed that their free and informed consent should be obtained whether or not the consent of a parent or guardian is required for any medical treatment or procedure.⁷¹ Therefore, children and adolescents have the right to consent to treatment, including admission to a mental health facility, in accordance with their age and maturity.

The CRPD also provides that States must ensure that health care for persons with disabilities is provided on the basis of free and informed consent (article 25 (d)). States have an obligation not to permit substitute decision makers to provide consent on behalf of persons with disabilities. Instead, States have an obligation to provide access to support for decisions regarding psychiatric and other medical treatment.⁷² The CRPD Committee has emphasized that involuntary treatment

is not only a violation to the right to health, but also to the right to equal recognition before the law, personal integrity, freedom from torture, and freedom from violence, exploitation and abuse.⁷³

Against this background, children and adolescents with disabilities have the right to consent to treatment on an equal basis with other children. Moreover, they have the right to be provided with disability and age-appropriate assistance to realize that right. The respect for the right of children with disabilities to preserve their identities, recognized in the CRPD, should act as a general guiding principle (article 3 (h)). Practices aiming at conforming people with disabilities to societal norms are contrary to this principle.

⁶⁹ Committee on the Rights of the Child, General Comment No. 15, 2013, para. 21.

⁷⁰ Committee on the Rights of the Child, General Comment No. 14, 2013, paras. 77–78; General Comment No. 15, 2013, para. 31.

⁷¹ Committee on the Rights of the Child, General Comment No. 20, 2016, para. 19.

⁷² Committee on the Rights of Persons with Disabilities, General Comment No. 1, paras. 41–42.

⁷³ *Ibid.*

2.4.4 The right to live independently in the community

Article 19 of the CRPD recognizes that all persons with disabilities have a right to live independently and be included in the community. Accordingly, persons with disabilities must have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others, without being obliged to live in a particular living arrangement, such as institutions. They must also have access to a range of community support services, including individualized disability-specific support and mainstream services and facilities for the general population in the community.

The CRPD Committee has stressed that the core of the right to live independently and be included in the community for children with disabilities entails a right to grow up in a family.⁷⁴ Children with disabilities have the right to be cared for and raised by their parents, as established in article 7 of the CRC and article 23 of the CRPD. Accordingly, when the immediate family is unable to care for a child with disabilities, States must provide alternative care within the wider family and, failing that, within the community in a family setting (article 23). Therefore, the placement of children with disabilities outside a family into institutions or residential homes not only contravenes the right to live independently and be included in the community, but also the right to home and family.

It must be noted that the notion of 'suitable institutions' under article 20 of the CRC and the Guidelines for the Alternative Care of Children contradicts the higher standards upheld by the CRPD. As noted by the CRPD

Committee, 'family-like' institutions, including small group homes, are still contrary to the right to live independently and be included in the community.⁷⁵ The CRC Committee and the CRPD Committee created, in September 2018, a joint Working Group to harmonize the terminology and concepts of both treaty bodies, including issues related to alternative care.

Along with adopting strategies and a concrete plan of action for deinstitutionalization, States have an obligation to ensure that all persons with disabilities, including children with disabilities and their families, have access to individualized support services in the community. Those services must be available, accessible, affordable, acceptable and adaptable to all children and adults with disabilities.⁷⁶ Support for persons with psychosocial disabilities may include personal assistance, support in decision making, communication support, mobility support, living arrangement services for securing housing and household help, and community services.⁷⁷

Persons with psychosocial disabilities may also need support in accessing and using general services, such as health, education and justice.⁷⁸ General health facilities and services, including mental health services, must be available, accessible, adaptable and acceptable for persons with disabilities in their communities.⁷⁹ Furthermore, in the light of article 25 (c), mental health services should be provided through a community-based approach, which places the emphasis on supporting individuals in achieving their own aspirations and goals.⁸⁰

⁷⁴ Committee on the Rights of Persons with Disabilities, General Comment No. 5, 2017, para. 37.

⁷⁵ *Ibid.*, para. 16.

⁷⁶ Devandas, Catalina, *Report of the Special Rapporteur on the rights of persons with disabilities*, A/HRC/34/58, 2016, paras. 48–56.

⁷⁷ *Ibid.*, para. 14.

⁷⁸ *Ibid.*, paras. 87–89.

⁷⁹ Devandas, Catalina, A/73/161, para. 49.

⁸⁰ Office of the High Commissioner for Human Rights, A/HRC/34/32, para. 54.

PART 3

SYSTEMATIC REVIEW OF GLOBAL MENTAL HEALTH AND ITS IMPACT ON PERSONS WITH PSYCHOSOCIAL DISABILITIES

3.1

DOMINANCE OF THE BIOMEDICAL MODEL

A major concern regarding the existing provision of mental health services is the prevalence of the biomedical model of mental illness, which emphasizes its biological factors rather than subjective and social ones.⁸¹ As neurobiological aspects and processes are seen as the main explanation for mental health conditions, this model gives priority to psychiatric diagnosis and pharmacological responses over other interventions.⁸²

Several scholars, experts and activists have criticized the biomedical approach for a number of reasons. First, it is credited with having prompted the overexpansion of diagnostic categories, thereby medicalizing and pathologizing social suffering and human diversity.⁸³ The *International Classification of Diseases* and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), in particular, have been criticized for expanding diagnosis criteria without “solid scientific basis”.⁸⁴

For example, the diagnosis of attention-deficit/hyperactivity disorder (ADHD) in children has increased dramatically in recent years, alongside a rise in the prescription of stimulant drugs. In the United States, 9.4

per cent of children aged 2–17 years (approximately 6.1 million) have received an ADHD diagnosis.⁸⁵ However, the diagnosis overlaps with behaviours commonly displayed by children when they feel frustrated, anxious, bored, abandoned, or in some other way stressed.⁸⁶ As Keith Conners – regarded as the ‘godfather’ of ADHD – has recognized, too many kids get the wrong diagnosis and are given a treatment they do not need.⁸⁷

While many biomedical explanations, such as the chemical imbalance theory, have been dropped,⁸⁸ the narrative of the biomedical model has significantly contributed to the dramatic increase in the number of people diagnosed with mental health conditions, which underpins the discourse of ‘burden of disease’ and ‘treatment gap’.

The biomedical framing has also attracted criticism for its overreliance on medication. In fact, the use of psychiatric medication has intensified over the last decades.⁸⁹ In many countries, children and adolescents are regularly prescribed ADHD drugs, antidepressants, antipsychotics and anti-anxiety drugs, notwithstanding their poor long-term mental health outcomes, and

⁸¹ Deacon, Brett J., ‘The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research’, *Clinical Psychology Review*, vol. 33, no. 7, November 2013, pp. 846–861; Beresford, Peter, Mary Nettle and Rebecca Perring, ‘Towards a social model of madness and distress? Exploring what service users say’, Joseph Rowntree Foundation, November 2010, <www.jrf.org.uk/sites/default/files/jrf/migrated/files/mental-health-service-models-full.pdf>, accessed 10 November 2020.

⁸² Puras, Dainius, A/HRC/35/21, para. 18.

⁸³ Beckett, Jonathan, ‘Evaluating Some of the Approaches: Biomedical Versus Alternative Perspectives in Understanding Mental Health’, *Journal of Psychiatry and Psychiatric Disorders*, 8 May 2007, ISSN: 2572-519X.

⁸⁴ Frances, Allen, *Saving Normal: An Insider’s Revolt against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life*, Harper Collins, New York, 2013; Puras, Dainius, A/HRC/35/21, para. 18.

⁸⁵ Centers for Disease Control and Prevention, Attention-Deficit/Hyperactivity Disorder (ADHD), Data and Statistics about ADHD, <www.cdc.gov/ncbddd/adhd/data.html>, accessed 10 November 2020.

⁸⁶ Double, Duncan, ‘The limits of psychiatry’, *British Medical Journal*, vol. 324, no. 7342, 13 April 2002, p. 901.

⁸⁷ Frances, Allen, ‘Keith Conners, Father of ADHD, Regrets Its Current Misuse’, *Psychology Today*, 28 March 2016, <www.psychologytoday.com>, accessed 10 November 2020.

⁸⁸ Leo, Jonathan, and Jeffrey R. Lacasse, ‘The Media and the Chemical Imbalance Theory of Depression’, *Society*, vol. 45, no. 1, 2008, pp. 35–45.

