

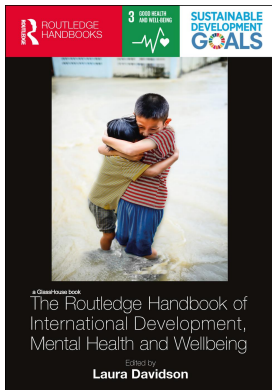
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The Rights to Mental Health and Development

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2

THE RIGHTS TO MENTAL HEALTH AND DEVELOPMENT

Lawrence O. Gostin and Laura Davidson†*

Introduction

It is often argued that there is a ‘right’ to mental health, but what does (or should) it mean? At present the right to mental health is insufficiently robust, but greater conceptual and normative clarity could make the right easier to identify, operationalise, and litigate, in parity with the right to physical health. A rights approach requires advancing the dignity and welfare of persons with mental disabilities, simultaneously helping to fulfil the UN health-related Sustainable Development Goal 3 (SDG3) within the new UN Agenda.¹ Vital, too, is monitoring international mental health obligations and measuring their impact. In this chapter, ideas are offered for comprehensive strategies to help states respect, protect, and fulfil the right to mental health, and to implement and enforce such strategies within available resources.

The mental health burden

Despite close to a third of all disability worldwide arising from mental illness,² it remains almost invisible in modern global health discourse, policy, funding, and action. Yet, mental disability causes untold misery for countless millions, and accounts for approximately 7% of disability-adjusted life years (DALYs) worldwide,³ with young people aged ten to 29 most

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1 *Transforming our world: the 2030 Agenda for Sustainable Development*, Resolution Adopted by the UN General Assembly, 70th Session, 25 Sept 2015, A/RES/70/1 (Agenda items 15 and 16). Available at: www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E.

2 See, e.g., Vigo, D., Thornicroft, G., & Atun, R. (2016), Estimating the true global burden of mental illness, *The Lancet Psychiatry*, 3(2): 171–178.

3 See, e.g., WHO (2014), Global Health Estimates: Deaths, Disability-adjusted Life Year (DALYs), years of life lost (YLL) and years lost due to disability (YLD) by cause, age and sex, 2000–2016. Available at: www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html. Developed in the 1990s, the DALY is a measure of overall disease burden expressed as the number of years lost due to

affected.⁴ Suicide results in an estimated 2,160 deaths daily.⁵ Scandalously, those with mental disorder are twice as likely as others to die prematurely,⁶ and there has been a lamentable failure to improve life expectancy. In 2018, the aetiology of all mental illnesses remains largely unknown. Psychotropic medication is outdated, crude, untailed to the individual, and frequently ineffective. Where efficacious, it often results in debilitating and stigmatising side-effects, such as tardive dyskinesia.⁷ Even the newer, second-generation psychotropic medications cause obesity, metabolic syndrome, and cardiovascular disease.

Worldwide, many psychiatric hospitals, particularly in low- and middle-income countries (LMICs), have grossly inadequate facilities for care and treatment. Hospital conditions frequently denigrate dignity and exacerbate mental disorder, rather than improve it. Human rights abuses are rife, perpetrated by family members, wider civil society, and even mental health professionals—mostly unwittingly, but at times maliciously. Resource constraints and weak or non-existent accountability structures proliferate abuse through inadequate monitoring of standards of care in psychiatric institutions—or no monitoring at all.⁸

Non-communicable diseases (NCDs) including mental disabilities are the primary contributor to the global economic burden.⁹ Despite the overwhelming economic argument for investment,¹⁰ mental health remains neglected in development assistance and health financing. Between 2007 and 2013, only 1% of international health assistance went to mental health.¹¹ The exclusion of mental health from the UN Millennium Development Goals (MDGs) exacerbated the problem. Further, national budgets for mental health are ‘still grotesquely out of proportion to the burden posed by mental health problems, resulting in slow progress in scaling up of care’,¹² as Patel *et al.* point out. Indeed, whilst mental illness accounts for approximately 13% of health care costs globally, it receives on average only 3% of healthcare funding, with

ill-health, disability or early death, to compare the overall health and life expectancy in different countries. See also Whiteford, H. A., Degenhardt, L., Rehm, J., *et al.* (2013), Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010, *The Lancet*, 382(9904): 1575–1586.

4 Whiteford *et al.* (2013), *ibid.*

5 WHO (2014), Preventing Suicide: A Global Imperative. Available at: apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf.

6 See, *e.g.*, Walker, E. R., McGee, R. E., & Druss, B. G. (2015), Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis, *JAMA Psychiatry*, 72(4): 334–341. Available at: <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2110027>.

7 For more on the effects of psychotropic medication, see Chapter 17 of this book by Peter Lehmann.

8 For a consideration of international monitoring systems intended to protect against human rights abuses, see Chapter 20 of this book by Laura Davidson.

9 Bloom, D. E., Cafiero, E. T., Jané-Llopis, E., *et al.* (2001), *The Global Economic Burden of Noncommunicable Diseases* (Geneva: World Economic Forum).

10 See further Chapter 3 of this book by Martin Knapp and Victoria Iemmi, and Chapter 4 by Judith Bass.

11 See para.39 of the *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UN Report A/HRC/35/21 to the Human Rights Council, 35th session, 6–23 June 2017 (28 Mar), pp.5–6, Agenda item 3. Available at: documents-dds-ny.un.org/doc/UNDOC/GEN/G17/076/04/pdf/G1707604.pdf?OpenElement. See also the report by the World Bank Group and the WHO (2016), *Out of the shadows: making mental health a global development priority*. Available at: documents.worldbank.org/curated/en/270131468187759113/pdf/105052-WP-PUBLIC-wb-background-paper.pdf.

12 Patel, V., Boyce, N., Collins, P. Y., *et al.* (2011), A renewed agenda for global mental health, *The Lancet* [online], 22 Oct, 378(9801): 1441–1442.

only 0.5% spent in low income countries.¹³ Even the World Health Organization (WHO), with its remit to protect global health and co-ordinate international health work,¹⁴ devotes only a tiny fraction of its budget to mental health.¹⁵ Major investment is crucial to strengthen mental health systems.¹⁶

Furthermore, the treatment gap between rich and poor is stark, and often a privilege of the wealthy, who have 50 times greater access to mental health care.¹⁷ Health insurance frequently excludes or limits coverage for mental illness, thereby exacerbating impoverishment or leaving the most vulnerable untreated.

The parameters of the right to mental health

In an era of cavernous health inequalities, the rights approach has not gained the traction it deserves. Is the right to health readily identifiable? The WHO's definition of 'health' is an aspirational 'right' that is virtually impossible to achieve: 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.¹⁸ In 2010 the European Community stated that a 'right to health' has 'no single definition. It is about worldwide improvement of health, reduction of disparities, and protection against global health threats'.¹⁹ Without an agreed definition, is it meaningless? How might the right to health be given conceptual and normative clarity, thereby becoming an identifiable, operational, justiciable and enforceable human right? Is there a separate right to mental health, rather than a general right to health which includes, but does not guarantee or prioritise, mental health?

13 WHO (2003), *Investing in Mental Health* (Geneva: WHO), p.38; WHO (2013), *Investing in Mental Health: Evidence for Action* (Geneva: WHO), p.15.

14 See Article 55, *Charter of the United Nations*, which entered into force on 24 Oct 1945. The most recent version of the Constitution is the 45th edn (Supp), Oct 2006. Available at: www.who.int/governance/eb/who_constitution_en.pdf. For more consideration of the WHO, see Chapter 1 of this book by Shekhar Saxena and Laura Davidson. For an in-depth discussion of the WHO's origins, including its founding ideals, core functions, normative powers, and governing structures, as well as internal institutional tensions, see L. O. Gostin (2014), *Global Health Law* (Cambridge: Harvard University Press), Chapter 4.

15 The WHO's approved Programme budget for it in 2018–2019 was US\$47 million; only just over a quarter of the budget for NCDs, and a tiny fraction of the approved overall budget of US\$4,421.5 million. Available at: <https://apps.who.int/iris/bitstream/handle/10665/272406/WHO-PRP-17.1-eng.pdf?sequence=1&isAllowed=y>.

16 See, e.g., Chisholm, D., Sanderson, K., Ayuso-Mateos, J. L., & Saxena, S. (2004), Reducing the global burden of depression: population-level analysis of intervention cost-effectiveness in 14 world regions, *Br J Psychiatry*, 184: 393–403. Available at: doi.org/10.1192/bjp.184.5.393. See also Eaton, J., McCay, L., Semrau, M., et al. (2011), Scale up of services for mental health in low-income and middle-income countries, *The Lancet*, 378(9802): 1592–1603. Available at: [doi.org/10.1016/S0140-6736\(11\)60891-X](https://doi.org/10.1016/S0140-6736(11)60891-X).

17 See WHO (2015), *Mental Health Atlas 2014*. Available at: www.who.int/mental_health/evidence/atlas/mental_health_atlas_2014/en/. See also 'Mental healthcare 50 times more accessible in wealthy countries', *The Guardian*, 20 July 2015. Available at: www.theguardian.com/global-development/datablog/2015/jul/20/mental-healthcare-world-health-organisation.

