General Assembly

Human Rights Council
Forty-first session
24 June–12 July 2019
Agenda item 3
Promotion and protection of all human rights, civil,
political, economic, social and cultural rights,
including the right to development

Right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health
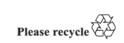
Summary

In the present report, submitted pursuant to Human Rights Council resolution 33/9, the Special Rapporteur elaborates on the critical role of the social and underlying determinants of health in advancing the realization of the right to mental health.

The Special Rapporteur outlines important opportunities and challenges associated with a human rights-based approach to actions on the determinants needed for mental health promotion. He argues that good mental health and well-being cannot be defined by the absence of a mental health condition, but must be defined instead by the social, psychosocial, political, economic and physical environment that enables individuals and populations to live a life of dignity, with full enjoyment of their rights and in the equitable pursuit of their potential.

The Special Rapporteur highlights the need for and States' obligations to create and sustain enabling environments that incorporate a rights-based approach to mental health, and which value social connection and respect through non-violent and healthy relationships at the individual and societal levels, promoting a life of dignity and well-being for all persons throughout their lifetimes.

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I. Introduction

1.   The promotion and protection of the right to mental health and well-being is a priority area for the Special Rapporteur (see A/HRC/29/33). In previous reports and other activities, the mandate holder has brought mental health into focus as a human rights and development priority. In the present report, the Special Rapporteur highlights the importance of the social and underlying determinants of health in advancing the realization of the right to mental health. He uses a mental health promotion framework that emphasizes the importance of improving well-being for everyone including, but not limited to, persons with intellectual, cognitive, psychosocial or other disabilities. A rights-based approach to the promotion of mental health offers an alternative to the biomedical, disease-oriented model that adopts a narrow, individual focus on the prevention of mental health conditions. He highlights the need for and States' obligations to create and sustain specific conditions that promote a life of dignity and well-being for all.

2.   International political processes and commissions have galvanized action on health promotion, commencing with the Ottawa Charter for Health Promotion, adopted in 1986 at the First International Conference on Health Promotion, which established a radical plan for public health action. In 2008, the World Health Organization (WHO) Commission on Social Determinants of Health published its findings on the determinants of health and their impact on global health inequity.[1] In 2011, States Members of the United Nations adopted the Rio Political Declaration on Social Determinants of Health, affirming a global political commitment to reduce health inequities by addressing social determinants. Similarly, in Goal 3 of the Sustainable Development Goals adopted by the General Assembly in 2015,[2] Member States recognize the interrelatedness and importance of social determinants of health to achieve "healthy lives and promote well-being for all at all ages".

3.   While some reference has been made to human rights in these global commitments, that reference has generally not been well developed, which has been acknowledged as a missed opportunity (see A/71/304). The work undertaken to develop and shape the right to health could more emphatically establish the critical role of the determinants of health. It is important that these two discourses – social determinants and human rights – continue to converge not only in theory, but also in policies and practice. The Special Rapporteur recognizes the amount of research and evidence that links the physical environment to health outcomes and to the enjoyment of the right to health. More research into the psychosocial environment is, however, needed from experts working on human rights and the social determinants of health.

4.   Conceptualizing the determinants of mental health requires a focus on relationships and social connection, which demands structural interventions in society and outside the health-care sector. There is still a tendency to use individualized, causal models to identify determinants of mental health, such as youth violence and self-harm. That tendency results in interventions that focus on immediate, individual behavioural factors, rather than adequately addressing the structural conditions, which are the root causes. The system-wide change that is required, even if formulated well in policy documents, is not usually made in practice. Narrow conceptions of determinants, together with an overreliance on biomedical explanations of emotional distress and mental health conditions, deflect political attention away from rights-based policies and actions that promote health. This grossly neglected human rights issue requires urgent action.

5.   The explanation of mental health inequities extends well beyond the biological and individual to the social, economic and political. People's lives are often constrained by inequitable laws, structures of governance and power, and policies that stratify society, profoundly affecting human relationships and how people act throughout their lives. The

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[1] WHO, *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health* (Geneva, 2008).

[2] See General Assembly resolution 70/1.

right to mental health complements this idea with the requirement that no one be denied access to a healthy psychosocial environment to sustain their well-being, and that everyone be entitled to a life with respect, social connection, equal opportunities and dignity.

6.   Work on determinants is also influencing the evolving issue of mental health. The WHO comprehensive mental health action plan 2013–2020 includes the promotion of mental health through action on social determinants as one of its five key objectives. However, this objective has not been translated into practical action. Policy, funding, research priorities and debate on how to strengthen the response to global mental health challenges are still dominated by targeting individuals and their mental health conditions, such as calls to scale up services that provide treatment. This approach has a tendency to reinforce a biomedical narrative that disregards alternative treatments, understates the role of psychotherapy and other psychosocial interventions, and, more importantly, does not address the determinants contributing to poor mental health.

7.   The burden of managing and coping with the systemic damage caused by ignoring the determinants of health has fallen on individuals. These individuals then turn to a mental health-care sector that often lacks adequate resources and appropriate approaches to cope with collective failures. States have an obligation to ensure that individuals can exercise their right to decline treatment and to help those seeking to gain access to rights-based treatment, care and support (including social support, user-led provision or other alternative services). States also have an obligation to create supportive and enabling environments that foster mental health and well-being.

8.   Human rights have the aim of protecting the well-being of people and are therefore determinants of mental health. Some 70 years after the adoption of the Universal Declaration of Human Rights, there is evidence that rights-based indicators of poor mental health are improving. These indicators include an overall reduction in suicide,[3] global advances in the reduction of extreme poverty,[4] a reduction in interpersonal violence,[5] greater gender equality,[6] a trend towards the abolition of child corporal punishment[7] and an overall reduction in totalitarian regimes.[8] This trend suggests that human rights-based policies and practices of societies around the world have had a positive effect. However, these successes are under threat from a growing movement of powerful global stakeholders who oppose universal human rights principles and argue that the post-war world order, which established those principles, has failed. This misrepresentation must be challenged as it undermines States' obligations to protect and promote human rights, including the right to health.

9.   The focus of the present report is on how these intersecting political discussions, economic and social rights imperatives, and the struggle to overcome structural obstacles, can be fortified by the right to the enjoyment of the highest attainable standard of health. In particular, the Special Rapporteur emphasizes how realization of the right to mental health can guide more holistic, equitable, responsible and community-centred action on the promotion of mental health.