⁸⁹ Hartz, Ingeborg, et al., ‘Psychotropic drug use among 0-17 year olds during 2004–2014: A nationwide prescription database study’, *BMC Psychiatry*, vol. 16, no. 12, 2016; Steinhausen, Hans-Christoph, ‘Recent international trends in psychotropic medication prescriptions for children and adolescents’, *European Child & Adolescent Psychiatry*, vol. 24, no. 6, 2015, pp. 635–640.

their lasting and damaging side effects.⁹⁰ People with intellectual disabilities and autistic people are more likely to be given these drugs than other people.⁹¹ The CRC Committee has regularly condemned these approaches and urged States to explore non-drug responses and multidisciplinary interventions.⁹²

At the same time, numerous alternatives to psychiatric diagnoses and treatment, which are neither stigmatizing nor harmful, remain underfunded. For example, many children and adolescents who could benefit from psychotherapy are receiving medication. Regrettably, as Puras has noted, the bias towards biomedical approaches and the power of pharmaceuticals has deeply influenced global mental health responses, including in low- and middle-income countries.⁹³

Another criticism of the biomedical model is the little attention paid to the social determinants of mental health, such as poverty, social inequalities, violence and abuse, adverse childhood experiences, or poor family

relationships. Research has consistently demonstrated a strong association between social disadvantage and mental health problems.⁹⁴

Therefore, successful interventions in mental health require action across multiple sectors and levels, as well as a life-course perspective, beyond the narrow and individualized responses of the biomedical model. Recognition of the social determinants has increased but has not translated into a transformation of mental health policy and practice.

Finally, the biomedical framing has been contested from a cultural perspective. If mental health is defined by the relationship between the individual and a given social context, it is argued that 'mental illness' cannot be defined in universal terms. Different regions of the world identify and understand their experiences of distress in ways that are culturally meaningful and valid to them, so it is necessary to pay attention to local and indigenous understandings of mental health and traditions of healing and recovery.⁹⁵

⁹⁰ Meerman, Sanne Te, et al., 'ADHD: a critical update for educational professionals', *International Journal of Qualitative Studies on Health and Well-Being*, vol. 12, suppl. 1, 22 May 2017; Rice, Jessie N., Carrie B. Gillett and Nasuh Malas, 'The Impact of Psychotropic Medications on Bone Health in Youth', *Current Psychiatry Reports*, vol. 20, no. 11, November 2018, p. 104; Giles, Lisa, and D. Richard Martini, 'Challenges and Promises of Pediatric Psychopharmacology', *Academic Pediatrics*, vol. 16, no. 6, August 2016, pp. 508–518.

⁹¹ United Kingdom National Health Service (NHS), 'Stopping over medication of people with a learning disability, autism or both (STOMP)', <www.england.nhs.uk/learning-disabilities/improving-health/stomp>, accessed 10 November 2020.

⁹² Committee on the Rights of the Child, CRC/C/JPN/CO/3, 2010; CRC/C/CHE/CO/2–4, 2015; CRC/C/AUS/CO/4, 2012.

⁹³ Puras, Dainius, A/HRC/35/21, para. 7.

⁹⁴ World Health Organization and Calouste Gulbenkian Foundation, *Social Determinants of Mental Health*, WHO, Geneva, 2014.

⁹⁵ Mills, China, *Decolonizing Global Mental Health: The psychiatrization of the majority world*, Routledge, East Sussex, 2014.

3.2

BARRIERS IN ACCESSING MENTAL HEALTH

While the discourse of ‘global burden of disease’ of mental health problems is controversial,⁹⁶ there is no doubt that mental health and psychosocial needs do not receive the attention they deserve. According to the WHO, for example, depression is one of the leading causes of illness and disability among adolescents, and suicide is the second leading cause of death among adolescents and young adults.⁹⁷ The harmful use of alcohol and illicit drugs and eating disorders among adolescents is also a major issue in many countries.⁹⁸

Despite this worrisome situation, levels of public expenditure on mental health are still very low. Worldwide, national spending in mental health is on average less than 2 per cent of the global median of government health expenditure.⁹⁹ Mental health expenditure is particularly meagre in low- and middle-income countries, where more than 80 per cent of these funds go to long-term institutional care and psychiatric hospitals, often associated with gross human rights violations.¹⁰⁰ This inadequate allocation of resources undermines the availability, acceptability, accessibility and quality of the right to access mental health services or support.¹⁰¹

Stigma and discrimination are significant barriers to access mental health and psychosocial support services.¹⁰² They can have substantial negative effects on all aspects of a person’s life, from employment and housing to social and family life.¹⁰³ Stigma can impact help-seeking behaviours as well as the quality of mental health care.¹⁰⁴ For example, people may choose not to seek help due to fear of judgement or stigma, as well as coercion and negative treatment in services. Indeed, the baseless belief among certain service providers that people with psychosocial disabilities are prone to violence leads to social distance, discrimination and coercive practices.¹⁰⁵ Research has identified a number of factors contributing to stigmatization in the context of health care, including negative attitudes and behaviours by service providers, lack of awareness, therapeutic pessimism and lack of skills.¹⁰⁶

The provision of services in a segregated manner also hinders access to mental health services. The investment of financial and human resources in interdisciplinary and community-based mental health services as close as possible to people’s own communities is insufficient, forcing people in rural and

96 See Chavan, B.S., and Jitender Aneja, ‘Global Mental Health Movement Has Not Helped in Reducing Global Burden of Psychiatric Disorders’, *Indian Journal of Social Psychiatry*, vol. 32, no. 3, November 2016, pp. 261–266.

97 World Health Organization, ‘Adolescents: health risks and solutions’, 13 December 2018, <<http://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions>>, accessed 10 November 2020.

98 Ibid.

99 World Health Organization, *Mental Health Atlas 2017*, WHO, Geneva, 2018, p. 26.

100 Ibid., p. 27.

101 Office of the High Commissioner for Human Rights, A/HRC/34/32, para. 19.

102 Kaushik, Anya, Evgenia Kostaki and Marinos Kyriakopoulos, ‘The stigma of mental illness in children and adolescents: A systematic review’, *Psychiatry Research*, vol. 243, September 2016, pp. 469–494.

103 Tanaka, Chika, et al., ‘A qualitative study on the stigma experienced by people with mental health problems and epilepsy in the Philippines’, *BMC Psychiatry*, vol. 18, no. 325, 2018.

104 Seeman, Neil, et al., ‘World survey of mental illness stigma’, *Journal of Affective Disorders*, vol. 190, 15 January 2016, pp. 115–121.

105 McAleenan, Kristen, ‘Perceptions of Mental Illness and Mental Health Policy’, *Psychology Honors Papers*, Connecticut College, no. 34, 2013, <<http://digitalcommons.conncoll.edu/psychhp/34>> accessed 10 November 2020.

106 Knaak, Stephanie, Ed Mantler and Andrew Szeto, ‘Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions’, *Healthcare Management Forum*, vol. 30, no. 2, 2017, pp. 111–116.

remote areas to travel long distances to access health care and support, often at high cost. While progress has been made over the last few decades, the segregation and centralization of mental health services around psychiatric hospitals and institutions continues.¹⁰⁷

As the OHCHR has noted, the idea that mental health has less value than physical health lies at the root of many of these challenges.¹⁰⁸ While from a normative viewpoint there is no hierarchy between mental and

physical health, the lack of parity of esteem remains the dominant perspective.¹⁰⁹ Accordingly, fewer financial and human resources are allocated for mental health, and mental health facilities tend to have lower quality standards. In addition, the preferential consideration given to physical health translates into significant data and research gaps in mental health, particularly in relation to the rights of users and persons with psychosocial disabilities.¹¹⁰

Charan (5), who has a disability, is held by his mother during a visit by a UNICEF Coordinator who is engaging with the family to help connect them to one of several monetary schemes under the alternative care and mental health psychosocial support programme in Kantivas Village, Banaskantha, Gujarat, India.

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¹⁰⁷ World Health Organization, *Mental Health Atlas 2017*, WHO, Geneva, 2018, p. 27.

¹⁰⁸ Office of the High Commissioner for Human Rights, *A/HRC/34/32*, para. 21.

¹⁰⁹ *Ibid.*

¹¹⁰ *Ibid.*

3.3

HUMAN RIGHTS CHALLENGES IN THE CONTEXT OF MENTAL HEALTH

Human rights violations in the mental health context remain a significant challenge around the world. As the WHO has recently noted, in many countries, the quality of care in both inpatient and outpatient mental health facilities is poor or even harmful.¹¹¹ Treatment is often provided to keep people and their conditions ‘under control’ rather than to enhance their autonomy and improve their quality of life.¹¹² Furthermore, the rights of people with psychosocial disabilities are frequently compromised in health care settings.

The involuntary commitment of persons with psychosocial disabilities in mental health facilities is not only common but rising. Despite the overall reduction of inpatient beds, rates of compulsory admission keep increasing across regions, particularly in high-income countries.¹¹³ Mental health laws, which regulate involuntary commitment, have also augmented. In 2017, 111 States reported having a stand-alone law on mental health, 12 more than in 2014.¹¹⁴ Common criteria for involuntary commitment, besides being diagnosed with a ‘mental illness’, include perceived dangerousness and alleged need for care and treatment. In most jurisdictions, involuntary commitment leads to forced medication or other interventions.