18 See the introductory declaration in the WHO Constitution. Available at: www.who.int/governance/eb/who_constitution_en.pdf.

19 Council of Europe (2010), *The EU Role in Global Health*, Communication from the commission to the council, the European parliament, the European economic and social committee and the committee of the regions, Brussels, 31 Mar 2010, COM(2010)128 final; SEC(2010)380–382, para. 1.

The right to health is rooted in economic, social, and cultural rights protected by numerous international Conventions. First articulated in the Universal Declaration on Human Rights (UDHR),²⁰ Article 25(1) affirms that

[e]veryone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Notably, mental health is not mentioned.²¹ Indeed, despite the recognition of the right to health in international law for over 50 years, mental health does not feature in most treaties—a major global obstacle to mental health service improvement. Yet, like the mandate of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, clearly the right to health encompasses both physical *and* mental health.²² The intersectionality of the right to mental health should also be noted. The 1986 UN Declaration on the Right to Development²³ describes that right in its Preamble as

a comprehensive economic, social, cultural and political process, which aims at the *constant improvement of the well-being of the entire population and of all individuals* on the basis of their active, free and meaningful participation in development and in the fair distribution of benefits resulting therefrom.²⁴

The UN International Covenant on Economic, Social and Cultural Rights (ICESCR) is unusual in that it explicitly includes mental health and provides the most comprehensive protection of the right to health in international law.²⁵ Article 12(1) states that everyone has the right to the ‘enjoyment of the highest attainable standard of physical *and* mental health’.²⁶ General Comment 14 of the ICESCR is the most authoritative statement on the scope and meaning of the right to health.²⁷ It observes that Article 12 embraces a wide range of socioeconomic conditions necessary for healthy lives, including the underlying determinants of health, such as nutrition, sanitation, housing, potable drinking water, safe workplaces and a healthy environment.²⁸ However,

20 Universal Declaration on Human Rights, UN GA RES/217 (III)A, UN Doc.A/810 (adopted 10 Dec 1948).

21 Although ‘disability’ is mentioned generally.

22 Hereafter, ‘the UN Special Rapporteur on health’. The current UN Special Rapporteur, Dainius Pūras, on health has co-authored a chapter of this book; see Chapter 15, also by Julie Hannah. See also his recent report on mental health, *Report of the Special Rapporteur, op. cit.*, nt. 11.

23 UN GA A/RES/41/128, *UN Declaration on the Right to Development*, 4 Dec 1986. The right to development is now within the mandate of several UN bodies. It was first articulated in the 1981 African Charter on Human and Peoples’ Rights, Art.22(1) of which provides that ‘[a]ll peoples shall have the right to their economic, social and cultural development with due regard to their freedom and identity and in the equal enjoyment of the common heritage of mankind’, and insists that ‘[s]tates shall have the duty, individually or collectively, to ensure the exercise of the right to development’.

24 Emphasis added.

25 International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted by UN GA RES/2200A (XXI) of 16 Dec 1966, and entered into force 23 Mar 1976.

26 Emphasis added.

27 Committee on Economic, Social and Cultural Rights (CESR), General Comment No.14 (2000), *The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4, adopted at the 22nd session, 11 Aug 2000.

28 *Ibid.*, para.4.

a US Court of Appeals decision has described Article 12 as ‘nebulous’, ‘infinitely malleable’, ‘boundless and indeterminate’, and ‘devoid of articulable or discernible standards and regulations’.²⁹ Such breadth and imprecision in a right makes it difficult to implement and enforce.

Article 12(1) of the ICESCR demands that states realise the right to health by (*inter alia*) taking steps to prevent and treat ‘endemic . . . and other diseases, and [ensure] . . . access to medical services for all’, which plainly applies to mental disorders and those suffering from them.³⁰ General Comment 14 explains the normative need for availability, accessibility, acceptability, and quality of care within facilities, medicines, and health services.³¹ Accordingly, ‘availability’ requires sufficient quantities of health facilities, plus access to essential medicines and trained healthcare professionals. For health services to be ‘accessible’, no access barriers such as cost or discrimination must exist; health care should be practically, financially, and geographically obtainable.³² ‘Acceptability’ requires ethical, culturally appropriate, and gender-sensitive health services that meet people’s needs. ‘Quality of care’ means states must provide appropriately trained professionals to run health services of a decent standard.³³

Sceptics argue that Article 12(1) only requires the ‘highest attainable’ standard of mental health.³⁴ The right to health is further weakened by the General Committee’s concession that ‘both the individual’s biological and socio-economic preconditions and a State’s available resources’ may be taken into account.³⁵ More importantly, states need only progressively realise the right,³⁶ as exemplified in the approach of the African Commission on Human and Peoples’ Rights in *Purohit and Moore v. The Gambia*.³⁷ Article 16 of the African ‘Banjul’ Charter states that ‘[e]very individual shall have the right to enjoy the best attainable state of physical and mental health’, with signatory states required to ‘take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick’. In addition to a violation of the right to liberty and security of the person, the Commission found a breach of Article 16³⁸ with respect to psychiatric patients detained at the Royal Victoria Teaching Hospital³⁹ under the Gambia’s Lunatic Detention Act 1917, due to the absence of detention review.⁴⁰ However, despite emphasising the crucial nature of the right to health, the Commission noted that African countries had significant financial constraints. Thus, regrettably, it interpreted the Charter

29 *Flores v. Southern Peru Copper Corporation*, 203 F.R.D. 92 (S.D.N.Y. 2001).

30 Art.12(2)(c). Steps required by Art.12(2) largely relate to child health, environmental hygiene, and epidemic control.

31 See para.12. of CESCR General Comment No.14, *op. cit.*, nt.27.

32 In many LMICs in rural communities, the cost of taking public transport to a health centre is prohibitive.

33 General Comment No.14, *op. cit.*, nt.27, para.12(c)–(d).

34 Emphasis added.

35 General Comment No.14, *op. cit.*, nt.27, para.9.

36 This means that states have an unspecified period of time to improve services incrementally in order to protect the right to health. It is a concept created by treaty Committees and the courts, and does not appear in Convention texts.

37 (2003) No.241/2001.

38 The right of people with disabilities to special measures of protection in keeping with their physical and moral needs under Article 18(4) was also found to have been violated.

39 Ironically, in Banjul, where the treaty was signed—The Gambia’s capital city.

40 Further, the Commission reminded the Gambia that psychiatric patients should be accorded special treatment to enable them to reach and sustain their optimum level of independence and functioning, in accordance with Art.18(4) and the (now outdated) MI Principles. It was also held that the legislation violated respect for human dignity as it used dehumanising terminology such as ‘idiots’ and ‘lunatics’ to describe persons with mental illness.

as merely requiring provision of the maximum *available* resources—despite the absence of such qualification within Article 16.

Although setting the standard too high risks rendering the right to health meaningless, all states, including LMICs, ought to be held accountable by concrete goals and timelines. The Convention on the Rights of Persons with Disability (CRPD) adopts a more robust approach.⁴¹ The definition of ‘disability’ in Article 1 clarifies that those with ‘long-term . . . *mental*, intellectual or sensory impairments’ are included within the scope of its protection.⁴² Whilst Article 25 protects only the right to ‘the enjoyment of the highest *attainable* standard of health’,⁴³ states cannot discriminate on the basis of disability.⁴⁴ Equal quality of service must be ensured, including ‘raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care’. This represents a significant parity requirement; a challenge, given that ‘nowhere in the world does mental health enjoy parity with physical health in national policies and budgets or in medical education and practice’, as noted recently by the UN Special Rapporteur on health.⁴⁵ Article 25 also requires prevention services, prompt diagnosis and intervention, and community service provision. Thus, transferring rural dwellers to a city hub as a first resort would breach the Convention.⁴⁶ Additionally, Article 25(e) of the CRPD requires states to ensure the availability of affordable health insurance which covers mental disorder.

Strengthening the right to mental health

If health is a human right, it must be actionable. Unfortunately, no rigorous international implementation and enforcement obligations exist.⁴⁷ The majority of outcome measurement indices, treaty reporting systems, and court adjudication processes are voluntary, with many states abstaining. How, then, can accountability improve?

Measuring improvements in the right to health via the SDGs

It is noteworthy that the right to health continues to evolve. Further, the inclusion of SDG3 in the new UN Agenda⁴⁸ (under which states must ‘promote healthy lives and enhance well-being for all at all ages’) has finally brought mental health sharply into focus. Despite the UN’s dogged

41 For an in-depth discussion of the impact of this, see Chapter 20 of this book by Laura Davidson. The CRPD is considered in detail in Part V of this book pertaining to legal perspectives.

42 It is unclear how the phrase ‘long-term’ might be interpreted by a national court in terms of mental disability.

43 Emphasis added.

44 Art.25(a) requires states to ‘provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons’.

45 *Report of the Special Rapporteur* (2017), *op. cit.*, nt.11, para.6.