10.   Terminology in the sphere of mental health is a contested terrain. There is a need to accept different terms according to how people define their own experiences of mental health. "Mental health" itself can signal a biomedical tradition for explaining and understanding lived experiences, psychic or emotional distress, trauma, voice hearing or disability. The Special Rapporteur acknowledges this contested area and the importance of the health sector and the medical model when used appropriately. He challenges

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[3] See Bertolote, J.M. and De Leo, D., "Global suicide mortality rates – a light at the end of the tunnel?" in *Crisis: the Journal of Crisis Intervention and Suicide Prevention*, vol. 33, No. 5 (2012), pp. 249–253.

[4] See https://ourworldindata.org/poverty-at-higher-poverty-lines.

[5] See World Bank Group, *World Development Report 2017: Governance and the Law* (2017), p. 133.

[6] See World Bank Group, "Women, business and the law 2019: a decade of reform" (2019).

[7] See Frank J. Elgar and others, "Corporal punishment bans and physical fighting in adolescents: an ecological study of 88 countries" in *BMJ Open* (2018).

[8] See Freedom House, "Freedom in the world 2018: freedom in crisis".

stakeholders to reflect on how biomedical dominance has led to overmedicalization in the health sector, particularly in mental health, diverting resources away from a rights-based approach to the promotion of mental health. The Special Rapporteur welcomes a diversity in terminology, which can promote different approaches to mental health that are equally important.

II. Promotion of mental health: a population-wide human right, not a luxury

A. A holistic framework for understanding obligations to promote mental health

11. In the WHO Constitution, health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This expansive understanding of health, in particular of mental health, is reaffirmed in a range of international instruments and political declarations, including the right to the enjoyment of the highest attainable standard of physical and mental health enshrined in the International Covenant on Economic, Social and Cultural Rights. The Special Rapporteur reminds stakeholders that the right to health is not the right to be healthy, but a right to both conditions and services that are conducive to a life of dignity and equality, and non-discrimination in relation to health.

12. Interdependence of rights is a foundational principle for a human rights-based approach to mental health. Attaining positive mental health and well-being is a product of, and a path towards, the full realization of the rights enshrined in international human rights law.

13. Giving effect to the full range of human rights is a core determinant of mental health. The relationship between the right to health and other human rights is indivisible: health enables the attainment of other rights, and certain rights promote the attainment of the right to health. Although the right to health is a social and economic right, that does not undermine the importance of civil and political rights for mental health promotion. Measures to enable everyone to participate actively and meaningfully in decision-making and civil action, and State accountability, are essential to the realization of mental health.

14. The Special Rapporteur remains concerned that certain rights that are vital to mental health, including the right to liberty, freedom from torture and the right to housing, are too often applied in isolation (see A/73/216). This narrow selection of human rights fails to illuminate the holistic experience of individuals and societies, especially those left furthest behind by existing mental health services. This is not a rights-based approach to mental health. Selectivity in understanding and responding to mental health does not adequately capture the grossly unmet need for rights-based action on the determinants of mental health. The systemic failures caused by such selectivity are illustrated by contemporary experiences of persons with serious mental health conditions. In many countries, these individuals are deprived of basic social and economic rights and are underhoused, underemployed, have little access to education, and no access to adequate or appropriate health services. It is equally unacceptable that, even when they receive services, including health care, food and shelter, such persons are deprived of their civil rights and freedoms when they are forced to live in closed psychiatric institutions.

15. Placing the right to health at the centre of rights-based action on the promotion of mental health ensures the inclusion of unique elements of the right to health: the obligation to promote and protect the determinants of health, international cooperation and assistance, the progressive realization of rights and allocation of the maximum available resources for health care.

16. In its general comment No. 14 (2000) on the right to the highest attainable standard of health, the Committee on Economic, Social and Cultural Rights set out a list of key determinants of health in support of an expansive understanding of health. The list is, however, not exhaustive in its nature and must be interpreted in the light of evolving norms

and scientific evidence. These developments include the recognition that an individual's autonomy and self-determination, including that person's right to be involved in medical decision-making, is essential for good health (see A/64/272 and A/HRC/32/44). [9] Conversely, relative powerlessness is a fundamental cause of social inequality and poorer mental and physical health. The psychosocial environment is increasingly recognized as just as important for health as the physical environment (see para. 53).[10]

17. The right to health is also enshrined in several international treaties. Treaty bodies have indeed progressively adopted interpretations to include not only material preconditions for individual health, but also psychosocial and structural determinants that promote the well-being of both individuals and society. These determinants include community inclusion,[11] an environment for children that is free from violence,[12] ending violence against women,[13] participation in cultural diversity[14] and eradicating xenophobia.[15] Likewise, the Special Rapporteur has previously discussed the normative importance of psychosocial determinants of health in relation to people on the move (see A/73/216), persons deprived of liberty (see A/HRC/38/36), persons with psychosocial disabilities (see A/HRC/35/21); and children and adolescents (see A/70/213 and A/HRC/32/32).

B. Obligations

18. States have a tripartite obligation to respect, protect and fulfil the right to mental health, including the underlying determinants to promote mental health. Respecting the right to mental health requires States to ensure policies, laws and practices that do not hinder the promotion of mental health or well-being, particularly for those in the most disadvantaged situations. Cuts to social welfare, laws and policies that restrict access to sexual and reproductive health information and services, the criminalization of drug possession or cultivation for personal use, laws that restrict civil society space and corporal punishment of children and adults illustrate how Governments can directly undermine the promotion of health.

19. Protecting mental health requires taking the measures necessary to prevent third party interference. Harmful practices such as "conversion therapy" for lesbian, gay, bisexual, transgender and intersex persons, private centres or "camps" using religion instead of science to treat drug dependence or mental health struggles, and the outsized influence of pharmaceutical companies in the dissemination of biased information about mental health issues (see A/72/137) all require positive, protective action from the State. In many parts of the world, these practices are the result of a complex set of factors, including power imbalances that lead to biased use of evidence, a lack of investment in rights-based policies and services, and overreliance on coercive, punitive and overmedicalized measures. These practices also reflect a failure to fulfil right to health obligations: they demonstrate a lack of political will to support, replicate and sustain evidence-based social interventions that foster well-being, prevent discrimination and promote community inclusion.

