

## PERSPECTIVE

# “Reducing the Treatment Gap” Poses Human Rights Risks

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### Introduction

The United Nations (UN) officially acknowledged the “global burden” of mental disorders in September 2015, when mental health was included in the UN Sustainable Development Goals (SDGs).<sup>1</sup> In so doing, the UN identified mental health as a priority for global development. The call to “close the treatment gap” was seen as a way to both uphold the right to treatment and integrate mental health into the SDGs, with many asserting that this is a human rights-based approach to transforming mental health.<sup>2</sup>

Although using the SDG framework is a sensible and necessary approach to catalyze action on mental health, the integration of mental health into the SDGs has sparked debates about the relevance and role of human rights frameworks in this area. For example, the latest draft resolution on mental health and sustainable development, presented by Mexico to the UN General Assembly, has been met with renewed calls to avoid the psychiatrization of the SDGs.<sup>3</sup> Psychiatrization, in this context, points to the process by which “psychiatric institutions, knowledge, and practices affect an increasing number of people, shape

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more and more areas of life, and further psychiatry's importance in society as a whole.<sup>24</sup> Concerns about psychiatrization stem from the fact that the focus is predominantly on scaling up the diagnosis and treatment of mental disorders, without paying attention to how a biomedical approach is limited in addressing the environmental, social, economic, and political determinants of mental health.<sup>5</sup> Further, the emphasis on "closing the treatment gap" selectively deploys human rights in order to promote increased access to Western biomedical treatments. In so doing, there is a risk that the foundational principles of interdependence and indivisibility of international human rights will not be brought to fruition. What is needed is a holistic, rights-based approach that focuses not only on the clinical or individual interventions and outcomes but also on the *process and contexts* of implementation. That is why it is critical to ask "what type of evidence is valued (and devalued)."<sup>26</sup> Thus, any discussions about the meaning and logistics of including global mental health as a priority for global development must include the voices of those most affected.

Indeed, advocates for global mental health, including the Movement for Global Mental Health, should engage more deeply with the meaning and the consequences of a human rights framework, as well as the tensions surrounding the idea of a right to mental health. That is, conflating the right to health with increased access to treatment deflects attention away from questions about the validity and sustainability of "closing the treatment gap."<sup>27</sup> The purpose of this paper is to articulate what a human rights perspective in mental health and psychosocial disabilities could mean, and how a more nuanced approach to rights can provide an important challenge to mainstream approaches in global mental health. As individuals within the fields of critical disability and anticolonial studies have long argued, we need an approach to human rights that does not assume that increased diagnosis and treatment will always lead to improvements in population or individual mental health. Our paper builds on and consolidates prior literature in critical disability studies and anticolonial scholarship

on mental health policy and human rights.<sup>8</sup>

After briefly describing a rights-based approach, we offer four suggestions for how to integrate such an approach into mental health policy and practice in a way that more fully addresses the social and structural determinants of emotional well-being.

## Pillars of a human rights-based approach

A rights-based approach to health and development integrates the norms and principles of human rights into the planning, implementation, monitoring, and evaluation of policies and programs. This approach not only focuses on the delivery of health services but also emphasizes the broader determinants of health that impact individuals' well-being. In essence, a rights-based approach ensures that every aspect of health care and its determinants is imbued with respect for, and the realization of, human rights.

At the heart of a human rights-based approach to mental health lies the commitment to uphold and integrate specific fundamental human rights norms in both policy formulation and practical implementation. There is a convergence between the SDGs and human rights standards, and thus a rights-based approach embraces the following core principles:<sup>9</sup>

- *Participation*: Central to a rights-based approach is the principle that all individuals have the right to actively engage in, contribute to, and influence—in a way that is meaningful and inclusive—processes, decisions, and activities affecting their lives.
- *Nondiscrimination and equality*: This principle mandates the elimination of all forms of discrimination and the assurance of equality before the law, in rights, and in opportunities. It underscores the importance of creating an environment where all individuals, irrespective of their race, gender, socioeconomic status, or any other characteristic, enjoy equal rights and opportunities.

- *AAAQ framework*: The AAAQ framework—availability, accessibility, acceptability, and quality—represents a comprehensive and action-oriented approach to economic, social, and cultural rights, such as the rights to health, education, food, and housing. Each component of the AAAQ framework serves as a critical standard for assessing and ensuring the realization of these rights.
- *Transparency and accountability*: These principles advocate for clear, open, and accessible information regarding policies and practices, and they ensure that individuals and entities are held accountable for upholding human rights standards.
- *Interdependence and indivisibility*: This principle recognizes that all human rights are interconnected and interrelated. The improvement or deprivation of one right affects the others. Hence, a holistic approach that respects the interdependence and indivisibility of all human rights is essential for the full realization of each right.