46 This is common in LMICs where psychiatric care is often only available at the tertiary level. However, high-income countries are not exempt—the UK has been criticised for this very recently: see, *e.g.*, Ben Kentish (2017), ‘Number of mental health patients treated hundreds of miles from home hits new high’, *The Independent*, 5 Mar. Available at: www.independent.co.uk/news/mental-health-patients-out-of-area-placements-theresa-may-psychosis-anorexia-schizophrenia-a7611571.html.

47 For a discussion of how to realise rights when violated, see Chapter 21 of this book by Laura Davidson.

48 UN Resolution (2015), *op. cit.*, nt.1.

avoidance of the words ‘mental health’ in the SDGs and the unnecessarily broad terms of SDG3, states now have a global responsibility to eliminate gross and unconscionable health inequities between the rich and poor, the urban and the rural. Health must be promoted and improved for everyone, but particularly for the marginalised. So how might the new UN Agenda strengthen the right to mental health?

SDG targets

The UN Secretary-General’s synthesis report rightly emphasises that implementation, monitoring and evaluation of the SDGs will require ‘[e]nhanced national and international statistical capacities, rigorous indicators, reliable and timely data sets, new and non-traditional data sources, and broader and systematic disaggregation to reveal inequities’.⁴⁹ Targets set under each goal measure whether states are meeting their SDG commitments. Focused, evidence-based, actionable, and inclusive targets and indicators ought to strengthen the right to health, and evidence its impact on social and economic determinants and development.

However, disappointingly, mental health is referred to in only two of the 13 targets under SDG3. Whilst three others are also relevant (targets 3.4, 3.5, 3.8⁵⁰ and 3.b⁵¹ and 3.c⁵² pertaining to the availability of medication, the training of professionals, and universal health coverage), those are all equally applicable to physical health.⁵³ Only target 3.4 is specific to mental illness, requiring states by 2030 to ‘reduce by one third premature mortality from non-communicable diseases through prevention and treatment’ and ‘promote mental health and well-being’. The latter requirement unnecessarily repeats SDG3, rather than setting a specific and concrete aim to help achieve the goal. Disappointingly, no positive target to ensure a healthy life expectancy was included. Decreasing premature mortality is imperative, but reducing disability and improving quality of life are equally important objectives.

Target 3.5 requires states to ‘strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol’.⁵⁴ Although subject to debate,

49 United Nations (2014), *United Nations Secretary-General Synthesis Report of the Secretary-General on the Post-2015 Agenda* (New York: UN).

50 Target 3.8 requires states to ‘[a]chieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all’. This is a particular challenge since traditionally many health insurance policies worldwide have excluded mental health unfairly from coverage.

51 Target 3.b repeats the need to ‘provide access to affordable essential medicines and vaccines . . . and, in particular, provide access to medicines for all’. It is clear that this is already a struggle in LMICs, despite the prevalence of generic medicines in the twenty-first century. Target 3.b is stated as in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which ‘affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-related Aspects of Intellectual Property Rights regarding flexibilities to protect public health’.

52 In accordance with target 3.c, states must ‘[s]ubstantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States’. If this was achieved in the mental health field, it would be a coup—although the word ‘substantially’ is open to interpretation. Further, the difficulties in meeting this target will be exacerbated in LMICs, as professionally trained staff are much more likely to be enticed abroad by higher salaries and better working conditions.

53 See further targets 3.8, 3.b, and 3.c.

54 SDG indicator 3.5.1 relates to ‘[c]overage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders’. SDG indicator 3.5.2 concerns

substance use is defined as a mental illness in the two main psychiatric diagnostic manuals, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) of the American Psychiatric Association,⁵⁵ and that of the WHO (the ICD-11).⁵⁶

The SDG indicators

SDG progress requires monitoring by clear indicators that promote multi-sector approaches and inter-SDG integration, along with sustainable funding. There are 241 indicators drafted to help states evaluate improvements in reaching targets.⁵⁷ A Final List of proposed Sustainable Development Indicators can be found in the Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators (the SDG Indicator Report).⁵⁸ The right to mental health could have been made more explicit and meaningful,⁵⁹ but, like the targets, the indicators barely refer to mental health. It may be that the lack of global consensus on how best to measure ‘wellbeing’ inhibited the incorporation of additional indicators for SDG3. Only three of 26 indicators under SDG3 pertain to mental health. The only indicator related to mental illness (rather than addiction) is indicator 3.4.2 concerning the population suicide mortality rate. A further five indicators apply both to mental and physical health:

3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders

3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol

3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include . . . non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)

3.8.2 Number of people covered by health insurance or a public health system per 1,000 population

[h]armful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol’.

55 ‘Addiction’ is not considered a specific diagnosis in the fifth edition of the DSM-5. Updated in 2013, the manual replaced the categories of substance abuse and substance dependence with a single category: ‘substance use disorder’. The symptoms associated with a substance use disorder are of four main types: impaired control, social impairment, risky use, and pharmacological criteria (in other words, tolerance and withdrawal).

56 First drafted in 1994, the new 2018 version has combined ‘substance abuse’ and ‘substance dependence’ so that they are interchangeable, which aligns with the DSM-5. The term ‘disorder’ is used in the classification rather than ‘disease’ and ‘illness’, and describes a clinically recognisable set of symptoms or behaviour generally associated with interference with personal function and distress.

57 Since 9 indicators repeat under several different targets, the actual total number of individual indicators in the list is 230.

58 See E/CN.3/2016/2/Rev.1, Annex IV. Available at: <https://sustainabledevelopment.un.org/content/documents/11803Official-List-of-Proposed-SDG-Indicators.pdf>.

59 It is debatable whether or not the SDG targets and indicators are now final or remain flexible. Although the SDG Indicator Report uses the word ‘proposed’ in terms of indicators despite reference to the list being ‘final’, the prevailing view appears to be that there is little likelihood of change at this stage, since the General Assembly would need to adopt such amendments.

3.b.1 Proportion of the population with access to affordable medicines and vaccines on a sustainable basis

3.b.2 Total net official development assistance to medical research and basic health sectors

3.c.1 Health worker density and distribution

Indicator 3.4.2

Currently, suicide mortality rates are highest in the WHO European Region (14.1 per 100,000 population) and lowest in the WHO Eastern Mediterranean Region (3.8 per 100,000 population).⁶⁰ However, national data on suicide rates from many countries (particularly LMICs) is often incomplete, inaccurate, or delayed.⁶¹ To measure progress towards meeting SDG3 and its targets, indicator 3.4.2 ought to require records not only of completed suicides, but also attempted suicides and self-harm, as recommended in 2014 in the WHO's first global report on suicide prevention.⁶² In view of the weak UN monitoring tools, mental health advocates (including those with lived experience) must pressurise governments and seek involvement in tracking progress towards relevant targets and indicators.⁶³ The importance of data collection to improve standards and quality of life for those with mental disability should be emphasised in professional training. The UN, European Union, and Commonwealth Secretariat⁶⁴ should provide technical assistance to LMICs to help strengthen data systems and build monitoring and evaluation capacity.

Disaggregation

The SDG Indicator Report states that the indicators 'should be disaggregated, where relevant, by income, sex, age, race, ethnicity, migratory status, disability and geographic location, or other characteristics'.⁶⁵ The words, 'where relevant', are unhelpful, since states may take differing views on relevance, complicating data comparison. Furthermore, regrettably the generic term 'disability' makes no distinction between mental and physical disability. National data disaggregation by mental disability could prove extremely useful, not least in advocacy. For example, the proportion of the population below the international and national poverty lines

60 WHO (2016), Global Health Estimates 2015: Deaths by Cause, Age, Sex, by Country and by Region, 2000–2015. Available at: www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html.

61 See, e.g., Hagaman, A. K., Maharjan, U., & Khort, B. A. (2016), Suicide surveillance and health systems in Nepal: a qualitative and social network analysis, *Int J Ment Health Syst*, 10: 46. Available at: doi.org/10.1186/s13033-016-0073-7.

62 WHO (2014), Preventing Suicide: A Global Imperative, pp.7 and 25–27. Available at: apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf?ua=1&ua=1.

63 Guidance on advocacy is available from the WHO via its QualityRights initiative, which has published 15 key training and guidance materials (see guidance tool 'Advocacy actions to promote human rights in mental health and related areas'). Available at: www.who.int/mental_health/policy/quality_rights/guidance_training_tools/en/.

64 For Commonwealth states, a Commonwealth Fund for Technical Cooperation exists at the UK's Commonwealth Secretariat in London, but access to it is dependent upon state contributions.

65 In accordance with the Fundamental Principles of Official Statistics (UN GA, RES/68/261); see the rubric prior to the list of indicators in the final indicator list, *op. cit.*, nt.58. *The Lancet's* Countdown for Global Mental Health initiative may help assist with disaggregation; see further nt.67 below.

(covered by indicators 1.1.1 and 1.2.1), or the population living in households with access to basic services under indicator 1.4.1 could be disaggregated according to mental disability. As the right to health includes a right to the underlying determinants of health, such data would illuminate where LMICs require support. However, it remains to be seen whether or not states will undertake such disaggregation.