In many countries, community treatment orders have increased, which force people to receive treatment on an involuntary basis in the community.¹¹⁵ Although they are extensively used to prevent relapse and readmission, there is little evidence of their effectiveness¹¹⁶ and serious abuses have been reported in their implementation.¹¹⁷

People with disabilities are also subjected to medical or scientific experimentation, without their free and informed consent in the context of mental health. For example, articles 6 and 7 of the Convention on Human Rights and Biomedicine of the Council of Europe, adopted in 1997, establishes exceptions to their right to be free from non-consensual medical hospitalization and experimentation. Numerous reports also document the administration of unknown or experimental medications by mental health professionals.¹¹⁸

United Nations experts have also reported different forms of abusive and non-consensual practices in mental health services, including forced medication, seclusion and restraint, involuntary sterilization, as well as non-consensual electroconvulsive therapy (ECT) and psychosurgery.

¹¹¹ World Health Organization and Calouste Gulbenkian Foundation, *Policy options on mental health*, WHO, Geneva, 2017, p. 18.

¹¹² Ibid.

¹¹³ See Turnpenny, Ágnes, et al., *Mapping and Understanding Exclusion: Institutional, Coercive and Community-based Services and Practices across Europe*, Mental Health Europe, Brussels and Tizard Centre, University of Kent, 2017.

¹¹⁴ World Health Organization, *Mental Health Atlas 2017*, WHO, Geneva, 2018, p. 18.

¹¹⁵ Molodynski, Andrew, Jorun Rugkåsa and Tom Burns, eds., *Coercion in community mental health care*, Oxford University Press, Oxford, 2016.

¹¹⁶ Rugkåsa, Jorun, ‘Effectiveness of Community Treatment Orders: The International Evidence’, *Canadian Journal of Psychiatry*, vol. 61, no. 1, 1 January 2016, pp. 15–24; Kisely, S. R., L. A. Campbell and R. O’Reilly, ‘Compulsory community and involuntary outpatient treatment for people with severe mental disorders’, *Cochrane Database of Systematic Reviews*, Issue 3, 17 March 2017.

¹¹⁷ See Devandas, Catalina, *Report of the Special Rapporteur on the rights of persons with disabilities, ‘Visit to France’*, A/HRC/40/54/Add.1, 2019.

¹¹⁸ Méndez, Juan, A/HRC/22/53, para. 41.

All these practices have a negative impact on the physical and mental well-being of individuals but are also counter-therapeutic and impede people's recovery.¹¹⁹ Moreover, as stressed by the former Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan Méndez, these practices can be considered as a form of torture and ill treatment.¹²⁰

The situation of people in mental health hospitals is particularly alarming. People may be kept in such facilities for weeks, months and sometimes years. According to the WHO, in certain regions, including the American, African and Western Pacific regions, a significant proportion (20 per cent or more) of mental health hospital residents have had a length of stay of more than one year or even five years.¹²¹

People in these hospitals usually experience poor living conditions and are subjected to dehumanizing, degrading treatment, including violence and abuse. Children and adolescents with disabilities are particularly vulnerable to institutionalization and violence and abuse.¹²²

As Puras and Gooding have stressed, the prevalence of rights abuse cannot be explained by a mere lack of resources.¹²³ Despite the transition towards community-based mental health in a number of high-income countries, many of these countries maintain high coercion rates and continue to invest in the renovation and expansion of large-scale residential and psychiatric institutions, which perpetuate a "vicious cycle of exclusion and despair".¹²⁴

Amir Ali (6) from Herat, Afghanistan, participates in activities at an informal learning centre for refugees in Athens, Greece. As an infant, Amir was injured in an explosion, resulting in a long-term physical disability. UNICEF supported child protection services in open reception facilities on the mainland and in urban sites in Athens, Thessaloniki and Ioannina. Vulnerable refugee and migrant families and children benefited from specialized psychological and mental health services in Athens and five open sites in the Attica region (Elefsina, Elliniko, Agios Andreas/NeaMakri, Rafina and Elaionas). ©UNICEF/UN057909/Gilbertson



¹¹⁹ Swartz, Marvin, Jeffrey Swanson and Michael Hannon, 'Does fear of coercion keep people away from mental health treatment? Evidence from a survey of persons with schizophrenia and mental health professionals', *Behavioral Sciences and the Law*, vol. 21, no. 4, 2003, pp. 459–472; World Health Organization, *QualityRights, Creating mental health and related services free from coercion, violence and abuse*, WHO/MSD/MHP/176, WHO, Geneva, 2017.

¹²⁰ Méndez, Juan, A/HRC/22/53, para. 64.

¹²¹ World Health Organization, *Mental Health Atlas 2017*, WHO, Geneva, 2018, pp. 37–38.

¹²² Rau Barriga, Shantha, et al., 'Children with Disabilities: Deprivation of Liberty in the Name of Care and Treatment', in *Protecting Children against Torture in Detention: Global Solutions for a Global Problem*, Center for Human Rights & Humanitarian Law, Washington College of Law, Washington, D.C., 2017, pp. 285–302.

¹²³ Puras, Dainius, and Piers Gooding, 'Mental health and human rights in the 21st century', *World Psychiatry*, vol. 18, no. 1, February 2019, pp. 42–43.

¹²⁴ *Ibid.*

3.4

SOCIAL DETERMINANTS OF MENTAL HEALTH

The link between mental health and social inequalities is strong. Social, economic and environmental factors decisively influence people's mental health. Inequities in the conditions in which people are born, live, work and age, which in turn are driven by other structural inequalities, determine people's mental health outcomes.¹²⁵ For example, adverse conditions in early life, particularly exposure to neglect and physical and psychological abuse, are associated with poor mental health outcomes and suicide.¹²⁶ Armed conflicts and natural disasters also cause significant psychological and social suffering to affected populations. Therefore, the failure to adopt policy approaches that take into account economic, social and cultural rights, such as the right to education, work, housing, food and water, represents a major barrier to the realization of the right to mental health.¹²⁷

The impact of social determinants varies across life.¹²⁸ The different factors that operate at each stage of life affect the vulnerability and exposure to harmful processes or stressors experienced by individuals. While many mental health conditions and experiences emerge later in life, often they have their roots in the

formative years of childhood. For example, exposure to stressors during early childhood can have a negative cumulative effect, especially if they are not buffered by family and social support.¹²⁹ Maternal care, childcare and education arrangements have a significant impact on the opportunities that empower children and adolescents to choose their own course in life.

Furthermore, social inequalities affecting persons with disabilities perpetuate inequalities in mental health and well-being. Persons with disabilities are affected by poverty in a disproportionate manner.¹³⁰ Children and adolescents with disabilities are less likely to attend and complete school, or to access higher education.¹³¹ Girls and young women with disabilities are disproportionately affected by different forms of gender-based violence, including physical, sexual, psychological and emotional abuse; bullying; female infanticide; trafficking; neglect; domestic violence; and harmful practices, such as child and forced marriage, female genital mutilation, forced sterilization and invasive and irreversible involuntary treatments.¹³² Adults with disabilities are also less likely to work and tend to earn less than their non-disabled peers.¹³³ All these challenges have an enduring impact on the enjoyment of the right to mental health.

¹²⁵ Donkin, Angela, et al., 'Global action on the social determinants of health', *BMJ*, vol. 3, no. 1, 2018; World Health Organization and Calouste Gulbenkian Foundation, *Social Determinants of Mental Health*, WHO, Geneva, 2014.

¹²⁶ Angelakis, Ioannis, Emma Louise Gillespie and Maria Panagioti, 'Childhood maltreatment and adult suicidality: a comprehensive systematic review with meta-analysis', *Psychological Medicine*, vol. 49, no. 7, May 2019, pp. 1057–1078.

¹²⁷ Office of the High Commissioner for Human Rights, A/HRC/34/32, para. 13.

¹²⁸ World Health Organization and Calouste Gulbenkian Foundation, *Social Determinants of Mental Health*, WHO, Geneva, 2014, p. 18.

¹²⁹ *Ibid.*, pp. 17–18.

¹³⁰ United Nations Department of Economic and Social Affairs (DESA), *Disability and Development Report: Realizing the Sustainable Development Goals by, for and with persons with disabilities*, DESA, New York, 2019, p. 57.

¹³¹ *Ibid.*, pp. 100–105.

¹³² Office of the High Commissioner for Human Rights, *Thematic study on the issue of violence against women and girls and disability*, A/HRC/20/5, 2012, paras. 12–27.