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[9] See Whitehead, M. and others, "How could 'control over destiny' lead to socioeconomic inequalities in health? A synthesis of theories and pathways in the living environment" in *Health & Place*, vol. 39 (2016), pp. 51–61.

[10] See Richard Wilkinson and Kate Pickett, *The Inner Level: How More Equal Societies Reduce Stress, Restore Security and Improve Everybody's Well-being* (Allen Lane, 2018).

[11] See Committee on the Rights of Persons with Disabilities, general comment No. 5 (2017) on living independently and being included in the community.

[12] See Committee on the Rights of the Child, general comment No. 13 (2011) on the right of the child to freedom from all forms of violence.

[13] See Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016) on the right to sexual and reproductive health, paras. 7–8.

[14] See Committee on Economic, Social and Cultural Rights, general comment No. 21 (2009) on the right of everyone to take part in cultural life, para. 16.

[15] See joint general comment No. 3 (2017) of the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families / No. 22 (2017) of the Committee on the Rights of the Child on the general principles regarding the human rights of children in the context of international migration, paras. 20 and 40.

20.   States must facilitate, provide and promote conditions in which mental health and well-being can be realized. Fulfilling the right to mental health requires the provision of not just equitable health care (and alternatives to the biomedical model), but also of public mental health interventions that can protect populations from key risk factors for poor mental health. It requires action outside of the health sector in homes, schools, workplaces and communities. It also includes facilitating the best possible start to life for children through evidence-based family support, such as parental leave and conditions for safe motherhood, supportive parenting interventions and early childhood education. States should provide an adequate workforce to support these efforts, and rethink how to build resources for social healing, community strengthening and the promotion of a healthy society. States should also formulate national policies aimed at reducing or eliminating the toxicity of the physical and psychosocial environment.

C.   Resource allocation

21.   Dedicating resources for the promotion of mental health is not an easy task, and resource constraints vary from one country to another. States have an obligation to commit a maximum of available resources to the progressive realization of the right to health. In its general comment No. 14, the Committee on Economic, Social and Cultural Rights acknowledged that resource constraints are impediments; the Covenant therefore provides for progressive realization of the right to health. While the Special Rapporteur is concerned that States do not invest enough resources in mental health in general, he is even more concerned that a larger proportion of available resources are directed to ineffective systems, reliant on excessive medicalization, coercion and institutionalization, breeding stigmatization, discrimination, disempowerment and helplessness.

22.   The right to mental health also includes obligations of immediate effect, such as the non-discriminatory provision of services to promote mental health and equitable access to interventions and core determinants for those in the most marginalized situations. Core obligations include the formulation and implementation of national public mental health strategies across public policy sectors, and not just within the health-care framework. The core obligations articulated by the Committee on Economic, Social and Cultural Rights in its general comment No. 14 should be considered in conjunction with developments in research and evidence on the promotion of mental health.

23.   In order to achieve progressive realization of the right to health, States should take deliberate, concrete and targeted action towards fulfilling the right to mental health in all its forms, including the promotion of mental health. By emphasizing the conditions necessary to thrive and flourish, benchmarks can not only close the "treatment gap" but can also support the development of indicators that focus on upstream protective factors, such as an adequate standard of living and social inclusion.[16]

D.   Availability, accessibility, acceptability and quality

24.   To be compliant with the right to health, determinants of mental health must always be available, accessible, acceptable and of good quality.

25.   Determinants of mental health and action to promote mental health must be available in sufficient and adequate quantity. Availability means the presence of core social and underlying determinants that are essential to the promotion of well-being for individuals and society, including access to health-related information and education, and healthy and positive relationships between individuals based on trust, respect and tolerance. Importantly, community relationships and kinship can have benefits when factors such as access to housing, food, social security and community integration are strengthened and

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[16] For a national example of the development of equity-based indicators for mental health, see National Health Service Health Scotland, *Scotland's mental health: Adults 2012* (Edinburgh, 2012).

when legal barriers, such as the criminalization of poverty, homelessness or drug use, are removed.

26.   Determinants of mental health and measures taken to promote mental health must be accessible without discrimination, particularly for those in vulnerable situations. This includes physical and economic accessibility to determinants, such as non-violent school and home environments, healthy workplaces that respect the full spectrum of labour rights, and a robust and active civil society supporting the struggles of those furthest behind.

27.   Determinants of mental health and measures taken to promote mental health must also be acceptable to the individuals and communities involved. Such a context requires the active participation of communities and the fostering of civic space. Acceptable action will be determined by the unique needs of society throughout its life cycle, as well as gender-specific requirements and respect for diversity, including cultural and neurodiversity.

28.   Actions taken to realize the right to mental health must be of good quality, and they require evidence-based data and information that is multidisciplinary. Responses to mental health conditions that are based on the use of coercion, as an exception allowed in legislation, are becoming the rule. Continued investment in policies and services, with prevailing patterns of coercion, excessive medicalization and institutionalization, are a serious obstacle to the effective realization of the right to mental health. Such systems reinforce vicious cycles of stigmatization, discrimination and social exclusion, and may be more detrimental than the mental health conditions they are supposed to treat.

E.   International assistance and cooperation

29.   The obligation of international cooperation for the realization of the right to mental health is recognized in international treaties and reinforced by the commitment to a global partnership for sustainable development made in Sustainable Development Goal 17. States in a position to assist must provide lower-income States with international assistance to help them realize the right to mental health. There is an immediate obligation to refrain (or withdraw) from the provision of development assistance that is discriminatory, or where violence or other human rights violations are committed. International cooperation to promote well-being must not be viewed as an economic or moral benefit for the Governments involved, but as a legal obligation.

30.   The Special Rapporteur reiterates previous calls for the allocation of adequate resources to international assistance, which requires a more balanced, rights-based response that emphasizes the promotion of mental health (see A/HRC/35/21). While development assistance towards the global promotion of mental health is on the rise, overseas development assistance budgets fail to exceed 1 per cent of investment in mental health.[17] Global aid indicators and trends continue to have a focus on biased knowledge from biomedical research and programmes, which, alone, cannot be considered compliant with right to health obligations. The Special Rapporteur is concerned that a human rights-based approach is not fully integrated into international projects that assist developing countries in improving their mental health policies and services. Without clear efforts to promote research and action on the political and social epidemiology of distress, including poverty, inequality, discrimination, State repression and corporate capture, these vital issues will remain on the margins of global mental health action.