Given the weakness of the indicators, the WHO's more technically rigorous indicators within its NCD and Mental Health Action Plans 2013–2020,⁶⁶ careful recording of Years of Life Lost (YLDs) and Years Lived with Disability (YLDs), and data collected and published under *The Lancet's* new Countdown for Global Mental Health initiative will perhaps enable more precise progress monitoring.⁶⁷

Strategies for protecting the right to mental health and meeting SDG3

Human resources for health

Sufficient human resources are crucial for the delivery of effective treatment. Social support from trained mental health professionals can improve psychosocial disability. However, the worldwide dearth of mental health professionals remains a global health crisis. Trained mental health professionals account for just 1% of the global health workforce. In 2014, the WHO estimated that 45% of the world's population had less than 1 psychiatrist for 100,000 people.⁶⁸ Globally, there was an average of only 7.7 mental health nurses per 100,000 population.

The reasons for the exacerbation of the global shortage of health care workers working in mental health are multifaceted. Like mental health patients, psychiatric professionals frequently are stigmatised, with nurses sometimes lacking wage parity with those nursing physically ill patients, even in high-income countries.⁶⁹ Thus, psychosocial specialists are less easy

66 WHO (2013), *Global Action Plan for the Prevention and Control of NCDs 2013–2020*; WHA (2013), Resolution WHA66.8, 'Comprehensive Mental Health Action Plan 2013–2020', 27 May.

67 The WHO's Mental Health Atlas is used to track progress in the implementation of WHO's Mental Health Action Plan 2013–2020. As this book was going to Press, *The Lancet* announced its Countdown for Global Mental Health initiative—an independent, multi-stakeholder monitoring collaboration for mental health. It plans to develop a robust comparative country index, with biennial reports tracking national, regional, and global progress from 2020 to 2030 published in *The Lancet*. It will work closely with existing Countdowns to ensure the integration of mental health across other global health domains. See further Saxena, S., Kestel, D., Sunkel, C., *et al.* (2019), Countdown Global Mental Health, *The Lancet*, 393(10174): 858–859. Available at: [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)30424-6/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)30424-6/fulltext). See also Whiteford, H. A., Ferrari, A. J., Baxter, A. J., *et al.* (2013), How did we arrive at burden of disease estimates for mental and illicit drug use disorders in the Global Burden of Disease Study 2010?, *Curr Opin Psychiatry*, 26(4): 376–383.

68 However, it should be noted that out of 194 countries, over a third of the world (69 countries) provided no data: see http://gamapserver.who.int/gho/interactive_charts/mental_health/psychiatrists_nurses/atlas.html.

69 See, *e.g.*, Morrisette, P. J. (2011), Recruitment and retention of Canadian undergraduate psychiatric nursing faculty: challenges and recommendations, *Journal of Psychiatric and Mental Health Nursing*, 18(7): 595–601. Available at: doi.org/10.1111/j.1365-2850.2011.01708.x. See also Wells, J. S. G. & McElwee, C. N. (2000), The recruitment crisis in nursing: placing Irish psychiatric nursing in context—a review, *Journal of Advanced Nursing*, 32(1): 10–18. Available at: doi.org/10.1046/j.1365-2648.2000.01460.x. For a consideration of South Africa, see Jansen, R. (2014), Psychiatric nursing: an unpopular choice, *Journal of Psychiatric and Mental Health Nursing*, 22(2): 142–148. Available at: doi.org/10.1111/jpm.12138.

to recruit, and staff shortages in combination with stigma contribute to exceptionally high burnout and attrition rates.⁷⁰

Further, typically, psychiatrists and psychologists are scarce in rural areas, preferring to reside and work in cities. Yet the right to health demands local health care services. A policy solution might involve the relocation of mid-level mental health workers to more rural areas. Without the support of family and/or community, those posted for lengthy periods may lose enthusiasm or suffer swift burnout, resulting in lacklustre care. Accordingly, hardship placement incentivisation is vital, such as higher salaries, meaningful career development, or the provision of cheap or free family accommodation—perhaps with geographical employment freedom upon successful completion of such service.⁷¹

Recruitment policy and global retention strategies

There are also worldwide inequalities in the *distribution* of health care workers. Shortages in human resources for health lead to uneven distribution of staff, gaps in skills and competencies, poor motivation, and low retention.⁷² Despite frequently having greater health needs, LMICs often suffer most. Indeed, of the 57 countries with critical shortages in 2013, 39 are in Africa, with 25% of the world's disease burden, yet only 3% of its health workers and 1% of its health financing.⁷³ Of the countries that provided data to the WHO in 2014, Eritrea (with a population larger than Scotland or Norway) and the Marshall Islands had no psychiatrists at all. Afghanistan, Burundi and Tanzania were little better, with only 0.01 per 100,000 people.⁷⁴ Although also inadequate in comparison with the disease burden, Monaco had 40.98 psychiatrists per 100,000 people, and Norway, 29.69.⁷⁵ The Maldives had no mental health nurses, with only 0.01 per 100,000 people in Togo.⁷⁶ Most were in Norway (123.08 per 100,000 people) and France (90.86).⁷⁷ Clearly, not one state meets the availability requirement extrapolated in General Comment No. 14 on the Article 12 ICESCR right to health. Further, people's needs cannot be met by insufficient numbers of trained professionals. Such dearths prevent states from meeting the acceptability requirement.

Regrettably, there is no SDG indicator demanding the creation of training *infrastructure*. However, the WHO has adopted several resolutions aimed at universal health coverage and improving equitable access to health professionals, which would also help states meet the SDGs.⁷⁸ The

70 See, e.g., Davidson, L., Liebling, H., Akello, G. F., & Ochola, G. (2016), The experiences of survivors and trauma counselling service providers in northern Uganda: implications for mental health policy and legislation, *Int J of Law and Psych*, Part A, Nov–Dec (49): 84–92, at 88.

71 Naturally, this is more difficult for LMICs, where transport costs can be prohibitive, yet arguably the need is greater in rural areas of LMICs.

72 See further Dal Poz, M. R., Quain, E. E., O'Neil, M., et al. (2006), Addressing the health workforce crisis: towards a common approach, *Hum. Resour. Health*, 4: 21.

73 Gostin (2014), *op. cit.*, nt.14, p.342.

74 Liberia and Niger were little better with 0.02 psychiatrists. Next in line were Laos, Sierra Leone and South Sudan, each with 0.03 psychiatrists per 100,000 people.

75 Belgium had 20.32 psychiatrists per 100,000 people, with 20.10 in The Netherlands.

76 Côte D'Ivoire was close behind with 0.02, and Mali and South Sudan with only 0.08 and 0.09 respectively.

77 Slovenia had 89.56 per 100,000 people, and Australia, 70.91.

78 See also the WHO *Global Code of Practice on the International Recruitment of Health Personnel* (2010) WHA63.16; *Health workforce strengthening* (2011), WHA64.6; *Strengthening nursing and midwifery* (2011) WHA64.7; *Transforming health workforce education in support of universal health coverage* (2013), WHA66.23; and *Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage* (2014), WHA67.24. See also Chapter 3 of the WHO Mental Health Atlas 2014 on

WHO Human Resources for Health Action Framework assists governments in developing and implementing a comprehensive strategy for a sustainable health workforce.⁷⁹ Six interconnected components for the development of human resources are proposed: policy, health workforce management, finance, education, partnerships, and leadership. Recognising that health specialist shortages in LMICs are exacerbated by migration to richer countries, in 2016 the WHO adopted the *Global Strategy on Human Resources for Health: Workforce 2030*.⁸⁰ It promotes international collaboration on ethical recruitment in conformity with the WHO Code of Practice on International Recruitment of Health Personnel.⁸¹

Increasing capacity—recruitment and training

In view of the human resource health crisis, SDG target 3.c requires the training of health professionals generally, with indicator 3.c.1 focused on worker density and distribution. Naturally, LMICs cannot be expected to provide the same level of care as more developed nations instantaneously.⁸² However, protecting the right to health and meeting SDG3 are international duties, which, even at their weakest, require progressive realisation and progress. Thus, all states must plan and implement national health policies which fund training for sufficient numbers of psychiatric professionals to ensure adequate countrywide support.⁸³ High-income countries have a responsibility to assist LMICs in this regard. Many such international development partnerships already exist, with specific hospitals or university departments pairing with LMIC counterparts for regular in-country training (sometimes enabling exchange placements in the partner country).⁸⁴

Human rights training

Providing health care of a range, quality and standard equivalent to that for physical disorder requires increased awareness and understanding from health care professionals on ‘the human rights, dignity, autonomy and needs of persons with disabilities’, as the CRPD states.⁸⁵ Article 25(d) of the CRPD proposes that this be accomplished through ‘training and the promulgation

funding/human resources. Available at: apps.who.int/iris/bitstream/10665/178879/1/9789241565011_eng.pdf?ua=1&ua=1.

79 WHO (2006), *The World Health Report 2006: Working Together for Health*. Available at: www.who.int/whr/2006/whr06_en.pdf.

