

Response to the Lancet Commission Report on Global Mental Health and Sustainable Development

Summary of the report

On World Mental Health Day, the Lancet Commission on Global Mental Health and Sustainable Development launched a report aiming at reassessing the global mental health agenda in the context of the 2030 Sustainable Development Goals (SDGs). The SDGs aim is to 'leave no one behind' and consist of 17 universal goals to achieve a better and more sustainable future for all. They address the global challenges we face, among which are poverty, inequality, climate, environmental degradation, prosperity, peace, justice, and mental health. References to mental health are included within SDG Goal number 3 seeking to ensure 'healthy lives and promote well-being for all at all ages'. In addition, as all SDGs interconnect, mental health is relevant through cross-links with other Goals such as the reduction of poverty, education, economic growth, etc.

Countries across the world, including the European Union (EU) and Member States have committed to implement the UN Sustainable Development Goals (SDGs) by 2030. The Lancet Commission acknowledges that despite significant research advances regarding prevention and promotion of mental health, translation into real-world impact has been slow, and that human rights violations and abuses persist in many countries, in addition to low levels of government investment and development assistance for mental health. The Lancet Commission grasps the opportunity presented by the SDGs to broaden the global mental health agenda 'from a focus on reducing the treatment gap for people affected by mental disorders to the improvement of mental health for whole populations and reducing the contribution of mental disorders to the Global Burden of Disease'.

Foundational pillars

The report is a step in the right direction of acknowledging that the treatment gap needs to expand from solely treatment and care to prevention of mental health problems, recovery and social inclusion. Mental Health Europe (MHE) welcomes the four foundational pillars of the report reflecting the limitations of the wholly bio-medical paradigm.

First, the report states that mental health should be considered a global public good, relevant to sustainable development in all countries, regardless of their socio-economic status. MHE agrees that mental health has been a forgotten issue for far too long and the promotion of good mental health and the prevention of mental ill health should be recognised for all people, countries and generations. We welcome a global approach to mental health which ensures the participation and empowerment of a diversity of rights-holders and relevant stakeholders including users and survivors, civil society and communities.

Second, the report acknowledges that mental health problems exist on a continuum from mild, time-limited distress to chronic, progressive and severely disabling conditions. The binary approach to diagnosing mental disorders fails to accurately reflect the diversity and complexity of mental health needs of individuals or populations. Indeed, mental health changes through the lifespan, and a one-size fits all approach in mental health services is not fit for purpose. MHE welcomes the focus on young people throughout the report as mental health problems in childhood and adolescence do not only affect young people, their families and friends but can also have a longer-term impact on their social development and their adult lives. Lack of prevention and treatment at the young age can lead to educational dropout or difficulties entering the workforce which may have lifelong implications, particularly so for women and people with lower socio-economic status. Addressing mental health problems during childhood and adolescence is therefore crucial and should form part of an integrated approach to mental health through the lifespan.

Third, the mental health of each individual is stated to be the unique product of social and environmental influences, in particular during the early life course. These include demographic (such as gender, age, ethnicity), economic (income and employment), neighbourhood (community, housing, built environment); environmental (climate change, war, migration), social and cultural determinants (education, family, social networks). Mental health is indeed not only about health but about the social issues and barriers we face, how we work, where we live, and our basic human rights: it cannot be addressed in silos. Inequalities, poverty and abuse all impact on our mental health, and the solutions are political and social as well as technical.

Fourth, the report refers to mental health as a fundamental human right for all people, necessitating a rights-based approach to the welfare of people with mental disorders, to those who face vulnerabilities or risk factors associated with poor mental health, and to enable an environment which promotes mental health for all. The report refers to both the right to mental health and the rights of persons with mental health problems or psychosocial disabilities.

Proposed recommendations

However, and despite these foundational pillars, the report's key recommendations still come from a biomedical starting point, and therefore fail to recognise fully both the psychosocial model of mental health and community services. Change would involve tackling the power of the national and global institutions that provide structural support for the medical model, which has presided over the escalating epidemic of mental ill health.

MHE would emphasise:

- ***The need to invest in psychosocial support respectful of local customs, practices and beliefs instead of biomedical interventions***

The report acknowledges the biomedical framing of the treatment gap as having attracted criticisms from scholars and activists championing a cultural perspective and representing persons with lived experience. Indeed, acceptance and respect for the wide range of experiences and behaviours inherent in global human diversity should be further emphasised and respect for diversity in experiences and abilities an overarching theme of the key recommendations. A cultural perspective needs to be guaranteed rather than a biomedical emphasis over indigenous traditions of healing and

recovery, and the medicalisation of social suffering. A 'western' psychiatric framework dominated by pharmaceutical interventions should be avoided within a global agenda for mental health.