31.   Rebalancing development assistance for mental health promotion requires diverse leadership and civil society engagement. There is a human rights imperative for mental health promotion to be scaled across the various development sectors: from rural farming, gender-based violence programming, migration and humanitarian assistance, private sector development and international trade to health-care sector reforms, including deinstitutionalization. All development stakeholders have an important role to play in supporting and enabling this work.

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[17]   See Patel, V. and others, "Sustainable development and global mental health – a *Lancet* commission" in *The Lancet*, vol. 387 (2016), pp. 1143–1145.

F. Participation

32.   The realization of the right to health requires the participation of everyone, particularly those living in poverty and those most excluded from society, in decision-making at all levels of public policy relating to mental health. Participation is only possible when all populations are recognized, respected and included in social conditions and structures. Enabling and resourcing civic space and building transparent health and social information systems will strengthen the right to participation and are essential for engaged and inclusive promotion of mental health. Populations and individuals must be provided with the space and resources necessary for civic debate and community action that can empower communities to develop strategies that shape their own well-being. Supporting members of civil society as key stakeholders in delivering action to promote health will foster the diversity of the community responses required to promote holistic well-being, offering diversity and autonomy to those seeking care and support rather than paternalism and coercion.

33.   Meaningful participation has been undermined by entrenched power asymmetries within traditional mental health settings (see A/HRC/35/21). Trust, the bedrock of therapeutic relationships, has been corroded, particularly where coercive and paternalistic practices are prioritized. User-led advocacy initiatives, peer support networks and, vitally, new working methods, such as co-production based on genuine equality for people with lived experience of mental health conditions and services,[18] are essential to restoring trust and building new alternatives. Such alternatives should ensure representative and meaningful participation to shape mental well-being and interventions. User-led research, with its emancipatory traditions in the production of knowledge and evidence, should be accorded equal standing to other approaches in the formulation of mental health policies that are compliant with human rights obligations.

34.   Laws, policies and practices that restrict the operation of civil society are retrogressive in nature and cannot be seen as compliant with the right to health. While everyone has the right to participation, persons in vulnerable situations should in particular be included in all mental health-related decision-making. This approach requires accepting that the biomedical model in mental health care does not work for everyone, and that its overuse has left countless people behind. Only with such acceptance, which requires political will and decisions, can people with intellectual, cognitive and psychosocial disabilities and other mental health conditions be empowered as active agents who can define their experiences and the type of support they need.

35.   Innovation in the promotion of mental health must be defined and created at the local level, with communities, individuals and families, which requires a shift to shared policy action that does not fit easily into one silo or into one ministry. Space for such innovation must be created in the civil, political and social realms.

G. Non-discrimination

36.   The right to mental health is dependent on non-discrimination in the enjoyment of all other human rights and is itself a critical determinant of mental health and well-being. Discrimination on any ground, within and beyond mental health settings, is both a cause and a consequence of poor mental health.

37.   Harmful stereotypes (including gender stereotypes) and stigmatization in the community, family, school and workplace settings undermine healthy relationships, dismantling the supportive and inclusive environments that are required for the good mental health and well-being of everyone. Discriminatory attitudes that increasingly influence laws, policies and practices undermine the social structures required to support well-being and inclusion. Xenophobia and intolerance create hostile emotional and psychosocial

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[18] See Peter Beresford and Sarah Carr, eds., *Social policy first hand: An international introduction to participatory social welfare* (Bristol, Policy Press, 2018). See also A/HRC/35/21.

environments and erode the quality of human relationships, bringing mistrust and disrespect into social life. Xenophobic rhetoric is particularly acute for people on the move in host countries, which further reflects complex social hierarchies and power relationships (see A/73/216). In many instances, xenophobia and intolerance interfere directly with the availability and accessibility of services to promote health, such as harm reduction and non-medicalized services for people in extreme distress, as well as access to housing, education and work. Consequently, individuals and groups in vulnerable situations, such as people on the move, are discriminated against by law and in practice and are denied their right to mental health.

38.   Respecting the diversity of human experience is crucial to ending discrimination, reducing power asymmetries and liberating the field of mental health from outdated policies and practices. States should support user- and peer-led movements, which help to demonstrate that human experiences that are considered unconventional represent just another form of human diversity and contribute to more tolerant, peaceful and just societies.

H.   Equality

39.   Equality supports well-being and the promotion of the right to mental health in a number of important ways. Too often, the rights-based framing of determinants is limited, viewed only by how equality affects an individual health outcome: access to housing promotes the health outcomes of individuals and therefore advances the right to health. More work is needed to understand how the collective dimensions of the right to health not only promote individual health outcomes, but also embed a framework of equality that is not just of individual status but also creates equal opportunities and outcomes for certain groups and society as a whole.

40.   Evidence on the mental health impact of equity contributes to a richer metric of what matters to well-being and the importance of the non-material dimensions of poverty, discrimination and deprivation. In other words, understanding the psychological and social experiences of persons in disadvantaged situations can point to protective factors that can make a positive contribution to individual and societal well-being.[19]

41.   Inequality is a key obstacle to mental health globally. Many risk factors for poor mental health are closely associated with inequalities in the conditions of daily life. Many risk factors are also linked to the corrosive impact of seeing life as something unfair and the psychosocial impact of structural factors that consistently put some groups in a vulnerable situation. These factors include the criminalization of poverty and of certain behaviours, such as drug use, the demonization of certain types of challenging behaviour in troubled young people, the criminalization of sexual and reproductive health services for women, the criminalization of non-legal entry into countries, and discriminatory and coercive mental health systems. The outcomes of structural inequality not only have a negative individual impact, but are also detrimental to societal health, as they break down key protective factors, such as trust, social inclusion and the healthy development of young people. Reducing inequalities is a precondition for promoting mental health and for reducing key risk factors, such as violence, disempowerment and social exclusion.