80 WHO (2016), WHA69.19, 69th World Health Assembly, 28 May.

81 WHO (2010), *WHO Global Code of Practice on the International Recruitment of Health Personnel*, Resolution WHA63.16, 63rd World Health Assembly, Geneva, 17–21 May, in Resolutions and decisions, annexes, WHA63/2010/REC/1, p.31. On the Code, see further Siyam, A., Zurn, P., Christian Rø, O., et al. (2013), Monitoring the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, *Bull World Health Organ*, 91(11): 816–823. Available at: doi.org/10.2471/BLT.13.118778.

82 For further discussion about the difficulties inherent in surmounting the resource gap in LMICs, see, e.g., Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007), Resources for mental health: scarcity, inequity, and inefficiency, *The Lancet*, 370: 878–889.

83 On LMICs, see further Patel, V. (2009), The future of psychiatry in low- and middle-income countries, *Psychol Med*, 39: 1759–1762.

84 E.g., Butabika National Referral Hospital in Kampala, Uganda has collaborated with East London NHS Foundation Trust in London, UK, since 2004; see further www.butabikaeastlondon.com.

85 Art.25(d).

of ethical standards for public and private health care'. Such standards should be integrated into training for new recruits, and added to ongoing career development.

The WHO has now finalised 16 training and guidance materials under its QualityRights initiative to assist mental health stakeholders in the implementation of a CRPD-compliant human rights and recovery approach.⁸⁶ These useful materials are freely available to high-income countries and LMICs alike. Six core mental health and human rights modules and four advanced modules (on, for example, supported decision-making and the elimination of seclusion and restraint) complement a service improvement instrument and four guidance tools.

An important objective of the WHO QualityRights initiative is to persuade governments to adopt international human rights norms and reform policies, laws, and programmes.⁸⁷ However, the UN's 1991 guidance, *The protection of persons with mental illness and the improvement of mental health care* (known as the MI Principles),⁸⁸ is now hopelessly out of date. So, too, is the WHO Resource Book on Mental Health, Human Rights and Legislation, drafted prior to the adoption of the CRPD. Due to its non-compliance with the CRPD, it has been withdrawn. To plug this gap, the WHO is currently revamping its mental health legislation guidance to help countries adopt current international human rights norms into domestic legislation. At the date of publication of this book, there was still no indication as to when it might be available. However, this is not an excuse for an impasse by states with no—or inadequately protective—mental health legislation.

Lay support and task-shifting

Given the psychiatric expertise gap in LMICs, numerous NGOs have piloted innovative strategies.⁸⁹ Short-term training and supervision of non-specialist health workers with monitoring by psychiatrists, neurologists, and psychosocial workers can meet mental health need effectively where professionals are either absent (such as in rural communities) or too few.⁹⁰ For example,

86 WHO, *op cit.*, nt.63.

87 It also seeks to improve quality of mental health care and human rights, create community-based and recovery-oriented services that respect and promote human rights, promote independent living in the community, and to develop a movement of people with mental disabilities to provide mutual support, conduct advocacy, and influence policy-making processes.

88 UN GA, A/RES/46/119, adopted at the 75th plenary meeting, 17 Dec 1991.

89 Kakuma, R., Minas, H., van Ginneken, N., *et al.* (2011), Human resources for mental health care: current situation and strategies for action, *The Lancet*, 378: 1654–1663. Available at: [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)61093-3/fulltext?code=lancet-site](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61093-3/fulltext?code=lancet-site).

90 For more on the use of mental health lay workers, see, *e.g.*, V. Patel, D. Chisholm, T. Dua, *et al.* (2015), *Mental, Neurological, and Substance Use Disorders: Disease Control Priorities* (3rd edn), Vol.4 (Washington, DC: World Bank); Patel, V., Belkin, G. S., Chockalingam, A., *et al.* (2013), Grand Challenges: Integrating Mental Health Services into Priority Health Care Platforms, *PLoS Med*, 10(5): e1001448. Available at: doi.org/10.1371/journal.pmed.1001448. See also van Ginneken, N., Tharyan, P., Lewin, S., *et al.* (2013), Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries, *Cochrane Database Syst*, 19 Nov (11): CD009149. Available at: doi.org/10.1002/14651858.CD009149.pub2. In addition, see Araya, R., Rojas, G., Fritsch, R., *et al.* (2003), Treating depression in primary care in low-income women in Santiago, Chile: a randomised controlled trial, *The Lancet*, 361: 995–1000; Rojas, G., Fritsch, R., Solis, J., *et al.* (2007), Treatment of postnatal depression in low-income mothers in primary-care clinics in Santiago, Chile: a randomised controlled trial, *The Lancet*, 370: 1629–1637; Ran, M. S., Xiang, M. Z., Chan, C. L., *et al.* (2003), Effectiveness of psychoeducational intervention for rural Chinese families experiencing schizophrenia: a randomised controlled trial, *Soc Psychiatry Psychiatr Epidemiol*, 38: 69–75; and Chatterjee, S., Pillai, A., Jain, S., *et al.*

simple case management in rural settings at the primary care level by peer-trained support workers has proved successful in Goa, India,⁹¹ and in Rwanda (utilising community health workers).⁹² Such systems free clinicians to assist with more complex psychiatric cases.⁹³

Another answer to the health worker drought in LMICs is task-shifting (also known as task-sharing),⁹⁴ defined as ‘delegating tasks to existing or new cadres with either less training or narrowly tailored training’.⁹⁵ For example, mental health care providers may be employed in various different sectors, or intersectoral collaborations with schools, prisons or other entities introduced. This both improves mental health awareness and ensures accurate and swift detection of mental disorders, triggering referrals and earlier treatment, thereby avoiding chronicity. It also leads to improved follow-up care and overall service delivery.

Tools such as the WHO’s mhGAP intervention guidelines on mental, neurological, and substance misuse disorders,⁹⁶ specifically created for use by such non-specialists in primary or secondary healthcare settings, are an excellent resource. Further, a broader set of workforce categories is likely to facilitate scaling-up mental health care in LMICs. Fulton *et al.* suggest LMICs take a ‘skill-mix’ rather than a staff-mix approach.⁹⁷ However, as Kukuma *et al.* observe, whilst task-shifting seems to be ‘an effective and feasible approach . . . it too will entail substantial investment, innovative thinking, and effective leadership’.⁹⁸

Research

Compared to the size of budgets for equally debilitating physical health problems such as cancer and HIV/AIDS, the amount spent on mental health research globally is paltry. The US’s National

(2009), Outcomes of people with psychotic disorders in a community-based rehabilitation programme in rural India, *Br J Psychiatry*, 195: 433–439.

- 91 See, *e.g.*, Patel, V., Weiss, H. A., Chowdhary, N., *et al.* (2011), Lay health worker led intervention for depressive and anxiety disorders in India: impact on clinical and disability outcomes over 12 months, *The British Journal of Psychiatry*, 199(6): 459–466. Available at: doi.org/10.1192/bjp.bp.111.092155. See further Patel, V., Weobong, B., Nadkarni, A., *et al.* (2014), The effectiveness and cost-effectiveness of lay counsellor-delivered psychological treatments for harmful and dependent drinking and moderate to severe depression in primary care in India: PREMIUM study protocol for randomized controlled trials, *Trials*, 15: 101; and Shinde, S., Andrew, G., Bangash, O., *et al.* (2013), The impact of a lay counselor-led collaborative care intervention for common mental disorders in public and private primary care: a qualitative evaluation nested in the MANAS trial in Goa, India, *Social Science & Medicine*, 88: 48–55.
- 92 See, *e.g.*, Condo, J., Mugeni, C., Naughton, B., *et al.* (2014), Rwanda’s evolving community health worker system: a qualitative assessment of client and provider perspectives, *Hum Resour Health*, 12: 71. Available at: doi.org/10.1186/1478-4491-12-71.
- 93 For consideration of strategies to counter lack of human resources in relation to mental health in LMICs, see, *e.g.*, Saraceno, B., van Ommeren, M., Batniji, R., *et al.* (2007), Barriers to improvement of mental health services in low-income and middle-income countries, *The Lancet*, 370(9593): 1164–1174. Available at: www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61263-X/fulltext.
- 94 See Chapter 4 of this book by Judith Bass for a discussion of how the task-sharing model has expanded and improved upon the task-shifting approach.
- 95 Fulton, B. D., Scheffler, R. M., Sparkes, S. P., *et al.* (2011), Health workforce skill mix and task shifting in low income countries: a review of recent evidence, *Hum Resour Health*, 9: 1. See also Chapter 4 of this book by Judith Bass, Chapter 6 by Sean A. Kidd and Kwame MacKenzie, Chapter 11 by Cornelius Ani and Olayinka Omigbodun, and Chapter 12 by Stephen J. Bartels.
- 96 WHO (2010), *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings: Mental Health Gap Action Programme (mhGAP)* (Geneva: WHO).
- 97 *Ibid.*
- 98 Kakuma, R., Minas, H., van Ginneken, N., *et al.* (2011), Human resources for mental health care: current situation and strategies for action, *The Lancet*, 5 Nov, 378(9803): 1654–1663.