¹³³ United Nations DESA, *Disability and Development Report*, pp. 189–196.

A shift of emphasis is needed towards addressing mental health problems by acting on the social determinants of health. Taking action to improve the conditions of daily life from birth, during early childhood, at school age and working ages, and beyond, provides opportunities both to improve population mental health

and to reduce the risk of those mental health problems associated with social inequalities.¹³⁴ For that purpose, coordinated efforts are needed among international cooperation actors, governments, civil society and the private sector.

Rawan Nabulsi (21) was only 15 years old when she was forced to leave her homeland in the Syrian Arab Republic. Six years later, her career took an unexpected positive turn, inspired by her involvement in UNICEF activities to support uprooted children. She is a facilitator at a family club in Cairo, helping children cope with the same hard times, trauma and negative feelings that she experienced when she was their age. ©UNICEF/UNI272253/Younis



¹³⁴ World Health Organization and Calouste Gulbenkian Foundation, *Social Determinants of Mental Health*, p. 43.

3.5

POLICIES AND PRACTICES PROMOTING RIGHTS-BASED RESPONSES

In addition to the right to health framework and the child rights-based approach, mental health policy and practice should adopt and integrate the rights-based approach to disability.

All these approaches require the unconditional application of the principle of non-discrimination and equality with regard to children, adolescents and adults with disabilities.

3.5.1 Practices to combat stigma and discrimination

Despite the negative impact of stigma and discrimination on the lives of users of mental health services and persons with psychosocial disabilities, knowledge of stigma reduction is still very limited. Few stigma reduction programmes have been subjected to independent review or evaluation and, while the literature in this area is growing, it remains insufficient, particularly in low- and middle-income countries.¹³⁵ Furthermore, findings from stigma research conducted among adults are not always applicable to children and adolescents and their families.¹³⁶

Common approaches to stigma reduction include awareness raising, literacy programmes, direct action, advocacy activities and social contact.¹³⁷ Awareness-raising interventions mobilize key stakeholders to engage in activities designed to increase the public profile of mental health issues. Literacy programmes usually aim to educate about 'mental illnesses' – signs, symptoms and treatments – but can also provide

training on how to implement a rights-based and recovery approach (e.g., WHO QualityRights). Direct interventions are designed to suppress stigma through objection, denouncement or public protest, attempting to change organizational behaviours and practices. Advocacy activities are aimed at addressing social inequalities that limit the rights of individuals. Social contact interventions promote positive interpersonal contact with persons with psychosocial disabilities as an attempt to replace flawed perceptions and generalizations, and thus reduce stigma and discrimination.¹³⁸

Building from best practices, Stuart stresses that stigma reduction programmes must be multifaceted to address the many mechanisms that can lead to disadvantaged outcomes (attitudes, beliefs, stereotypes, discrimination, social inequality), and multilevel, addressing stigma perpetuated at the individual and social-structural

¹³⁵ Stuart, Heather, 'Reducing the stigma of mental illness', *Global Mental Health*, vol. 3, e17, 2016, pp. 1–14.

¹³⁶ Mukolo, Abraham, Craig Anne Heflinger and Kenneth A. Wallston, 'The stigma of childhood mental disorders: a conceptual framework', *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 49, no. 2, February 2010, pp. 92–103.

¹³⁷ Stuart, Heather, 'Reducing the stigma of mental illness', pp. 1–14.

¹³⁸ Kolodziej, Monika E., and Blair T. Johnson, 'Interpersonal contact and acceptance of persons with psychiatric disorders: a research synthesis', *Journal of Consulting and Clinical Psychology*, vol. 64, no. 6, 1996, pp. 1387–1396.

levels.¹³⁹ While traditional approaches to stigma reduction have focused on public perceptions of mental illnesses, targeting only one mechanism has proved ineffective as broader social factors can undermine the intervention.¹⁴⁰

Therefore, to mitigate the adverse impacts of stigma, it is essential to transform health and social care provision.¹⁴¹ This is consistent with the rights-based approach to disability that emphasizes the importance of social and economic rights for people with disabilities (such as equitable access to services, education, work, etc.). Stigma reduction programmes should also target a broad range of stakeholders, including persons with mental health problems, families, health workers, public safety officers, schools, community stakeholders, and/or the general public.

It is worth noting that ill-conceived anti-stigma programmes can produce detrimental effects. For example, biological explanations for mental health conditions can generate an oversimplified view of mental health problems, disregarding the role of environmental and social factors. Pescosolido et al. have noted that holding a neurobiological conception of mental illness does not reduce stigma and actually increases the odds of a stigmatizing reaction.¹⁴² Furthermore, they can create a fatalistic view of recovery as well as generate self-stigma.¹⁴³

Mental health prevention campaigns can also be problematic. While the prevention of mental health

problems is a valid element of public health policy, ill-conceived prevention campaigns can be stigmatizing in the use of language and imagery.

Media coverage of mental health can also be stigmatizing and can reinforce the stereotype that persons with psychosocial disabilities are dangerous and unpredictable.¹⁴⁴ To avoid this, health promotion campaigns need to involve media and be sensitive and respectful of the rights and dignity of people with disabilities.

Targeting self-esteem and self-stigma is an important aspect of combating stigma and discrimination, particularly in the case of children and adolescents. Parental secrecy has been found to increase self-stigma, resulting in greater personal rejection and shame, whereas parental optimism and greater faith in the child's ability to control behaviour seem to protect children against self-stigmatization.¹⁴⁵ The implementation of Mental Health First Aid training programmes among adolescents, which educate teenagers on how to recognize and assist someone to seek appropriate help, has been found to be successful in ending secrecy around mental health problem or crisis.¹⁴⁶

Finally, States should revise and adopt legislation and policy to combat discrimination against users of mental health services and persons with psychosocial disabilities. States must guarantee them equal and effective legal protection against discrimination on all grounds.

¹³⁹ Stuart, Heather, 'Reducing the stigma of mental illness', p. 2.

¹⁴⁰ Link, Bruce G., and Jo C. Phelan, 'Conceptualizing Stigma', *Annual Review of Sociology*, vol. 27, August 2001, pp. 363–385.

¹⁴¹ Tanaka, Chika, et al., 'A qualitative study on the stigma experienced by people with mental health problems and epilepsy in the Philippines', *BMC Psychiatry*, vol. 18, no. 325, 2018.

¹⁴² Pescosolido, Bernice, et al., "'A Disease Like Any Other'? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence', *American Journal of Psychiatry*, vol. 167, no. 11, November 2010, pp. 1321–1330.

¹⁴³ Ibid.

¹⁴⁴ Stuber, Jennifer, et al., 'Conceptions of Mental Illness: Attitudes of Mental Health Professionals and the General Public', *Psychiatric Services*, vol. 65, no. 4, 1 April 2014, pp. 490–497.

¹⁴⁵ Kaushik, Anya, Evgenia Kostaki and Marinou Kyriakopoulos, 'The stigma of mental illness in children and adolescents: A systematic review', *Psychiatry Research*, vol. 243, September 2016, pp. 469–494.

¹⁴⁶ Ross, Anna M., et al., 'Development of key messages for adolescents on providing basic mental health first aid to peers: A Delphi consensus study', *Early Intervention in Psychiatry*, vol. 6, no. 3, 2012, pp. 229–238.

BOX 1.

Legal harmonization of the CRPD

Peru has embarked on a comprehensive legal reform process that has resulted in one of the most CRPD-compliant legal frameworks to date.

In 2012, Peru adopted a national law on persons with disabilities, Law No. 29973, which introduced a veritable shift in the approach to the rights of persons with disabilities based on equality and non-discrimination. The law recognizes that persons with disabilities are entitled to the same rights as the rest of the population, including the rights to legal capacity and to personal liberty and security, and to live independently in the community.

In the same year, Peru also adopted Law No. 29889, which amended article 11 of the General Health Law and removed the provision permitting involuntary commitment and treatment. Furthermore, the law introduced several changes to the delivery of mental health care, including a mandate to reform mental health services in order to ensure a community-based health care model and a rights-based approach.

In 2018, Peru became the first country to fully recognize the legal capacity of persons with disabilities by amending its Civil Code, Procedural Code and Notary Act. The reform eliminates all restrictions to the legal capacity of persons with disabilities and replaces the guardianship system with different schemes of supported decision making.

Source: Peruvian Law No. 29973 (2012), Law No. 29889 (2012) and Legislative Decree No. 1384 (2018).