42.   Equality is a central element of an evolving human rights framework for promoting and protecting mental health. The profound and dynamic cause and effect relationship between mental health and inequalities compellingly suggests that mental health equity may be an especially important marker of social progress. Action on inequality is a human rights issue; it reflects a global injustice produced by entrenched power asymmetries. Given the deep connections between inequality and poor health, States are required to act on structural interventions far upstream, including in the political arrangements that allocate resources and enable (or restrict) the voices of those in the most marginalized situations.

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[19] See Lynne Friedli, *Mental health, resilience and inequalities* (Copenhagen: WHO Regional Office for Europe, 2009).

I. Accountability

43.   Accountability within the determinants of health is a particular challenge that tests the strength of governance. The right to health requires accountability across a range of domains, which can help to ensure that the action required for the promotion of mental health does not get diluted in the broader policies of other sectors. Successful accountability requires a range of elements that includes monitoring, review (judicial, quasi-judicial, political, administrative and social accountability mechanisms), remedies and methods of redress.

44.   The participatory development of indicators and benchmarks to monitor progress towards the full realization of the right to mental health is essential. Indicators must move away from biomedical traditions, such as the number of diagnosed mental health conditions, beds, hospitals and specialized health workers. A rebalanced focus that equally targets population-wide determinants at the community and structural levels, such as violence, civil society and social participation, discrimination, equality and social support, is a more promising way to monitor meaningful progress.[20]

45.   Participation forms one of the underlying tenants of social accountability, and ensures that policies are developed and reviewed with civil society central to the process. These constructive conversations are vital, and as such, civil society and user-led groups must be empowered with the resources and the space necessary to mobilize. Without such a participatory decision-making process, mental health inequalities and underlying causes cannot be addressed.

J. Mental health care and support

46.   While in the present report the Special Rapporteur focuses on strengthening the case for action on the determinants of health to promote the well-being of everyone, he expresses his continued concern about the status quo of the provision of mental health services, which particularly affects the promotion of the right to health for many who have been harmed, abused or left abandoned by health-care services. While the promotion of mental health requires action to support healthy and positive relationships in society, it applies equally and is of critical importance to the health-care sector itself.

47.   Promoting supportive, respectful and non-violent relationships in health-care settings, especially in mental health-care settings, is a special priority for the mandate holder, correlating with the healing dimension of the health profession and the ethical requirement to do no harm. Research shows that many users of mental health services have experienced widespread forms of violence and harm while in care. This is an issue of great concern for the Special Rapporteur.[21]

48.   Acceptable and high-quality therapeutic relationships (those between providers and users of services) must be based on mutual respect and trust. The Special Rapporteur regrets that trends in modern mental health legislation and clinical practices worldwide have allowed the proliferation of non-consensual measures. Coercion is widely used in mental health-care services, and there is evidence that the prevalence of coercive measures in mental health-care services is growing.[22] These tendencies risk eroding trust in mental health services, damaging the image and reputation of mental health service providers and, most importantly, continue to raise serious concerns about systemic human rights violations in the field of mental health care.

49.   Current mental health policies have been affected to a large extent by the asymmetry of power and biases because of the dominance of the biomedical model and biomedical

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[20] See National Health Service Health Scotland, *Scotland's mental health: Adults 2012*.

[21] See Diana Rose, *Users' Voices: The Perspectives of Mental Health Service Users on Community and Hospital Care* (London, Sainsbury Centre for Mental Health, 2001).

[22] See Sashidharan, S.P. and Saraceno, B., "Is psychiatry becoming more coercive?" in *British Medical Journal*, vol. 357 (2017), art. 2904.

interventions. This model has led not only to the overuse of coercion in case of psychosocial, intellectual and cognitive disabilities, but also to the medicalization of normal reactions to life's many pressures, including moderate forms of social anxiety, sadness, shyness, truancy and antisocial behaviour. The most vocal message that can reach stakeholders with the resources and power to support meaningful transformation in global mental health is the need to close the "treatment gap". The Special Rapporteur is concerned that this message may further the excessive use of diagnostic categories and expand the medical model to diagnose pathologies and provide individual treatment modalities that lead to excessive medicalization. The message diverts policies and practices from embracing two powerful modern approaches: a public health approach and a human rights-based approach.

50.   Any effective engagement with violence as a determinant of mental health therefore needs to address the role of mental health services in perpetuating violent and paternalistic practices, which have reinforced the myth that individuals with certain diagnoses are at high risk of perpetuating violence and posing a threat to the public. There is no scientific evidence to support this myth, which is instrumentalized by discriminatory mental health laws that deprive people of liberty and their autonomy.

51.   Regrettably, many parts of mental health-care systems, such as residential institutions and psychiatric hospitals, too often themselves breed cultures of violence, stigmatization and helplessness. The models that have reinforced the legacy of discrimination, coercion and overmedicalization in mental health care should be abandoned. Efforts should be refocused towards non-coercive alternatives that respect the rights of persons with a lived experience of mental health conditions and mental health-care services. Such alternatives should address holistic well-being, and place individuals and their definition of their experiences, and their decisions, at the centre.

III. Issues in focus

A. Relationships across the life cycle

52.   The quality of social relationships – the complex social tapestry of affiliation and connections between individuals, families and communities – over the course of life, across generations, between government and people, between different nations, and between mankind and nature, is a crucial determinant of health, and mental health in particular. Respectful, non-violent relationships, and opportunities for solidarity, mutual support and trust are the foundation of well-being and resilience and offer strong protection in times of adversity.

53.   Relationships at all levels and throughout the life cycle are shaped dynamically by wider social, economic, political and cultural factors; broadening the scope of determinants to include the emotional and psychosocial environment is therefore crucial. The quality of relationships and community identity between individuals in society is an increasingly important factor in the realization of the right to health and the prevention of violence.

54.   When basic needs are not met, support or care responsibilities not addressed, and rights (particularly maternal and reproductive rights) are not protected, positive family and community relationships are undermined, as is the care of those who are in a vulnerable situation. Respectful human relationships lie at the heart of policies that support inclusion, diversity, dignity and human rights.

55.   Abusive relationships, gender-based violence, sexual abuse, violence against children and other forms of violence are closely associated with imbalances of power and restricted rights and freedoms, and with political, economic and cultural structures that determine conditions throughout a person's lifetime at home, in schools, at work, in health-care settings and in the community. Socioeconomic conditions that generate insecurity and fear for the future increase the risk of conflict between communities. These conditions are felt individually and collectively, and these experiences have intersectional implications, particularly for persons belonging to ethnic and racial minorities, indigenous communities,

members of the lesbian, gay, bisexual, transgender and intersex community, and persons with disabilities.