Institute of Mental Health (NIMH) is the largest mental health research funder in the world, yet its 2015 budget for research was on a par with that of 1999.⁹⁹ In the UK, no research charity with an exclusive mental health research remit even existed until as recently as 2008.¹⁰⁰ However, the dearth of research and investment in mental health cannot be blamed on its intractability or the complexity of the brain, since HIV/AIDS also affected a vulnerable, marginalised, and unfairly stigmatised community, and seemed equally obdurate. Yet by 2011, unprecedented scientific progress due to research commitment meant that the seemingly unstoppable 1980s HIV/AIDS epidemic had been almost eradicated in only two decades. Indeed, a newly diagnosed 20-year-old who receives treatment is now likely to live another 50 years.¹⁰¹

Presently, complete understanding of the aetiology of mental illness is a distant hope. However, both SDG3 and the need for the progressive realisation of the right to mental health demand that states invest in scientific research. Although there are some affordable and efficacious prevention and treatment interventions in existence,¹⁰² new innovations remain vital. Despite the frequent call for evidence-based research on effective treatments in LMICs, little has been undertaken on culturally appropriate mental health interventions;¹⁰³ in the words of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health in 2017, '[t]he scaling-up of care must not involve the scaling-up of inappropriate care'.¹⁰⁴ Additionally, the world's many ineffective treatments and inefficient models of care must not be replicated in LMICs.

Furthermore, treatments developed and effective in high-income countries do not necessarily translate well into LMICs. For example, most research on post-traumatic stress disorder (PTSD) occurred in high-income countries' military populations. Virtual reality headsets have been shown to

99 For a critique of this funding gap, see the Post by Former NIMH Director Thomas Insel (2015), *Funding Science*, 23 Jan. Available at: www.nimh.nih.gov/about/directors/thomas-insel/blog/2015/funding-science.shtml.

100 Mental Health Research UK, which was co-founded by Laura Davidson, one of the co-authors of this chapter. A subsequent UK charity, MQ: Transforming Mental Health, was founded in 2013, with initial funding from the Wellcome Trust. Whilst it has a similar remit, it funds research projects globally (unlike Mental Health Research UK, which seeks to capacity-build research within the UK).

101 See, e.g., May, M. T., Gompels, M., Delpech, V., *et al.* (2014), Impact on life expectancy of HIV-1 positive individuals of CD4⁺ cell count and viral load response to antiretroviral therapy, *AIDS*, May, 28(8): 1193–1202. For more on the lessons mental health should take from the successful battle against HIV/AIDS, see Gostin, L. O. (2015), A Tale of Two Diseases: Mental Illness and HIV/AIDS, *Milbank Q*, Dec, 93(4): 687–690. Available at: doi.org/10.1111/1468-0009.12161.

102 See, e.g., Patel, V., Simon, G., Chowdhary, N., *et al.* (2009), Packages of care for depression in low- and middle-income countries, *PLoS Med*, 6(10): e1000159. Available at: [doi: 10.1371/journal.pmed.1000159](https://doi.org/10.1371/journal.pmed.1000159). See also Tol, W. A., Barbui, C., Galappatti, A., *et al.* (2011), Mental health and psychosocial support in humanitarian settings: linking practice and research, *The Lancet*, 378(9802): 1581–1591. Available at: www.ncbi.nlm.nih.gov/pubmed/22008428. In addition, see Chisholm, D., Lund, C., & Saxena, S. (2007), Cost of scaling up mental healthcare in low- and middle-income countries, *Br J Psychiatry*, 191: 528–535. Available at: doi.org/10.1192/bjp.bp.107.038463. See further Chisholm, D. & Saxena, S. (2012), Cost effectiveness of strategies to combat neuropsychiatric conditions in sub-Saharan Africa and South East Asia: mathematical modelling study, *BMJ*, 344: e609. Available at: doi.org/10.1136/bmj.e609.

103 For a consideration of traditional healing and cultural approaches in the contexts of Bhutan and the native American Indian population, see Chapter 7 of this book by Joseph D. Calabrese.

104 See the *Report of the Special Rapporteur* (2017), *op. cit.*, nt.11, para.55. See also para.77, where caution is urged against LMICs following the lead of high-income countries, which have '[t]he largest concentration of mental hospitals and beds separated from regular health care'.

reduce PTSD symptoms¹⁰⁵—an entirely impractical treatment for resource-strapped, post-conflict in possession of neither the necessary funds nor the energy sources in rural areas of great need.¹⁰⁶

Multilateral cooperation

Massive global social, economic, and political changes over numerous decades have resulted in transnational health hazards beyond the field of health care.¹⁰⁷ Increasing industrialisation and urbanisation are causing serious environmental issues. Migration, international drug trafficking, and international corporations selling tobacco, food, and medicine all influence health. Today, multilateral cooperation in the field of public health is essential. Cooperation on the right to health is an international legal obligation now set out in SDG17, thus reinforcing the responsibility of commitment to global partnerships.¹⁰⁸ The international community rallies upon a natural disaster or conflict when, 'in both the relief and recovery stages, international support must include psychosocial support to strengthen resilience in the face of enormous adversity and suffering'.¹⁰⁹ Whilst such crises provide a unique opportunity to scale up care to affected populations,¹¹⁰ collaborations between LMICs and wealthier states with global development budgets to respect, protect, and fulfil the right to mental health are just as necessary during peace and stability.

A systemic approach is needed. Wealthy nations should help fund research into culturally appropriate evidence-based interventions and assist in cost-effectiveness, affordability and feasibility analysis to inform scale-up prioritisation of the most promising strategies, as various targets under SDG17 require.¹¹¹ Further, to aid research and policy-making, mental health funding and the effect of development activities on mental illness (both positive and negative) should be tracked.¹¹²

Public-private partnerships

Major international organisations and partnerships exist for infectious diseases, such as UNAIDS, the Global Fund, and the GAVI Alliance. Yet, there is no single equivalent international agency or public-private partnership devoted to ending mental illness. At least there is now a funding stream. Valuable lessons can be gleaned from the global fight against HIV/AIDS, where networks of funders, researchers, clinicians, and patients shared information that led to standardised care protocols created by international working groups, civil society, and UNAIDS.¹¹³ The remarkable advances in funding, care, and rights in the HIV/AIDS sphere were due in large part to powerful mobilisation by civil society groups.

105 See, e.g., Lake, J. (2015), The integrative management of PTSD: a review of conventional and CAM approaches used to prevent and treat PTSD with emphasis on military personnel, *Advances in Integrative Medicine*, 2: 13–23.

106 Furthermore, the virtual reality scenes developed for the western military are unlikely to resonate or assist in the recovery of civilian LMIC populations.

107 The UN General Assembly deliberated upon such issues when considering the post-2015 Agenda.

108 SDG17 requires states to '[s]trengthen the means of implementation and revitalize the global partnership for sustainable development'.

109 See *Report of the Special Rapporteur* (2017), *op. cit.*, nt.11, para.39.

110 Tol *et al.* (2011), *op. cit.*, nt.102.

111 See, e.g., targets 17.2, 17.3, 17.6, 17.9, 17.14, 17.16, 17.18 and 17.19.

112 See, e.g., Lund, C., De Silva, M., Plagerson, S., *et al.* (2011), Poverty and mental disorders: breaking the cycle in low-income and middle-income countries, *The Lancet*, 378(9801): 1502–1514. Available at: www.ncbi.nlm.nih.gov/pubmed/22008425.

113 Similar networks exist in vaccine and contraception research.

Happily, several global mental health initiatives have been launched more recently. The US National Institute for Mental Health ‘Grand Challenges in Global Mental Health’ initiative supports a new generation of research. Grand Challenges Canada also has a global mental health programme which provides funding to improve treatments and expand access to care via six goals.¹¹⁴ The initiative invested Can\$42 million in 85 projects in 31 countries in 2016–2017.¹¹⁵ The Movement for Global Mental Health¹¹⁶—a network aimed at improving services worldwide (particularly in LMICs) for those with psychosocial disabilities via scientific evidence and human rights—had its genesis in 2007. Its online platform enables idea-sharing amongst 200 institutions and 10,000 individuals.¹¹⁷ Very recently, *The Lancet* unveiled its Countdown Global Mental Health initiative, described as an independent, multi-stakeholder monitoring collaboration for mental health, within an initial timeframe of the UN SDGs. It aims to increase accountability and decrease population-level disparities for mental health by developing a country comparison index. It has partnered with the WHO, Global Mental Health at Harvard, the Global Mental Health Peer Network, and United for Global Mental Health (UnitedGMH) – a major new civil society organisation founded in late 2018 which aims to mobilise political and financial resources for mental health worldwide.¹¹⁸ Such collaboration is key to making the right to mental health meaningful, and in meeting not only SDG3, but also SDG1 which seeks to ‘end poverty in all its forms everywhere’.

State commitment

The breadth of the right to health requires governments to assure both quality mental health services and the determinants of good mental health. The concept of progressive realisation does not apply to some international freedoms and core obligations and thus must be implemented immediately, such as the elaboration of a national public health strategy and non-discriminatory access to services.¹¹⁹ Under international law, states must eliminate discrimination against those with psychosocial disabilities and ensure they are treated with dignity. This is also specified in

114 This is separate from the Grand Challenges in Global Mental Health Initiative. Its six goals are to (i) provide effective and affordable community-based care; (ii) develop treatments for use by non-specialists; (iii) improve children’s access to evidence-based care; (iv) reduce cost and improve supply of medication; (v) integrate screening and services into primary care; and (vi) develop mobile and IT technologies. It supports the online Mental Health Innovation Network, which facilitates the development and uptake of effective mental health innovations by enabling learning, enhancing linkages, disseminating knowledge and leveraging resources.