## Suggestions for a more robust integration of a rights-based approach into mental health policy and practice

### *Consider the lessons learned from social medicine and social epidemiology*

[S]ocieties cannot improve the health status of their populations and reduce significant health inequalities solely or primarily by increasing the resources devoted to medical services. While necessary and significant, investments to improve availability of health services and enhance their quality and relevance cannot compensate for significant disparities in access to the social determinants of health.<sup>10</sup>

In 2017, depressive disorders were ranked as the third leading cause of “years lost to disability.”<sup>11</sup> The World Health Organization ranks depression as the single largest contributor to global disability.<sup>12</sup> Thus, it is unsurprising that policy makers are advocating for scaling up mental health diagnosis and treatment.

However, following Audrey Chapman, we believe that focusing on intra-individual interventions and conflating access to psychiatric services with mental health equity often keeps the status quo intact and does little to animate our political imagination.<sup>13</sup> One of the most important lessons from the fields of social medicine and social epidemiology that is relevant to the mainstream agendas in global mental health is that we must guard against reducing rights to the right to receive treatment. Population-based health promotion is a fundamental human right that is as important as individual health treatment. As argued by the former UN Special Rapporteur on the right to health, child psychiatrist Dainius Pūras, mental well-being can be achieved only by *creating environments* that allow individuals, families, communities, and populations to live lives of dignity with the full enjoyment of all of the rights to which they are entitled.<sup>14</sup>

The capabilities approach (CA), a conceptual and normative framework developed by Amartya Sen, is consistent with the focus on creating environments that facilitate well-being.<sup>15</sup> According to the CA, rights and capabilities are interdependent: having a right to do or have something will not guarantee that people are *actually able* to do what they value and thus live a life of dignity and meaning. The opportunity to develop capabilities is central to human freedom and dignity. Rather than focus predominately on scaling up the diagnosis and treatment of mental health conditions, the CA shifts our attention toward the possibilities for well-being and, most importantly, the resources and rights needed to achieve well-being. In order for capabilities to be realized, for people to be able to lead meaningful lives worthy of human dignity, governments need to provide actual opportunities and political entitlements.<sup>16</sup> The 2007 United Nations Declaration on the Rights of Indigenous Peoples, which established a human rights framework to ensure “the survival, dignity and well-being of indigenous peoples,” is relevant here. Specifically, article 24 requires states to take the necessary steps to achieve the full realization of the right to physical and mental health. As Laurence Kirmayer and colleagues note, strengthening the agency and

dignity of Indigenous peoples through political activism (e.g., negotiating land claims) enhances mental health.<sup>17</sup>

*Incorporate an epistemic injustice framework as part of a robust human rights approach*

[There are] structural prejudices in the processes involved in knowledge production, use, and circulation in global health.<sup>18</sup>

In global mental health research, it is crucial to acknowledge the presence of bias, prejudice, and power disparities that influence the creation, use, and dissemination of knowledge. A significant proportion of this bias stems from the dominance of Western perspectives in mental health research. When applied to non-Western contexts, Western theories and frameworks may fail to capture the cultural entanglements and drivers of mental health and illness.<sup>19</sup>

Power asymmetries exacerbate the issue.<sup>20</sup> Scholars from affluent countries typically have access to more resources and higher chances of getting published in high-impact journals, which inherently disadvantages researchers from lower- and middle-income countries. Language poses another barrier since high-impact academic journals publish in English, which may leave out valuable research and insights from non-English-speaking researchers. Additionally, the stigmatization associated with mental illnesses worldwide often results in the devaluation of lived experience as a legitimate source of knowledge in research, policy-making, and practical applications. The dominance of the biomedical model often neglects the social, economic, and cultural context of mental illnesses.

Conflating increased access to diagnosis and treatment with the fulfillment of a right to mental health is made possible because the epistemic injustice involved in mental health research is rendered invisible, and diverse voices and approaches are sidelined in order to promote a single dominant approach. Addressing these asymmetries thus requires an emphasis on epistemic justice and human rights. Implementing epistemic justice involves incorporating diverse perspectives in mental

health research, policy, and practice, validating local knowledge systems, and recognizing the importance of the lived experiences of individuals affected by mental health issues.<sup>21</sup>

*(Re)cast mental well-being in a moral, not economic, framework<sup>22</sup>*

While it is uncontroversial to note that millions of people around the world are grossly underserved, the current “burden of disease” approach firmly roots the global mental health crisis within a biomedical model, too narrow to be proactive and responsive in addressing mental health issues at the national and global level.<sup>23</sup>

The prevailing discourse on the “global burden” of mental disorders often deploys the disability-adjusted life year (DALY) metric as a gauge of economic loss. This composite measure—combining years of life lost from premature death and years lost due to disability—converts emotional distress into economic burden. Such quantification is not without its flaws. For example, a recent critical appraisal of the epidemiological evidence for the 2017 global burden of disease estimates for major depressive disorder found that the estimates were based on incomplete country and population coverage and used unclear methodologies. The authors concluded that there were critical flaws in the data underpinning the global burden of disease estimates and that “policymakers should interpret disease estimates with caution.”<sup>24</sup>