56.   Relationships are also deeply influenced by scars of the past, such as historical injustices, the legacy of colonialism, racism, slavery and land appropriation, the subjugation of women and violations of sexual and reproductive rights, the historic oppression of the lesbian, gay, bisexual, transgender and intersex community and the denial of the rights of children. Social trauma, such as systemic racism, violent conflict and displacement, can damage communities for generations. Poverty, inequality and power asymmetries make it difficult or even impossible to build and sustain relationships of mutual trust and respect. Reducing inequalities, systemic socioeconomic disadvantages, disempowerment, social exclusion, insecurity and displacement is a precondition for enabling respectful, non-violent relationships that support mental health.

57.   The central contexts for human relationships are protected by international human rights law, such as the right to family life, participation in the cultural life of a community, community responsibilities, protection from attacks on honour and reputation, protection from discrimination and equality in dignity. Greater emphasis is needed on the extent to which restrictions or infringements of human rights have a negative impact on human relationships and community cohesion.

1.   Early childhood

58.   Promoting and protecting human relationships starts with the relationship between infants and primary care givers. Interventions that foster emotional health and social development from early childhood should be given priority as investments in human development and global health. To give every child the best start in life begins with supporting maternal health, including mental health, as the foundation for the emotional health and cognitive development of the child. This includes maternal education, family leave and decent working conditions and nutrition, as well as social and emotional support.

59.   When one considers the powerful evidence linking adverse childhood experiences with life-long poor mental and physical health and well-being, there is a strong argument for structural interventions to address these indicators of poor well-being. Early childhood trauma can include exposure to a traumatic event prior to the age of early adolescence, such as child abuse, sexual violence, exposure to verbal or physical fights within the home, armed conflict, refugee status, or the unexpected death of a close relative or friend. Early childhood development can be protected by supporting children, parents and families. Early detection of social and emotional difficulties and screening for different diagnostic categories without family support programmes in place may lead to exclusion, institutionalization and overmedicalization. Approaches of this type cannot be considered compliant with right to health obligations. Instead, early detection should be viewed as complementary to community-based support for parents and children.

60.   Barriers to positive family and community relationships, such as economic conditions or laws that separate families, have damaging long-term consequences for children's emotional and cognitive development.[23]

61.   States should take immediate measures to progressively replace the institutional care of children, with a view to its full elimination. These measures should include, first of all, progressively investing in a variety of community-based and family-focused services. With regard to children under 5 years of age, with or without disabilities, institutional care should be qualified as a form of violence and harmful practice, and therefore should be banned. States should prioritize the right of children to emotional and social development, tantamount to efforts made globally to reduce mortality rates for children under the age of 5.

62.   Overmedicalization is especially harmful to children,[24] and global trends to medicalize complex psychosocial and public health issues in childhood should be addressed with a stronger political will.

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[23] See Emma Sammans and others, *Women's work: mothers, children and the global childcare crisis* (London, Overseas Development Institute, 2016).

2. Children and adolescents

63. Adolescence is a critical phase for achieving human potential and a period of dynamic brain and personality development, during which social relationships and the social environment shape capabilities that are the foundation for future health and well-being. Investment in the development of adolescents brings benefits today and for the next generation.

64. Supporting access to free and quality secondary education for all adolescents is the single most effective investment.[25] Schools play a crucial role in nurturing the development of adolescents, and are especially important in mitigating the effects of violence and conflict. There is considerable evidence of the effectiveness of a whole-school approach to promote mental health and to tackle problems such as bullying. Skills-based interventions in schools and families help to prevent involvement in gangs.[26] Education should equip children to flourish socially, emotionally and economically.[27] When all young people have opportunities to succeed, the risk of the development of subcultures of exclusion is reduced. Social support in the family and the wider community, and positive beliefs related to optimism, self-esteem and a sense of control, can also counter the effects of stress and trauma as children transition to adulthood.

65. Sexuality education for children is a powerful measure for promoting and protecting sexual and reproductive rights and for the promotion of mental health and well-being in adolescence and later in adulthood. Sexuality education with a focus on consent, respect and mutual pleasure is important for forming positive, healthy relationships in the future and helps to empower young people against sexual violence.[28] In many countries, children have no access to comprehensive sexuality education, reflecting a failure to comply with the realization of the right to physical and mental health. The Special Rapporteur emphasizes that sexual health and rights should not be undermined in the formulation and implementation of health-related policies.

66. Social exclusion in adolescence increases vulnerability to group violence. Violent extremism in defence of the group is driven by the motivation to restore personal significance or self-worth, often following profound loss or humiliation.[29] States should invest in empowering adolescents by respecting their rights and autonomy, recognizing their capacities and investing in their health, resilience and stake in the future. All initiatives to address the physical, mental and sexual health of adolescents should be implemented in compliance with international human rights obligations, taking into account the views and evolving capacities of adolescents and adopting evidence-based approaches (see A/HRC/32/32).

67. The different vulnerabilities of adolescent girls and boys should be recognized in youth violence prevention policies and programmes, which should include gender-sensitive initiatives that transform gender norms. Actively involving all people, whether girls or women, boys or men, is a critical component of rights-based action to promote well-being and reduce the toxic effects of harmful gender stereotypes later in life.

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[24] See Sami Timimi, "Children's mental health: time to stop using psychiatric diagnosis" in *European Journal of Psychotherapy & Counselling*, vol. 17, No. 4 (2017), pp. 342–358.

[25] See Every Woman, Every Child, *The global strategy for women's, children's and adolescents' health (2016–2030): survive thrive transform* (2015).

[26] See Robyn M. O'Connor and Stephanie Waddell, *What works to prevent gang involvement, youth violence and crime: a rapid review of interventions delivered in the UK and abroad* (London, Early Intervention foundation, 2015).

[27] See WHO and University of Cambridge, Institute of Criminology, Violence Research Centre, "Strategies to reduce global violence by 50% in Thirty Years" (Cambridge, 2015).