115 For further information see: www.grandchallenges.ca/programs/global-mental-health/.

116 It began with a Call for Action published in the first *Lancet* series on global mental health. It is a network of individuals and organisations that aim to improve services for those with mental health issues and psychosocial disabilities worldwide, especially in LMICs, through scientific evidence and human rights.

117 The Movement’s organisation is the joint responsibility of the Secretariat based at the South African Federation for Mental Health, and an international Advisory Board has a mandate through the Movement’s Charter.

118 The Countdown initiative will work closely with existing Countdowns to ensure the integration of mental health across other global health domains. See further nt.67 above. For a considered approach to mental health collaboration published as this book was going to press, see Vigo, D. V., Patel, V., Becker, A., *et al.* (2019), A partnership for transforming mental health globally, *The Lancet*, 6(4): 350–356. Available at: [www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(18\)30434-6/fulltext#articleInformation](http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(18)30434-6/fulltext#articleInformation).

119 Committee on Economic, Social and Cultural Rights, General Comment No.14 (2000) on the right to the highest attainable standard of health, paras.43–45.

SDG16, with target 16.b requiring states to ‘[p]romote and enforce non-discriminatory laws and policies for sustainable development’. A multifaceted approach is necessary, involving national interdisciplinary and multi-sectoral collaborations amongst government ministries, researchers, NGOs, health professionals, patients, caregivers, and local communities.

However, providing a basic mental health service package globally would require six to eight times more investment than currently—an estimated US\$6.6 to US\$9.33 billion in lower middle-income countries, and approximately US\$1.6 billion in low-income countries.¹²⁰ Proposed action number 36 of the WHO’s Mental Health Action Plan 2013–2020¹²¹ requires states to ensure ‘a budget across all relevant sectors that is commensurate with identified human and other resources required to implement agreed-upon evidence-based mental health plans and actions’. Whilst a sound intention, how is this achievable in countries with pitiful and/or no ring-fenced mental health budgets?

Despite the WHO’s history, enormous expertise, and broad remit,¹²² surprisingly, it has had little influence in ensuring respect for the right to mental health. Its resources are ‘entirely incommensurate with the scope and scale of global health needs’.¹²³ In 2010 the WHO had a US\$300 million deficit. Its two year US\$4 billion budget fell sharply from 2010 to 2012, and then did not increase until 2016. A non-mandatory ‘assessed contribution’ was requested from member states, with the balance (77%) from voluntary contributions provided by the wealthiest states and foundations. Pledges varied as much as 30%.¹²⁴ More recently, the WHO’s limited funds have been spent on emergencies such as humanitarian disasters, SARS (severe acute respiratory syndrome), and the Ebola outbreak. Despite the contemporaneity of the latter, few states provided additional funding for the new Health Emergencies Programme. Such a non-enforceable funding model was wholly inadequate for the global age. Fortunately, member states voted in favour of major modernising budgetary reforms in May 2013, and now there are fixed voluntary contributions, rather than pledges.¹²⁵ This may ensure that the WHO has more influence upon its member states. However, the WHO itself has failed to prioritise mental health. Indeed, the WHO’s budget for mental health and substance abuse in 2018–2019 was a paltry US\$4.7—an increase of only US\$1 million from 2016–2017—compared to US\$351.4 million earmarked for the NCD category as a whole.¹²⁶

120 Gilbert, B. J., Patel, V., Farmer, P. E., *et al.* (2015), Assessing Development Assistance for Mental Health in Developing Countries: 2007–2013, *PLoS Med*, 12(6): e1001834. Available at: doi.org/10.1371/journal.pmed.1001834.

121 WHO (2013), *op. cit.*, nt.66.

122 According to Gostin, ‘the WHO is the only institution with the legitimacy to rationalize global health funding and activities and to advocate for health in the trade, intellectual property, and environmental sectors’; see Gostin (2014), *op. cit.*, nt.14, p.127.

123 *Ibid.*

124 See Butler, D. (2013), Agency gets a grip on budget, *Nature*, 6 June, 498(7452): 18–19. Available at: doi.org/10.1038/498018a. Another innovation was an ability to move up to 5% of one budget line to another, providing flexibility in addressing unforeseen needs.

125 The WHO’s total Programme budget 2018–2019 represented an increase of US\$81 million from that of 2016–2017, but a reduction of US\$24.6M for NCDs. Available at: apps.who.int/gb/ebwha/pdf_files/WHA70/A70_7-en.pdf?ua=1.

126 WHO (2017), Programme Budget 2018–2019, WHO/PRP/17.1. Available at: https://apps.who.int/iris/bitstream/handle/10665/272406/WHO-PRP-17.1-eng.pdf?sequence=1&isAllowed=y.

Suicide prevention strategies

To meet SDG indicator 3.4.2, the systematic implementation of suicide prevention strategies is crucial,¹²⁷ yet at present such strategies exist in only 28 countries worldwide.¹²⁸ As the WHO extols, policies should emphasise early identification and treatment of both mental disorders and substance use disorders, with input from both health and social sectors, from ministerial to community level.¹²⁹ Accessible psychosocial support and rehabilitation must be provided by doctors, nurses and mental health professionals who have received suicide training.¹³⁰

Firearms, hanging, and pesticide poisoning are the most common methods used for suicide globally.¹³¹ Gun control laws must be tightened. Seventy-five per cent of suicides occur in LMICs, where widespread agriculture and subsistence farming make pesticides widely available.¹³² Restricting ease of access can reduce impulsive suicide attempts arising from crisis.¹³³ In Guyana, which had the highest suicide rate in the world in 2012¹³⁴ (five times higher than the world average),¹³⁵

127 For further information on suicide prevention, see WHO (2014), Preventing Suicide: A Global Imperative. Available at: www.who.int/mental_health/suicide-prevention/world_report_2014/en/. See also WHO (2016), Preventing suicide: a community engagement toolkit. Available at: <https://apps.who.int/iris/handle/10665/272860>

128 WHO (2014), *op. cit.*, nt.5.

129 *Ibid.*, pp.8–9.

130 Regarding the high suicide rate in men, see Chapter 9 of this book by Svend Aage Madsen, and particularly the section on the Men's Shed movement.

131 WHO (2014), *op. cit.*, nt.5, p.7.

132 *Ibid.*, p.11. The proportion of pesticide suicides amongst all suicides is over 60% in Guyana, Dominica, El Salvador, Honduras and Suriname); see further WHO (2016), Safer Access to Pesticides for Suicide Prevention: Experiences from Community Interventions, WHO/MSD/MER/16.3, p.6. Available at: www.who.int/mental_health/suicide-prevention/pesticides_community_interventions/en/. According to a systematic review, fatal pesticide self-poisoning is also a method of suicide in some African countries; see Gunnell, D., Eddleston, M., Phillips, M. R., & Konradsen, F. (2007), The global distribution of fatal pesticide self-poisoning: a systematic review, *BMC Public Health*, 7: 357. Available at: doi.org/10.1186/1471-2458-7-357. See also WHO (2016), Safer Access to Pesticides for Suicide Prevention: Experiences from Community Interventions, WHO/MSD/MER/16.3. Available at: www.who.int/mental_health/suicide-prevention/pesticides_community_interventions/en/.

133 WHO (2014), *op. cit.*, nt.5, p.11. See also Deshpande, R. S. (2002), Suicide by farmers in Karnataka: agrarian distress and possible alleviatory steps, *Economic and Political Weekly*, 37(26): 2601–2610; and WHO (2016), Safer Access to Pesticides for Suicide Prevention: Experiences from Community Interventions, WHO/MSD/MER/16.3, pp.8–23, which discusses a pilot study of the use of lock boxes in suicide prevention in China, India and Sri Lanka. Available at: www.who.int/mental_health/suicide-prevention/pesticides_community_interventions/en/.

134 Guyana has 44.2 suicides per 100,000 people compared to a global average of 16, and has an estimated 1,500 to 2,000 attempted suicides annually, or about one attempt every five hours. Only one out of every four suicides is carried out by a woman, and most are in the age 15 to 34 bracket.

135 The head of psychiatry at Georgetown Public Hospital estimated that for each successful suicide, there were up to 25 more attempted cases. See further G. Handy (2016), 'How Guyana is trying to combat its high suicide rate', *BBC News*, 16 Oct. Available at: www.bbc.com/news/world-latin-america-37618854.

pesticide lock boxes have been introduced with some success.¹³⁶ Responsible media reporting also has a role to play in decreasing suicide.¹³⁷

A global health convention

A right to health lacking clarity hinders accountability. How might the global community forge a more meaningful right, particularly when international treaty bodies and courts promulgate the concept of progressive realisation? The WHO, with a mandate and powers to draft health Conventions,¹³⁸ has the global influence to persuade states to opt into a new framework treaty incorporating the right to the highest attainable standard of physical and mental health. This would help states not only to meet SDG3, but also to bring clarity to norms and standards surrounding the right.¹³⁹ Legal and policy implementation and analysis could improve health equity and justice across all socioeconomic groups. State accountability via mandatory monitoring, reporting and enforcement mechanisms through domestic judicial systems would empower citizens to claim their right to health.