Millah (12), who has an intellectual disability, plays with her cousin, Ririn in their home in Ungaran, Central Java. Millah is a student at Madrasah Ibtidaiyah Keji (MI Keji) in Ungaran and dreams of becoming a doctor. ©UNICEF/UNI358760/ljazah



3.5.2 Recovery-oriented and community-based approaches

Recovery-oriented and community-based approaches are growing in support and are being adopted in an increasing number of countries as a way to ensure the provision of mental health services from a human rights-based perspective.¹⁴⁷

The recovery approach promotes people's active engagement in their own personal recovery journey. Recovery is about helping people to regain or stay in control of their life, and to have meaning and purpose in life; it is not about 'being cured' or 'being normal again'.¹⁴⁸

As recovery is a personal process, different for everyone, recovery may or may not involve treating or managing symptoms. Therefore, recovery-based services seek to integrate the input of, and achieve the outcomes prioritized by, service users.

The principles of the recovery approach include: (i) maintaining hope and optimism for the future; (ii) respecting people's identities, personhood, expertise and the personal meaning of their experience; (iii) connecting people with their family, friends and

communities, including peers; (iv) implementing 'trauma-informed' approaches that explore the impact of interpersonal violence and victimization on an individual's life and development; (v) emphasizing empowerment, collaborative decision making, self-determination, choice and risk-taking in individualized, person-centred recovery planning; (vi) focusing on tackling the social, political and economic barriers to citizenship, social inclusion and participation; and (vii) prioritizing user involvement and peer-led initiatives.¹⁴⁹

While the recovery approach originated in the survivors' movement as a response to the psychiatric experience, some mental health service users and persons with psychosocial disabilities believe the approach has been co-opted and reduced to an individual medicalized model of 'mental illness'.¹⁵⁰ Notwithstanding, many see it as helpful and feel that it helps emphasize service users' strengths and upholds a more person-centred approach to services and support.

Community-based approaches to mental health encompass a wide variety of programmes and services designed to provide mental health services in the community. Under this approach, mental health programmes are delivered mainly by primary health care services and community stakeholders and, exceptionally, by general hospitals or health clinics. Community-based mental health contributes to improved access to services and allows people to maintain family relationships, friendships and employment while receiving treatment

¹⁴⁷ Slade, Mike, Michaela Amering and Lindsay Oades, 'Recovery: An international perspective', *Epidemiologica e Psichiatria Sociale*, vol. 17, no. 2, April–June 2008, pp. 128–137; Thornicroft, Graham, Tanya Deb and Claire Henderson, 'Community mental health care worldwide: current status and further developments', *World Psychiatry*, vol. 15, no. 3, 22 September 2016, pp. 276–286.

¹⁴⁸ World Health Organization, QualityRights, *Promoting recovery in mental health and related services*, WHO/MSD/MHP/17.10, WHO, Geneva, 2017, p. 15.

¹⁴⁹ Jacob, Sini, et al., 'Mental health recovery: A review of the peer-reviewed published literature', *Collegian*, vol. 24, no. 1, 2017, pp. 53–61; O'Keeffe, Donal, et al., "'Recovery' in the Real World: Service User Experiences of Mental Health Service Use and Recommendations for Change 20 Years on from a First Episode Psychosis', *Administration and Policy in Mental Health and Mental Health Services Research*, vol. 45, no. 4, July 2018, pp. 635–648, World Health Organization, QualityRights, *Promoting recovery in mental health and related services*, WHO/MSD/MHP/17.10, WHO, Geneva, 2017.

¹⁵⁰ McWade, Brigit, 'Recovery-as-Policy as a Form of Neoliberal State Making', *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice*, vol. 5, no. 3, 2016, pp. 62–81.

and support.¹⁵¹ It is associated with continuity of care, greater user satisfaction, better protection of human rights and the prevention of stigmatization.¹⁵²

Some principles of community-based mental health services include: (i) a population approach to mental health that focuses on promoting mental health across the whole population; (ii) a focus on addressing the needs of traditionally underserved populations in ways that are accessible and acceptable; (iii) a long-term, longitudinal, life-course perspective; (iv) the development of recovery-oriented approaches; (v) a systemic view of service provision that emphasizes the continuity of care; (vi) enhanced attention to the social determinants of mental health; (vii) the promotion of a wide network of supports, services and resources of adequate capacity, and (viii) deinstitutionalization strategies.¹⁵³

The adoption of community based mental health systems and the promotion of the recovery approach can lead to significant progress in policy and service provision from a rights-based perspective, such as respect for the autonomy, dignity and diversity of individuals and their support needs; improved information, availability, accessibility and range of services; the development of culturally sensitive interventions; the promotion of full and effective participation and inclusion in society; and greater service user empowerment and involvement.

In the humanitarian context, the Inter-Agency Standing Committee (IASC) – an inter-agency coordination

mechanism of humanitarian assistance involving key United Nations and non-United Nations humanitarian partners – developed ‘Guidelines on Mental Health and Psychosocial Support in Emergency Settings’,¹⁵⁴ whose primary purpose is to enable humanitarian actors and communities to plan, establish and coordinate a set of minimum multisectoral responses to protect and improve people’s mental health and psychosocial well-being in the midst of an emergency. These guidelines are based on six core principles: (i) human rights and equity; (ii) participation; (iii) do no harm; (iv) building on available resources and capacities; (v) integrated support systems; and (vi) multi-layered supports, including community and family supports.

As part of the minimum responses to emergencies, the guidelines call for applying a human rights framework through mental health and psychosocial support. This involves: (i) advocating for compliance with international human rights standards in all forms of mental health and psychosocial support in emergencies; (ii) implementing mental health and psychosocial supports that promote and protect human rights; (iii) including a focus on human rights and protection in the training of all relevant workers; (iv) establishing mechanisms for the monitoring and reporting of abuse and exploitation; and (v) advocating for bringing relevant national legislation, policies and programmes in line with international standards and for enhancing compliance with these standards by government bodies. While the guidelines are recovery-oriented and community-based, and

¹⁵¹ EU Joint Action on Mental Health and Wellbeing, ‘European Framework for Action on Mental Health and Wellbeing’, Final Conference, Brussels, 20–22 January 2016, p. 11.

¹⁵² Ibid.

¹⁵³ Thornicroft, Graham, Tanya Deb and Claire Henderson, ‘Community mental health care worldwide: current status and further developments’, *World Psychiatry*, vol. 15, no. 3, 22 September 2016, pp. 276–286; Kidd, Sean A., Larry Davidson and Kwame McKenzie, ‘Common factors in community mental health intervention: A scoping review’, *Community Mental Health Journal*, vol. 53, no. 6, 2017, pp. 627–637; Caldas Almeida, J.M., Pedro Mateus and Gina Tomé, *Towards Community-Based and Socially Inclusive Mental Health Care*, EU Joint Action on Mental Health and Well-being, 2017.

¹⁵⁴ Inter-Agency Standing Committee, ‘IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings’, IASC, Geneva, 2007.

grounded in a human rights-based approach, responses to the needs of people with ‘severe mental disorders’ and those institutionalized may need more clarity on the use of the human rights framework, including the use of some outdated language (e.g., ‘disorder’) and references to restraint and isolation.

More recently, the IASC finished drafting guidelines on ‘Inclusion of Persons with Disabilities in Humanitarian Action’.¹⁵⁵ These guidelines include a section on mental health and psychosocial support and maintain the overall approach of the ‘Guidelines on Mental Health and Psychosocial Support in Emergency Settings’, but reinforce the human rights component. The guidelines, for example, stress the importance of the participation

of persons with disabilities in all decision that concern them, including persons with psychosocial disabilities, and expressly refer to the WHO QualityRights tools.

UNICEF has also published operational guidelines for community-based mental health and psychosocial support in humanitarian settings, which aim to help UNICEF staff and partners support and promote safe, nurturing environments for children’s recovery, psychosocial well-being and protection.¹⁵⁶ These guidelines are framed within UNICEF’s ‘Mental Health and Psychosocial Technical Note’, which provides an overview of guidance, evidence-based interventions, standards, resources and UNICEF country examples of successful mental health and psychosocial support programmes.¹⁵⁷

BOX 2.

Policy reform towards community-based responses

Trieste, a city in the north-eastern region of Italy, has what is regarded as one of the most progressive community-based mental health systems in the world. The ‘Trieste model’ started in the 1970s under the direction of Franco Basaglia, a pioneer psychiatrist who had a vision of anti-institutional democratic psychiatry. The model led to the closure of all mental health hospitals in Italy and the development of a community-based mental health system.

The Trieste model places the person – not their mental health conditions – at the centre of the health care system, promoting their social inclusion and full citizenship. The core of the model is a network of community mental health centres active 24 hours a day, 7 days a week, with relatively few beds in each. Community mental health centres operate under an ‘open door’ policy. The system also comprises one general hospital psychiatric unit, a network of supported housing facilities and several social enterprises.

Trieste has been a collaborating centre of the WHO since 1987 with a goal of disseminating its practices around the world.