[28] See United Nations Educational, Scientific and Cultural Organization, *International technical guidance on sexuality education: an evidence-informed approach* (Paris, 2018).

[29] See Clara Pretus and others, "Neural and behavioral correlates of sacred values and vulnerability to violent extremism" in *Frontiers in Psychology*, vol. 9 (2018) art. 2462; and Arie W. Kruglanski and others, "The psychology of radicalization and deradicalization: how significance quest impacts violent extremism" in *Advances in Political Psychology*, vol. 35, No. S1 (2014), pp. 69–93.

68.   Similarly, bullying in schools and other settings negatively affects the right to health of children and can have a long-lasting impact on well-being. Prevention of bullying through the promotion of respectful and non-violent relationships from an early age is vital to advancing the right to mental health. The most effective approach to addressing and preventing bullying requires an ecological lens that focuses on the societal level to empower teachers, parents and members of the community rather than on individual perpetrators or victims. Most importantly, children should be supported and empowered with practical skills in how to engage in respectful, non-violent relationships.

69.   Investing in the right to health of adolescents in a sustainable way offers huge potential for capitalizing on positive investments in early years, while providing an opportunity to mitigate the impact of negative early experiences and to build resilience to minimize future harm (see A/HRC/32/32).

3.   Adulthood and working life

70.   How work is organized has profound and lasting social and psychological repercussions. Global shifts in conditions and patterns, and the intensity and distribution of work, have a profound impact on relationships: on family life, the care of children, ageing, and the social structure of whole communities.[30]

71.   Many studies link psychosocial stress associated with work, finances and childcare with strains in close relationships.[31] The most promising social protection policies are those that take a more integrated, multigenerational approach, with the recognition that income is only one of many needs.

72.   History shows that improving conditions in the formal and informal labour market and strengthening the accountability of employers depend on freedom of association or affiliation: the opportunity for meaningful relationships of mutual recognition with other workers. Relationships of solidarity, including through unionization to secure better pay, conditions and dignity at work, are critical to the promotion of mental health.

73.   While action to improve conditions at work, and recognition and fairer distribution of unpaid work, are important goals for the right to mental health, employment and improving economic productivity should not be the only priorities.

74.   There is concern that poor mental health is a threat to economic productivity and that responses should be formulated primarily to restore the workforce.[32] The emphasis on mental health conditions as a global burden and the call to reduce the treatment gap and to bring people affected by such conditions back to the workplace have been increasingly cited when making the economic case for prioritizing global mental health issues.[33]

75.   The Special Rapporteur expresses his concern with regard to setting priorities that focus on "restoring the workforce" and not on promoting dignity and securing the quality care needed for those left furthest behind. Firstly, improving economic productivity should not be the main reason for investing in good mental health and well-being for everyone. Instead, the promotion and protection of human rights that can effectively transform society should be the first priority.

76.   Secondly, while mental health policies and services should address the rights of all persons, there is an immediate obligation to include those who are furthest behind and who may suffer from discrimination, such as those with lived experiences or persons with

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[30]   See Pan American Health Organization, *Just Societies: Health Equity and Dignified Lives. The Executive Summary Report of the Commission of the Pan American Health Organization on Equity and Health Inequalities in the Americas* (Washington D.C., 2018).

[31]   See Rosemarie Edillon, *The effects of parent's migration on the rights of the children left behind* (United Nations Children's Fund, 2008).

[32]   See China Mills, "From 'invisible problem' to global priority: the inclusion of mental health in the Sustainable Development Goals" in *Development and Change*, vol. 49, No. 3 (2018), pp. 843–866.

[33]   See Patricio V. Marquez and others, *Moving the needle: mental health stories from around the world* (Washington D.C., World Bank Group, 2018); and Patel V. and others, "Sustainable development and global mental health – a *Lancet* commission".

psychosocial, intellectual and cognitive disabilities, whether or not they are part of the labour force. The future focus of international investment and global mental health must delink mental health from productivity. The concept of well-being as an economic asset reflects a selective approach to the right to health and cannot be considered compliant with a rights-based approach to mental health.

4. Older persons

77. The global rise in life expectancy brings opportunities and challenges. The older generation is not only a conduit for family connection and wisdom; older persons also provide invaluable care and support for younger generations.

78. Older persons enrich family and community life, and their active involvement not only promotes healthy ageing but also makes a positive contribution to the development of the community and society in general.

79. At the same time, demographic and family changes require a wider range of support. They demand an age-friendly environment where older persons are valued and able to live active lives; connected, mobile and engaged with their social communities. The mental well-being of ageing populations faces a number of risks; some can be attributed to the prevalence of age-related degenerative conditions, such as dementia and Alzheimer's disease, affecting both the biomedical and social prevalence of poor mental well-being. Many of the mental health issues faced by ageing populations, however, have shared risk factors, such as a decline in functional ability, experiences of bereavement, isolation or the loss of socioeconomic status that often accompanies retirement. The risk of abuse, such as in the excessive provision of psychotropic medications to older persons, both within and outside of institutional residential care settings, is also significant. Risks of this type also reveal the positive effect that interventions to promote healthy living conditions can have, such as working to ensure that older persons have the resources to achieve well-being, including security and freedoms, adequate housing, social support, inclusion programmes and community development programmes. This also includes palliative care and the right to age and to spend the end of one's life in dignity.

5. Strengthening community relationships

80. The quality and strength of community relationships and civil society are of profound importance to mental health. A quality relationship includes social connectedness, a sense of belonging and opportunities to collaborate for health and social gain, such as improving living conditions, protecting the environment, gaining equitable access to resources and preventing displacement. The degree of community well-being is also determined by governance: political empowerment and strengthening civil society to increase the involvement of local people and communities in defining problems, and generating and implementing solutions. Empowering persons in a vulnerable situation so that they can participate on equal terms is an important factor in the promotion of mental health. Social exclusion, powerlessness, discrimination and other indicators of a lack of control or influence can cause major harm to both self-care and care for others.