An ambitious treaty could require positive social determinants within every environment, including the most remote and impoverished communities. For example, it might demand quality health care and treatment, access to a nutritious diet, safe drinking water, and a healthy environment (including clean air). An enforceable duty could ensure economic and social conditions conducive to good health, such as employment, safe work environments, decent housing, income support, and gender equality. Importantly, a responsibility to build capacity to fulfil the right to health would require adequate funds to be ring-fenced.

A treaty could boost confidence in national governments through the incorporation of high standards of good governance, involving inclusive participation, transparency, anti-corruption strategies, accountability, and stewardship. This would encourage high-income countries to increase commitment to help overcome challenges in global governance for health. Conversely, increased national investment in health would be more likely in states confident of international financing, leading to a more genuinely equal partnership. Instead of a profitability model, incentives could be provided for research and development based on global health needs with flexibility to adapt global standards to local priorities, systems and knowledge, ensuring *local* ownership and accountability.¹⁴⁰

136 Personal communication between the Ambassador to Guyana (Frederick Hamley Case) and Laura Davidson, Nov 2016. See also Farahnaz Mohammed (2015), 'Guyana: mental illness, witchcraft, and the highest suicide rate in the world', *The Guardian*, 3 Jun. Available at: www.theguardian.com/global-development-professionals-network/2015/jun/03/guyana-mental-illness-witchcraft-and-the-highest-suicide-rate-in-the-world. The WHO's 2016 suicide rates for Lithuania and Russia slightly surpassed that of Guyana. See further, <http://apps.who.int/gho/data/node.main.MHSUICIDE?lang=en>.

137 The WHO has published suicide prevention guidance: see WHO (2014), *Preventing Suicide: A Global Imperative*. Available at: www.who.int/mental_health/suicide-prevention/exe_summary_english.pdf?ua=1.

138 For more on the powers of the WHO see Chapter 1 of this book by Shekhar Saxena and Laura Davidson.

139 See Gostin, L. O., Friedman, E. A., Buse, K., *et al.* (2013), Towards a framework Convention on global health, *Bulletin of the World Health Organization*, 91: 790–793. Available at: dx.doi.org/10.2471/BLT.12.114447. See also Friedman, E. A., Gostin, L. O., & Buse, K. (2013), Advancing the right to health through global organizations: the potential role of a framework Convention on global health, *Health Hum Rights*, 15: 71–86.

140 For discussion of several innovative approaches to mental health care and treatment in LMICs, see Chapter 6 of this book by Sean A. Kidd and Kwame McKenzie.

There is already a broad civil society movement for a Framework Convention on Global Health.¹⁴¹ Advancing a rights-based approach to global mental health could be transformative. Partnering with national stakeholders to highlight in-country health needs, an international body—perhaps akin to the Intergovernmental Panel on Climate Change—could be mandated to modernise treaty norms and standards where necessary. Such a Convention could adjust in the future to new international structures and changes in the global burden of disease.

Conclusion

Inaction and indifference to improving mental health services have always been inexcusable, and the UN must take some responsibility for its regrettable MDG focus on physical health alone. Almost 20 years on, mental disabilities continue to affect us all individually, nationally, and globally. It is abundantly plain that there can be no health without mental health.¹⁴²

The need to include mental health in the UN's new goals was compelling. However, the disappointingly lacklustre focus on mental health encourages continued non-prioritisation by governments. The tools for ensuring monitoring, evaluation and, more importantly, the *achievement* of improved wellbeing under SDG3 are hopelessly flawed. Neither the current SDG3 targets nor the indicators adequately set out steps required to improve mental health. The UN's belligerent failure to include mental health in clear terms in the SDGs was another missed opportunity which cannot have been by chance. Did stigma and perceived intractability dissuade UN actors from including the term? Was the comparative weakness of mental health advocacy compared to that of other sectors a factor? This book is an attempt to counterbalance the failure.

More positively, the inclusion of SDG3 within the new UN Agenda creates a global duty to tackle the misery caused by mental disorder and its enormous burden.¹⁴³ It is time that the right to health was taken seriously as an international responsibility binding on all countries. As Patel *et al.* advocated in 2011, the issue of the human rights of people with mental health problems should be placed at the foreground of global health—the abuse of even basic entitlements, such as freedom and the denial of the right to care,¹⁴⁴ constitute a global emergency on a par with the worst human rights scandals in the history of global health, one which has rightly been called a 'failure of humanity'.¹⁴⁵

In the words of the UN Special Rapporteur on health, the global community must 'harness the momentum of the 2030 Agenda to address mental health'. In 2017, the UN High Commissioner for Human Rights called for the integration of a human rights perspective in mental

141 The Framework Convention on Global Health Alliance (FCGHA). More information available at: www.fcghalliance.org/. See also Gostin, L. O. & Friedman, E. A. (2013), Towards a Framework Convention on Global Health: A Transformative Agenda for Global Health Justice, *Yale J. Health Policy, Law & Ethics*, 13(1): 1–75. Available at: <http://ssrn.com/abstract=2273749>. Further argument can be found in Gostin, L. O., Friedman, E. A., Buse, K., *et al.* (2013), Towards a Framework Convention on Global Health, *WHO Bulletin*, 91(10): 790–793. Available at www.who.int/bulletin/volumes/91/10/12-114447.pdf.

142 See, *e.g.*, Prince, M., Patel, V. Saxena, S., *et al.* (2007), No Health Without Mental Health, *The Lancet*, 370(9590): 859–877. Available at: [dx.doi.org/10.1016/S0140-6736\(07\)61238-0](http://dx.doi.org/10.1016/S0140-6736(07)61238-0).

143 *The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level*, 65th World Health Assembly, WHA65.4, 25 May 2012.

144 Drew, N., Funk, M., Tang, S., *et al.* (2011), Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis, *The Lancet*, 378(9803): 1664–1675. Available at: [doi.org/10.1016/S0140-6736\(11\)61458-X](http://doi.org/10.1016/S0140-6736(11)61458-X).

145 Kleinman, A. (2009), Global mental health: a failure of humanity, *The Lancet*, 374: 603–604.

health, and the realisation of those rights,¹⁴⁶ questioning whether or not the current approaches to mental health, which use a biomedical model involving a vast power imbalance, are supported by evidence, medical ethics, and human rights. Those with psychosocial disability (and serious mental disorders particularly) bear a disproportionate burden of human rights abuses, and must be empowered to live lives of dignity. As recently highlighted, the right to quality mental health ‘compels going beyond the idea of users as mere recipients of care towards their full consideration as active holders of rights’.¹⁴⁷ Efficient systems and institutions staffed by highly trained, empathetic professionals respectful of human rights must be the worldwide norm. Governments committed to health and good governance strategies are a prerequisite for making the right to mental health meaningful. To scale up mental health care, significant budgetary, systemic and human resources are required.¹⁴⁸ Naturally, domestic law and policy must ensure the enforceability of the right.

The WHO has an important role in persuading states to take their commitment to SDG3 and the protection of the right to mental health seriously. It must embrace a renewed monitoring role, admonishing country failures in adhering to Conventions, Recommendations, annual reporting requirements, and even soft law. Such obligations and the quest for global social justice in mental health would be greatly enhanced by the adoption of a binding international framework Convention on global health. Will the WHO use its mandate? The new Director-General of WHO, Dr Tedros Adhanom Ghebreyesus,¹⁴⁹ began his five-year term on 1 July 2017. It remains to be seen whether or not he has the courage, with the WHO behind him, to fill the gap created by the weak SDG target and indicator process.

The right to health and SDG3 both demand increased research capacity to develop better, culturally appropriate, evidence-based mental health interventions. Innovation through online and in-country collaborations should be embraced. The provision of robust research, training and capacity-building support to LMICs from high-income countries can help both the supporting and supported countries to meet their SDG3 obligations, thereby upholding the right to the highest attainable standard of health. International collaborations and intersectoral multi-stakeholder discussions are essential at all stages. Public-private partnerships should be developed and nourished. States must appreciate the importance of accurate data, and disaggregate it according to mental disability to illuminate where expert support is required. All mental health stakeholders must come together to invest in social and economic rights that protect the international right to health, improve global mental health, narrow worldwide health inequities, ensure healthy lives, and promote wellbeing for all at all ages.¹⁵⁰

146 See *Report of the Special Rapporteur* (2017), *op. cit.*, nt.11.

147 *Ibid.*, para.61.

148 Patel, V., Boyce, N., Collins, P. Y., *et al.* (2011), A renewed agenda for global mental health, *The Lancet*, 378 (9801): 1441–1442.

149 Elected by the World Health Assembly on 23 May 2017.

150 Gostin (2014), *op. cit.*, nt.14, p.72.