Source: Roberto Mezzina, ‘Community Mental Health Care in Trieste and Beyond: An “Open Door–No Restraint” System of Care for Recovery and Citizenship’, The Journal of Nervous and Mental Disease, vol. 202, no. 6, 2014.

¹⁵⁵ Inter-Agency Standing Committee, ‘IASC Guidelines, Inclusion of Persons with Disabilities in Humanitarian Action’, IASC, Geneva, 12 November 2019.

¹⁵⁶ United Nations Children’s Fund, ‘Operational guidelines on community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families (field test version)’, UNICEF, New York, 2018.

¹⁵⁷ United Nations Children’s Fund, ‘Mental Health and Psychosocial Technical Note’, UNICEF, New York, 2019, <www.unicef.org/documents/mental-health-and-psychosocial-technical-note>, accessed 10 November 2020.

3.5.3 Non-coercive responses in mental health

The CRPD establishes a clear call for action to end all forms of coercion in mental health. Because of that, despite the steep rise in coercive psychiatric interventions over the last decade, the interest in alternative practices to coercive measures in mental health care has increased.¹⁵⁸ Just in the past few years, a number of publications have systematized efforts to reduce, end and prevent coercion in the mental health context, including involuntary commitment, forced treatment, seclusion and restraint.¹⁵⁹

While no ‘perfect’ nationwide model exists in which coercion is absent, a number of interventions have shown promising potential in preventing and ending the use of coercion. Examples of efforts to reduce, end and prevent coercion in mental health care include legal and policy reform, hospital-based strategies, community-based practices, as well as other ad hoc strategies, such as advanced planning or advocacy.

Legal reform can be effective in limiting coercion in mental health settings by prohibiting specific practices (e.g., involuntary ECT, seclusion, cage beds and straps) or limiting the scope of ‘exceptions’ (e.g., criteria for involuntary commitment). For example, the Italian Mental Health Act of 1978 (also known as the Basaglia Law) led to a deinstitutionalization process that included the closing of all mental health hospitals and a dramatic reduction in the rates of involuntary treatment. Mechanical restraints were also abolished in health and social care.¹⁶⁰ As different United Nations mechanisms

have stressed, mental health laws must be rethought, including their necessity and approaches, from a human rights-based perspective.¹⁶¹ Guidance is needed to make the leap from reducing to ending all forms of coercion.

Policy reform can also contribute to reduce and eliminate coercion by transforming mental health systems and programmes. The implementation of a community-based approach to mental health and deinstitutionalization strategies should lead to changes in service provision, resulting in less coercive practices. Implementing ‘recovery-oriented’, ‘trauma-informed’ and/or ‘peer-led’ approaches, which place high priority on self-determination and avoiding revictimization, can have a positive impact in reducing and ending coercion.¹⁶² As Puras has recently noted, developing and strengthening existing non-violent, peer-led, trauma-informed, community-led programmes may be a better investment than focusing efforts on reform systems that violate rights.¹⁶³

Hospital-based strategies have proved effective to reduce seclusion and restraint. For example, many services have reported a significant decrease in the use of seclusion and restraint after the implementation of the ‘Six Core Strategies to Reduce Seclusion and Restraint Use’ developed by the National Technical Assistance Center in the United States.¹⁶⁴ These strategies involve top-down organizational leadership, the use of data, workforce development, de-escalation and debriefing techniques, and user

¹⁵⁸ See, for example, World Psychiatric Association, ‘Position Statements: Implementing Alternatives to Coercion: A Key Component of Improving Mental Health Care’, October 2020, <www.wpanet.org/position-statements>, accessed 10 November 2020.

¹⁵⁹ Gooding, Piers, et al., *Alternatives to Coercion in Mental Health Settings: A Literature Review*, Melbourne Social Equity Institute, 2018; Mental Health Europe, ‘Promising practices in prevention, reduction and elimination of coercion across Europe’, 2019; World Health Organization, QualityRights, *Strategies to end the use of seclusion, restraint and other coercive practices*, WHO/MSD/MHP/17.9, WHO, Geneva, 2017.

¹⁶⁰ Mezzina, Roberto, ‘Community Mental Health Care in Trieste and Beyond: An “Open Door–No Restraint” System of Care for Recovery and Citizenship’, *The Journal of Nervous and Mental Disease*, vol. 202, no. 6, June 2014, pp. 440–445.

¹⁶¹ Office of the High Commissioner for Human Rights, A/HRC/39/36, para. 41.

¹⁶² Gooding, Piers, et al., *Alternatives to Coercion in Mental Health Settings: A Literature Review*, Melbourne Social Equity Institute, 2018, pp. 31–36.

¹⁶³ Puras, Dainius, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/HRC/44/48, 2020, para. 12.

¹⁶⁴ National Association of State Mental Health Program Directors (NASMHPD), ‘Six Core Strategies to Reduce Seclusion and Restraint Use’, NASMHPD Publications, 2008, <www.nasmhpd.org/content/six-core-strategies-reduce-seclusion-and-restraint-use>, accessed 10 November 2020.

involvement. Open door policies, an emphasis on environmental factors, better targeted reporting tools and an improved staff-to-service-user ratio have also proved helpful to reduce seclusion and restraint.¹⁶⁵

Community-based strategies encompass a broad range of programmes and services to avoid hospitalization and provide assistance during crisis situations. For example, community-based crisis services, such as peer-run crisis houses, respite services, crisis resolution teams and intensive home-based support, can provide effective crisis support outside the hospital. These services tend to involve non-medical staff, minimal use of medication, peer support, empowerment of service users, social networking and mutual responsibility.¹⁶⁶ They also have greater user satisfaction and lower costs than inpatient admission, with comparable effectiveness.¹⁶⁷ Nevertheless, they also face a number of challenges to

thrive in mental health systems, including scalability, replicability and rapid response.¹⁶⁸

It must be noted that the elimination of coercion in mental health systems demands a systemic approach. As Devandas has noted, the roots of involuntary commitment and other coercive practices are mainly social and related to the failure of States to ensure their human rights obligations towards persons with disabilities.¹⁶⁹ Therefore, ending coercion requires sustainable multisectoral strategies to, *inter alia*, combat stigma and discrimination, transform mental health provision, implement deinstitutionalization and develop community support, guarantee effective access to justice, and ensure capacity building and awareness-raising activities. The increasing evidence of the effectiveness of non-coercive services unavoidably challenges the claim that coercion is a 'necessary evil'.

BOX 3.

Teen-to-teen youth crisis and support services

Although suicide crisis hotlines have been around for a long time, their effectiveness has long been doubted because they are mostly operated by volunteers. However, evidence shows they are successful in providing emotional support and discouraging suicidal behaviour by ensuring safe spaces to discuss suicidal thoughts.¹⁷⁰

YouthLine is a US teen-to-teen youth crisis and support service provided by Lines for Life, a non-profit dedicated to preventing substance abuse and suicide. YouthLine operates a national helpline from Oregon that provides crisis support and referrals via call, text and chat. Since young people in distress are more likely to turn to peers than adults, volunteers are between 15 and 20 years of age. They go through a three-hour orientation and 55 hours of training, during which they listen as their peers take calls. SafeTALK (Suicide Alertness for Everyone) training helps them recognize thoughts of suicide, while more experienced volunteers learn ASIST (Applied Suicide Intervention Skills Training), which prepares them to intervene during a moment of crisis.

Teens who reach out to YouthLine are not required to give any identifying information to ensure confidentiality. Although YouthLine is obliged to report to child protective services or emergency services if they speak with anyone who is being abused or in danger, they rarely have to do so.

Source: YouthLine website, <<https://oregonyouthline.org>>, accessed 10 November 2020; and Catherine Cheney, 'It Takes a Teenager to Help a Teenager in Crisis', *The New York Times*, 24 September 2019.

¹⁶⁵ Gooding, Piers, et al., *Alternatives to Coercion in Mental Health Settings: A Literature Review*, pp. 53–67.

¹⁶⁶ *Ibid.*, pp. 67–81.

¹⁶⁷ Lloyd-Evans, Brynmor, and Sonia Johnson, 'Community alternatives to inpatient admissions in psychiatry', *World Psychiatry*, vol. 18, no. 1, February 2019, pp. 31–32.

¹⁶⁸ *Ibid.*

¹⁶⁹ Devandas, Catalina, *Report of the Special Rapporteur on the rights of persons with disabilities*, A/HRC/40/54, 2019, para. 86.

¹⁷⁰ Gould, Madelyn S., et al., 'Follow-up with Callers to the National Suicide Prevention Lifeline: Evaluation of Callers' Perceptions of Care', *Suicide and Life-Threatening Behavior*, vol. 48, no. 1, February 2018, pp. 75–86.