Also, at an empirical level, the DALY model struggles with the heterogeneity of mental health conditions. For instance, depression manifests with varying severity, making it nearly impossible to quantify its economic impact accurately. Yet the DALY metric endeavors to compute the economic “loss” attributed to conditions such as depression, rendering the approach not just imprecise but arguably inappropriate. Derek Summerfield has pointed out that applying the DALY metric to depression is “epistemologically lamentable.”<sup>25</sup> Such criticisms highlight the need to place emotional distress within its broader moral and political context, as an increasing number of psychiatrists argue. Indeed, a

dominant view of mental health conditions is that dignity is not inherent. Rather, it is lost through the “disorder” and regained through specialist intervention. However, a rights-based approach to mental health rejects this view and instead asserts that “the absence of dignity and the power to restore it, is the absence of rights, and a license for unaccountable intervention.”<sup>26</sup>

As a result, a human rights-based approach to mental well-being offers a different lens, facilitating a nuanced understanding of the relationship between human rights and the social determinants of health. By reconceptualizing human rights as “social ethics,” we can better understand the psychosocial contexts from which symptoms emerge.<sup>27</sup> Specifically, we need to move away from reductive economic metrics and toward a framework that recognizes mental health as a complex interplay of individual, social, and systemic factors.

### *Create mechanisms for protecting fundamental liberties and human dignity when developing mental health policies and interventions*

*The current approach [to global mental health] emphasizes the development of mental health services and interventions in “silos,” focusing on the treatment of mental illnesses at the exclusion of a holistic and contextualized approach to people’s needs.*<sup>28</sup>

A rights-based approach to mental health recognizes that people with psychosocial disabilities and mental illnesses are often systematically made vulnerable by legal restrictions imposed by states on their capacity to decide for themselves. In many states, a diagnosis of a psychiatric disorder (e.g., schizophrenia) gives health care professionals the authority to deprive persons of liberty and subject them to in-patient admission treatments, which are otherwise sanctioned by next of kin who act as substitute decision-makers. In the Philippines, for example, persons diagnosed with drug dependency or disorders undergo court-ordered compulsory rehabilitation, which is often militaristic or centered on religious or spiritual frameworks.<sup>29</sup> Relapse is attributed to a personal failing of the person under

treatment, and the power imbalance between the patient and the physician prevents accountability; there is no review of the treatment protocol in terms of whether it is evidence based or effective, or if the harms outweigh the benefits.

Indeed, the practice of court diversion to compulsory treatment in the community—often done with the best of intentions—is deeply problematic and raises important human rights considerations. As legal scholar Linda Steele cogently argues, court-mandated compulsory treatment exacerbates disability oppression.<sup>30</sup>

Human dignity, which in its core respects a person’s autonomy and capacity to decide and give informed consent, is often lost when a label of psychosocial disability is medically introduced. Essentially, a state-sanctioned global policy directive that medicalizes mental health enables injustices that are then perpetuated (often unwittingly) by mental health service providers. It is therefore critical that safeguards and accountability structures be included in mental health policies and practices—structures that can ensure that human rights are being upheld in health care contexts. Human rights literacy of health care professionals and program implementers must be mainstreamed as the core prevention tool for violations of fundamental liberties. A rights-based mental health framework acknowledges the accountability of actors and provides effective remedies for the promotion and protection of liberties.

### **Conclusion: How might we build a decolonial politics of care?**<sup>31</sup>

Current efforts to prioritize and embed mental health into the SDGs through the scaling up of evidence-based interventions can have the unintended effect of undermining the development of social, local, and structural interventions.<sup>32</sup> As we have shown here, a robust human rights approach to global mental health refuses one-size-fits-all solutions, is grounded in epistemic humility, and creates mechanisms and policies for protecting the liberties that allow for human dignity. Certainly, not all mental health obstacles are structural, but

large-scale transformations and improvements in population health will not be achieved if we continue to view mental illness as a universal and technical problem that can be ameliorated by closing the treatment gap.<sup>33</sup>

As human rights scholar and activist Alicia Ely Yamin argues, we are at a critical inflection point in human rights, and what is needed is “epistemic disobedience.”<sup>34</sup> This is because, as Yamin rightly notes, there is a complex and ambivalent relationship between biomedicine and human rights. Too often in health, the language of rights is invoked without critical reflection on what the experts are assuming constitutes a right to a healthy life. The call to “scale up the diagnosis and treatment of mental disorders” is an example of the seductive neutrality of the way in which the language of human rights is invoked in mental health. The assumption is that if everyone everywhere had the right to (Western) psychiatric assessments and treatment, the world would be a much better place and a human rights-based approach would be brought to fruition. However, as we have argued here, a genuinely transformative (and decolonial) human rights approach to mental health requires us to problematize the framing of the problem (e.g., “the global burden of mental disorders”). Problematizing the frame is the first step in animating our political imaginations and addressing the sociopolitical determinants of well-being.

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