In addition, positive measures to foster well-being through the community and community participation should be promoted. Participation and inclusion are central to the process of development and psychosocial support should be tailored to the needs of individuals, recognising each person's growth potential.

- ***The need to further strengthen and address the social basis or roots of psychological wellbeing and mental health***

As previously mentioned, the report refers to social and environmental influences on mental health and to public policies and development efforts within and beyond health such as education, workplace, social welfare, gender empowerment, child and youth services, criminal justice and development and humanitarian assistance.

MHE would go further in acknowledging the role of inequalities, violence and poverty as determinants of mental health, emphasising the need for political, social, economic and cultural interventions within a global mental health agenda. Reducing inequalities or addressing social factors through investment in peer supporters and community health workers are one of many possibilities to tackle social and structural determinants of mental health.

- ***The need to strengthen the CRPD as the overarching human rights framework to mental health***

The 2006 United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) is only partially acknowledged, and as mentioned by the UN Special Rapporteur on rights of persons with disabilities, 'the report fails to understand the potential of the CRPD to reframe, transform and enhance the global response to mental health in light of the rights of persons with disabilities'. The CRPD represents a paradigm shift in moving away from a biomedical approach to disability to a social and human rights-based approach which states that people with disabilities, including people with psychosocial disabilities, must fully enjoy their human rights. Since the adoption of the CRPD persons with psychosocial disabilities 'are no longer considered as patients or recipients of care and charity but as autonomous rights holders, entitled to claim and realize all human rights on an equal basis with others, as members of the human family.'

The CRPD's worldwide ratifications, including by the European Union, express the global commitment to promote and implement the rights of persons with disabilities, among which are persons with psychosocial disabilities. At the core of the CRPD lies the right to legal capacity, i.e. the right to make your own choices and have those respected by others. The report of the Lancet Commission mentions the tension between the interpretation of the CRPD as autonomy for all persons and those who consider that substituted decision-making can be in the interests of a person, without positioning itself.

Moreover, the report fails to address the use of coercion in the mental health field as a violation of human rights. The CRPD Committee, the UN Special Rapporteurs on the rights of persons with disabilities, on the right to health, and on torture, all emphasized the need to end non-consensual placement and treatment for reasons linked to impairment or disability. Such measures are in

violation of articles 5 (equality and non-discrimination), 12 (equal recognition before the law), 14 (liberty and security of the person), 15 (freedom from torture, inhumane and degrading treatment), 17 (right to physical and mental integrity) and 25 (right to health) of the CRPD.

MHE would like to underline that one cannot bargain with human rights. Either rights are respected and implemented in practice or they are not – there is very little in between. The implementation of the right to legal capacity should be achieved for all. Real alternatives to substituted decision-making exist and they need to be publicised, scaled up and implemented in practice as soon and as widely as possible.

- ***The need to include diversified funding for (alternative) evidence***

Reference to evidence-based foundations is a driver of the report. The document acknowledges the limited impact of pharmacological and other clinical interventions for mental health problems but its key recommendations remain within the realm of biomedical research.

A variety of effective practices and alternatives exist within a human rights and recovery-based paradigm of mental health, such as recovery-oriented practice, solutions to coercion and investment in non-coercive mental health services, best practices of supported decision-making, etc. Such practices must be scaled up and invested in, in collaboration with user-led organisations. As stated by the [UN Rapporteur on the Right to Health](#), there is a need for a shift in investments in mental health, from focusing on “chemical imbalances” to focusing on “power imbalances and inequalities.”

- ***The need to use human rights compliant language***

Finally, the repeated references to persons with ‘mental disorders’ in the report should be avoided within a human rights framework. MHE advocates for a language as descriptive as possible and promotes avoiding reductive, labelling or stigmatising terms. For example, a person is not a person with a mental disorder, as that reduces them to a label, but is ‘experiencing mental ill health’ or ‘mental distress’. We also recommend using persons with mental health problems, service users or CRPD compliant language (persons with psychosocial disabilities) where appropriate.

Conclusion

While welcoming a broader global approach to mental distress, MHE regards the report as a missed opportunity. Significant developments have happened over the past years to implement a human rights-based approach on mental health, as exemplified by the adoption and worldwide ratification of the CRPD, and as reflected in the [report of the Special Rapporteur on the right to health](#). We would like to recall the required shift in paradigm, in line with the CRPD, away from coercive and medicalised mental health services to recovery-oriented and community-based services, promoting social inclusion and offering support at primary and specialised care levels. Reframing recommendations for the global agenda on mental health in line with these recent developments, driven by (ex-)users and persons with lived experience, would allow addressing the ‘global burden of obstacles’ which are preventing our mental health systems from adopting a human rights-based approach instead of the ‘global burden of disease’ rooted in a biomedical model.