3.5.4 Support beyond mental health services

Given the connection between mental health outcomes and the social determinants of health, rights-based responses to mental health need to encompass support beyond the area of mental health, such as child and family services, education, protection and prevention against violence, community support, housing and social protection.

A number of studies have demonstrated the causal effect of social and economic interventions on mental health. For example, poverty-targeted unconditional cash transfer programmes have shown improvement in the mental health of young people in low-income countries.¹⁷¹ Housing assistance policies have also proved to improve mental health outcomes of persons with mental health problems, including children and adolescents.¹⁷² For example, the 'Un chez-soi d'abord' programme in France, which provides unconditional housing support to persons with psychosocial disabilities, has shown to reduce the number of hospitalization days by 50 per cent.¹⁷³

Parenting and family-oriented interventions have also proved beneficial for children and young people with disabilities.¹⁷⁴ For example, the WHO recommends parent skills training as a key intervention for children

with developmental disabilities, such as autistic children.¹⁷⁵ Low-intensity parenting skills training instruction, such as the WHO Caregiver Skills Training programme,¹⁷⁶ can improve developmental, behavioural and familial outcomes of children, even if delivered by non-specialist providers.¹⁷⁷

Schools also play an important role in supporting students' mental health and well-being. Research shows that teacher behaviours and teacher–student relationships influence children's social and emotional outcomes.¹⁷⁸ Moreover, teachers are regularly confronted with, and called to act upon, incidents of violence, harassment and bullying, both at home and at school, which increase students' risk of mental health problems. An inclusive and supportive school environment therefore promotes good mental health in children and adolescents, which in turn can improve child behaviour and relationships and stimulate academic achievement.

Peer support can also help foster self-esteem and recovery. A pilot study on peer support among adolescents with eating disorders, for example, revealed a significant decrease in participants' feelings of stigma, a significant increase in hope and motivation for recovery and a better future, and improved trust and acceptance of the hospital treatment they were

¹⁷¹ Kilburn, Kelly, et al., 'Effects of a Large-Scale Unconditional Cash Transfer Program on Mental Health Outcomes of Young People in Kenya', *Journal of Adolescent Health*, vol. 58, no. 2, February 2016, pp. 223–229.

¹⁷² Fenelon, Andrew, et al., 'The Impact of Housing Assistance on the Mental Health of Children in the United States', *Journal of Health and Social Behavior*, vol. 59, no. 3, 1 August 2018, pp. 447–463.

¹⁷³ Délégation Interministérielle à l'Hébergement et à l'Accès au Logement (DIHAL), 'Un chez-soi d'abord, Retour sur 6 années d'expérimentation', <www.gouvernement.fr/sites/default/files/contenu/piece-jointe/2017/04/ucsa.pdf>, accessed 10 November 2020.

¹⁷⁴ Dunst, Carl J., Carol M. Trivette and Deborah W. Hamby, 'Meta-analysis of family-centered helping practices research', *Mental Retardation and Developmental Disabilities Research Reviews*, vol. 13, no. 4, 2007, pp. 370–378.

¹⁷⁵ See Patel, Vikram, et al., 'The Lancet Commission on global mental health and sustainable development', *The Lancet*, vol. 392, no. 10157, 27 October 2018.

¹⁷⁶ World Health Organization, Mental health, WHO Caregiver Skills Training programme, <www.who.int/mental_health/maternal-child/PST/en>, accessed 10 November 2020.

¹⁷⁷ Reichow, Brian, et al., 'Non-specialist psychosocial interventions for children and adolescents with intellectual disability or lower-functioning autism spectrum disorders: a systematic review', *PLoS Medicine*, vol. 10, no. 12, December 2013.

¹⁷⁸ Pianta, Robert C., B. Hamre and M. Stuhlman, 'Relationships between teachers and children', in *Handbook of Psychology: Educational Psychology*, vol. 7, edited by W. M. Reynolds and G. E. Miller, John Wiley & Sons Inc., Hoboken, New Jersey, 2003, pp. 199–234; Lynn, Cynthia, Mary McKernan McKay and Marc S. Atkins, 'School Social Work: Meeting the Mental Health Needs of Students through Collaboration with Teachers', *Children & Schools*, vol. 25, no. 4, 1 October 2003, pp. 197–209.

receiving.¹⁷⁹ Peer support programmes have further proved effective in helping young people to engage with mental health services.¹⁸⁰

In the context of humanitarian emergencies, evidence shows the importance of economic and social justice in people's mental health and psychosocial well-being.

Interventions targeting exposure to violence, increasing community empowerment, strengthening education and child protection, and building social cohesion have a direct impact on children and adolescents' mental health and well-being.¹⁸¹ The mobilization of community support networks and the integration of psychosocial support in education are also essential elements of a sustainable psychosocial response.

BOX 4.

Peer support alternatives

In Kenya, people with psychosocial disabilities and users of mental health services have been running peer support groups since 2012. These groups are fully community-based, operate outside Kenya's mental health system and are not linked to any mental health institution.

Users and Survivors of Psychiatry Kenya (USPK), a national membership organization, has established 15 support groups across the country. USPK also has a virtual support group on WhatsApp. While most of these efforts were funded by private donors, since 2016 the Kenyan Government has also been allocating funding to USPK to establish new peer support groups.

The peer support groups help USPK members to feel empowered and to advance a view of autonomy and decision making. During meetings, peers discuss a wide variety of issues, including mental health care and treatment. This enables people to share information on coping strategies, to learn about their rights, to form relationships with each other, to trigger self-reflection and, in general, to enhance their mental well-being.

Peer support presents a non-coercive environment for decision making, which reinforces individual autonomy.

Source: Users and Survivors of Psychiatry Kenya, The Role of Peer Support in Exercising Legal Capacity, USPK, Nairobi, 2018.

¹⁷⁹ Wade, Stephanie, et al., 'Peer support for eating disorders: a pilot open trial of peer support for children and adolescents with eating disorders', *Journal of Eating Disorders*, vol. 2, suppl. 1, 2014, O64.

¹⁸⁰ Biddle, Lucy, et al., 'Explaining non-help-seeking amongst young adults with mental distress: A dynamic interpretive model of illness behaviour', *Sociology of Health & Illness*, vol. 29, no. 7, November 2007, pp. 983–1002.

¹⁸¹ United Nations Children's Fund, *Growing Up in Conflict: The impact on children's mental health and psychosocial well-being, Report on the symposium, 26–28 May 2015, New Babylon Meeting Center, The Hague*, UNICEF, New York, 2015.

Olive Uzayisenga (24) poses with her twin daughters, Celine and Fiona. At 17 years of age, Olive gave birth to twins with albinism. Her family cast her out and the father of her children abandoned her, forcing her to drop out of school to provide for her infant daughters. Olive was consumed by shame until, one day, when visiting a local government office, a woman noticed her hiding behind the building to breastfeed. "She asked me why I was hiding and told me that I should not be afraid," Olive recalls. "Mama Julienne encouraged me to share my story with her. This gave me more confidence to be open about my children and meet other mothers my age." It took only this small, kind gesture from one person to change Olive's life – and her daughters' – for the better. But her daughters still face discrimination from community members, and she has noticed this affects their confidence. Olive believes this is clear evidence of the work that needs to be done. "Even other children need to learn how to interact with children with disabilities. Every single person should learn to care." ©UNICEF/UN0375726/Rudakubana



PART 4

THEORY OF CHANGE

THEORY OF CHANGE

CONTEXT

- Global mental health momentum
- Sustainable Development Goal implementation
- Human Rights Council engagement on mental health and human rights
- CRPD standards
- Universal Health Coverage (UHC)
- Mental health and psychosocial support as an institutional priority for UNICEF

CHALLENGES

- Biomedical approach to mental health
- Stigma and discrimination
- Limited availability and access to quality mental health and psychosocial support
- Extensive practice of coercion in mental health services
- Tensions between expanding mental health coverage and ensuring human rights
- Public policies and planning decisions that do not consider the voices and needs of girls, boys, adolescents and persons with psychosocial disabilities

STRATEGIES

- Improving law and policy response (community-based approaches)
- Ending coercion in mental health
- Promoting interventions beyond mental health services (multisectoral intervention)
- Improving participation
- Promoting accountability and monitoring

Target constituencies

- UNICEF divisions and partners
- States and territories
- International civil society organizations and organizations of persons with disabilities

OUTCOMES

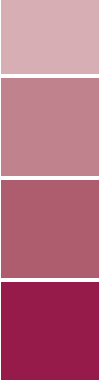
- Improved awareness of the rights of boys, girls, adolescents and persons with psychosocial disabilities
- Increased organizational capacity to promote rights-based mental health and psychosocial support interventions
- Reduced human rights violations in the context of mental health
- Increased representation of boys, girls, adolescents and persons with psychosocial disabilities' needs and voices in mental health reform debates

VISION

- Promoting a rights-based approach to disability and inclusion in mental health policies across countries and territories

PART **5**

**PROGRAMMATIC
RECOMMENDATIONS**



UNICEF works in 190 countries and territories to protect the rights, lives, well-being and future of every child, from early childhood through adolescence. UNICEF's Strategic Plan 2018–2021 is driven by the 2030 Agenda for Sustainable Development, having as an overarching goal to drive results for the most disadvantaged children and young people.

The Strategic Plan establishes five interrelated goal areas: (i) every child survives and thrives; (ii) every child learns; (iii) every child is protected from violence and exploitation; (iv) every child lives in a safe and clean environment; and (v) every child has an equitable chance in life. In addition, humanitarian action and gender equality are recognized as two cross-cutting priorities, which should be integrated into everything UNICEF does. To achieve these results, the Strategic Plan identifies eight change strategies and four organizational enablers. While mental health is only mentioned once as an 'emerging issue', most goals, priorities, strategies and enablers – if not all – are closely linked with the enjoyment of the right to mental health.

Against this background, and based on the systematic review conducted, ***the following recommendations aim to strengthen UNICEF's work in realizing the right to mental health and psychosocial well-being of children and young people from a rights-based approach to disability and inclusion.***

5.1

IMPROVING THE LAW AND POLICY RESPONSE

The need to improve law and policy responses at the national and subnational levels is pressing. Mental health-related legislation needs to be reviewed in light of CRPD standards and to respect the rights of service users and persons with psychosocial disabilities on an equal basis with others.

In addition, mental health strategies and policies need to ensure a community-based approach and encompass recovery-oriented interventions in order to ensure the availability, accessibility, quality and acceptability of mental health programmes and services.

UNICEF can contribute to this goal by:

Strengthening the disability perspective, including changing attitudes and raising awareness of the human rights-based approach to disability, in all of UNICEF's mental health-related interventions across the organization, including regional and country offices, with particular attention to the challenges faced by children and adolescents with psychosocial disabilities;

Supporting law and policy reform to enable the sustainable scale-up and delivery of quality community-based and recovery-oriented mental health programmes and services, including in humanitarian emergencies;

Promoting a human rights-based approach to disability in the process of policy formulation, implementation and evaluation of mental health programmes and services;

Mobilizing resources for community-based, peer-led and human rights-based responses and services that are inclusive of persons with disabilities;

Fostering intersectoral collaboration to ensure that mental health and psychosocial support programmes and services involve actors from other sectors, including health, community-based protection, child protection and education;

Raising awareness of the risks of overdiagnosis, overtreatment and overmedicalization of children and adolescents; and

Working collaboratively with other United Nations agencies, particularly the OHCHR and WHO, to align approaches to technical cooperation in mental health and psychosocial support, in both developmental and emergency settings.



5.2

ENDING COERCION IN MENTAL HEALTH

Ending coercion should be a priority. Coercive practices such as institutionalization, forced treatment, involuntary sterilization, seclusion and restraint hinder processes of healing and recovery, and have a lasting negative impact on children and adolescents' mental health and well-being.

UNICEF can contribute to this goal by:

- Raising awareness of the right to informed consent of children and adolescents, with or without disabilities, in the context of mental health;
- Supporting law reform processes to abolish laws and regulations that permit coercion and discriminate against service users and persons with disabilities receiving mental health care;
- Promoting a process of deinstitutionalization of all children and adolescents with disabilities from all kinds of institutions;
- Mobilizing resources for outreach activities for individuals who are institutionalized, live in confinement or are restricted or deprived of liberty at home or within their community;
- Supporting the expansion of alternative responses to coercion, including the development of support services for persons experiencing crises and emotional distress; and
- Fostering research, innovation and cooperation on best practices to reduce and end coercive practices in mental health programmes and services.

5.3

INTERVENTIONS BEYOND MENTAL HEALTH SERVICES

Social determinants have an impact on mental health and well-being. Ensuring a rights-based approach to mental health demands addressing the individual needs of people, as well as the physical, psychosocial, political and economic environment that surrounds them.

The rights to family life, freedom from violence, education, employment and living in the community are key to securing the right to mental health.

UNICEF can contribute to this goal by:

Promoting early childhood development and the provision of support to families of children with disabilities or experiencing emotional distress, to increase their understanding and skills to address the mental health needs of their children without stigma or discrimination;

Promoting inclusive education systems where children and adolescents with disabilities or experiencing emotional distress feel safe, valued and supported;

Supporting policy reform to ensure that persons with disabilities and their families have access to a wide range of community-based support services, including child protection services and housing;

Promoting support to families and caregivers of children with disabilities, particularly those in a complex family situation (e.g., single-parent families), in receiving information, overcoming social isolation and benefiting from assistance in exercising rights and accessing services;

Supporting the implementation of disability-inclusive social protection systems that mainstream disability in all programmes and interventions, while ensuring access to specific programmes and services for disability-related needs; and

Fostering the inclusion of children with disabilities or experiencing emotional distress in all stages of humanitarian action, including preparedness, response, recovery and mitigation.

5.4

IMPROVING PARTICIPATION

Children and adults with disabilities have the right to be consulted and actively involved in all decisions affecting them, including the implementation of mental health care services.

They know best which barriers they face in the enjoyment of the right to mental health, and how this affects their lives.

No policy should be decided without their direct and full involvement ('Nothing about us without us').

UNICEF can contribute to this goal by:

■ Consulting with and involving international organizations of persons with psychosocial and intellectual disabilities and autistic people in the design, implementation and evaluation of UNICEF's mental health and psychosocial support strategy;

■ Raising awareness of the right of children and adolescents with disabilities to express their views freely on all matters affecting them, on an equal basis with other children;

■ Promoting the consultation and active involvement of persons with disabilities, including children and adolescents with disabilities, in the development and implementation of legislation and policies that directly or indirectly concern them, including mental health-related law and policies;

■ Promoting the provision to children with disabilities of disability, age- and gender-appropriate assistance, including supported decision making, to allow them to participate in decision-making processes that may be relevant in their lives; and

■ Supporting the establishment and functioning of international, national and local representative organizations of persons with psychosocial and intellectual disabilities and autistic people, including children and adolescents.



5.5

ACCOUNTABILITY AND MONITORING

Accountability and monitoring are crucial to ensure that mental health care services are inclusive and respectful of human rights. They help service users and persons with disabilities to know how States fulfil their obligations towards them and to claim redress when their rights have been violated.

UNICEF can contribute to this goal by:



Promoting data collection, disaggregated on the basis of disability, age and gender, to adequately assess the situation of the rights of persons with disabilities in mental health contexts;



Promoting the adoption of accountability mechanisms, with indicators and benchmarks, for measuring and monitoring mental health-related strategies, policies and programmes;



Supporting the creation and functioning of independent monitoring mechanisms to ensure the respect of the rights of service users and persons with psychosocial disabilities in mental health programmes and services;



Promoting access to justice and access to effective remedies to all persons with disabilities whose rights have been violated in the context of mental health provision; and



Promoting research in relation to best practices on disability inclusion in the context of mental health, identifying resources, guidelines and tools that could be adapted to different settings.

5.6

AWARENESS RAISING TO ADDRESS STIGMA AND DISCRIMINATION

Stigma and prejudices against people with psychosocial disabilities or experiencing emotional distress affect their self-esteem, produce isolation and prevent them from seeking help. Furthermore, they may lead to discrimination, violence and social exclusion, negatively affecting peoples' lives in a variety of ways.

UNICEF can contribute to this goal by:

Promoting positive perceptions and greater social awareness of persons with psychosocial disabilities and users of mental health services, changing attitudes and combating negative stereotypes, labelling, stigma and discrimination against them;

Promoting awareness of the multiple and intersectional discrimination experienced by children with disabilities, including in emergency situations;

Mobilizing influential community members to challenge norms and attitudes that perpetuate negative stereotypes, labelling, stigma and discrimination against persons with disabilities;

Ensuring that awareness-raising and literacy programmes on mental health are anchored in the recovery approach and do not reproduce or create further stigma and discrimination;

Supporting training and awareness-raising programmes on the rights of persons with psychosocial disabilities and users of mental health services, particularly in health settings; and

Supporting the prohibition and prevention of discrimination against persons with psychosocial disabilities and users of mental health services, as well as their access to equal and effective legal protection.

A young girl being held by a UNICEF staff member at Aziz Abaza Primary School in Alexandria, Egypt is among 5,000 differently-abled children enrolled in 290 inclusive schools in seven governorates across the country. They all benefit from the interventions of the UNICEF-supported and European Union-funded 'Expanding Access to Education and Protection for At Risk Children in Egypt' project. ©UNICEF/UNI277684/Labib





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