81. The importance of nature to social relationships and community life is enshrined in many national constitutions.[34] More work is needed to understand how threats to the environment, such as climate change, and a lack of human engagement with the natural world may contribute to the subsequent breakdown of our "human ecosystems": the loss of social and cultural resources and damage to community life. Being able to live with concern for and in relation to the natural world fulfils the psychological need for nature relatedness and is associated with positive outcomes for such problems as a lack of attention, anger, fatigue and sadness, and with higher levels of well-being and lower levels of psychological

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[34] See S. Borràs, "New transitions from human rights to the environment to the rights of nature" in *Transnational Environmental Law*, vol. 5, No. 1 (2016), pp. 113–143.

stress.[35] Healthy, non-violent relationships contribute effectively to sustainable development and include not only human relationships but also the relationship between humankind and nature.

B. A public mental health approach to violence

82. Interpersonal and collective violence are matters of global concern, and have a profound and lasting impact on mental health, particularly on the mental health of children. Many of the Sustainable Development Goals are directly aimed at preventing violence or addressing many of its underlying causes. Preventing violence in the home, in health-care and educational settings and in society at large is a prerequisite to the realization of the right to mental health. Although a full review of violent practices is outside the scope of the present report, the Special Rapporteur emphasizes the effects of suicide, structural violence, and interpersonal and collective violence on mental well-being to illustrate the relevance of violence throughout a person's lifetime. Bullying is also of importance, as discussed above.

83. A public health approach to preventing violence addresses the underlying structural, community and close relationship factors that exert a long-term influence on risks of violence. Interventions include the implementation of early-year and school programmes, strengthening communities, changing cultural norms, reducing income inequality and improving social welfare. Efforts should be made to balance the focus on violence against women and girls with an equally strong focus on violence against males of all ages. Understanding the human need for social recognition, respect, dignity and status will make an important contribution to understanding the connection between unequal power relations, unequal life chances, social exclusion, male unemployment and the increased risk of violence.

84. Suicide is a form of self-directed violence that is often a response to adversity. It is a public health issue that requires population-based interventions that tackle determinants, strengthen life skills and resilience, and promote social connection and support, particularly in the case of groups who feel excluded or who are in a vulnerable situation. Such interventions empower individuals in a vulnerable situation, and may be more effective than individually targeted interventions that tend to medicalize emotional pain. If too much is expected from and invested in high-risk interventions, this can reinforce ineffective and coercive practices, such as involuntary hospitalization and treatment, excessive use of psychotropic medications and social exclusion. When these common responses are overused, they disempower individuals, reinforce their lack of control and autonomy, instil a sense of helplessness and stigmatization, and may negatively affect their long-term outcomes. Many experiences of distress are shaped by poverty, inequality, discrimination and violence, which thus emphasizes the need for interventions that address health determinants, improving human living conditions rather than pathologizing diverse responses and different ways of being.

85. The Special Rapporteur welcomes the debate on addressing depression as a risk factor for suicidal behaviour, but is concerned by the remaining global tendency to medicalize depression and suicidal behaviour, and by the further promotion of the disproven theory of "chemical imbalances". All major national and international stakeholders should do more to address the determinants of depression and suicide. While severe forms of depression may require treatment with biomedical interventions, persons with a milder form of depression and related conditions may benefit from other forms of care and support that avoid overmedicalization and are evidence-based and culturally appropriate.

86. Structural violence stems from unequal power relationships in social structures, notably exemplified by racism, sexism, heterosexism and ableism, where groups in a vulnerable situation are systematically prevented from meeting basic needs and suffer from

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[35] See Baxter, D.E., and Pelletier, L.G., "Is nature relatedness a basic human psychological need? A critical examination of the extant literature" in *Canadian Psychology/Psychologie canadienne*, vol. 60, No. 1 (2019), pp. 21–34.

unequal life chances. Violence and discrimination are themselves inextricably linked; many people worldwide have their mental health placed at risk as a result of avoidable forms of violence or socially normalized discriminatory practices. Research on violence and mental health has too often focused on diagnostic criteria, with less consideration given to determinants such as poverty, experiences of trauma and violence, including adverse childhood experiences.[36]

87.   Cultural violence refers to behaviours and norms in societies that are used to legitimize violence. These forms of violence can be interdependent and interrelated in terms of cause and effect, including gender-based violence, family violence, racism, hate crimes, xenophobic nationalism, State violence, police violence and armed conflict, all of which are indicators and determinants of mental well-being. Initiatives to protect "traditional family values" over the rights of individuals prioritize and reinforce harmful gender stereotypes and outdated hierarchical family roles in family relations, and may contribute to tolerance of and the condoning of discrimination and violence.

IV.   Conclusions and recommendations

88.   **The recognition of mental health as a global health imperative, including within the 2030 Agenda for Sustainable Development, is welcome progress. With mental health emerging from the shadows, it is now critical to reach agreement on how to invest in the mental health and well-being of individuals and populations.**

89.   **Good mental health and well-being cannot be defined by the absence of a mental health condition, but rather must be defined by the social, psychosocial, political, economic and physical environment that enables individuals and populations to live a life of dignity, with full enjoyment of their rights and in the equitable pursuit of their potential. This requires the creation of enabling environments that value both social connection and respect through non-violent and healthy relationships at the individual and societal levels throughout life.**

90.   **To effectively promote mental health, discrimination should be eliminated both within and beyond mental health-care settings. The Special Rapporteur is concerned that the field of mental health remains, at the global level, hostage to discriminatory laws, policies and practices, and that this hinders the attempts of many progressive stakeholders to effectively promote mental health.**

91.   **Mental health services suffer from an excessive focus on outdated approaches through which the majority of resources are allocated to individual treatment for diagnosed mental health conditions, including psychotropic medications and institutional care. This global imbalance continues to reinforce an equity, evidence and implementation gap.**

92.   **Global trends indicate a proliferation of policies and practices in which universal human rights principles are actively undermined or human rights are applied in a selective way. These trends include prioritizing punitive policies and legislation to address different social problems (such as drug use), discriminating by law and in practice against certain populations (such as refugees and migrants, young people and women), political decision-making that reduces social support and increases inequalities, and legislative action that shrinks the participatory space for civil society. There is an intentional divide in how these broader global trends affect the mental health and well-being of societies: xenophobia, "traditional family values" and other forms of discrimination actively erode social cohesion, affecting everyone.**

93.   **The lack of political will to invest holistically in mental health and well-being fuels this cycle of discrimination, inequality, social exclusion and violence. Those who are most in need of action that promotes their health – persons with psychosocial,**

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[36] See Mohit Varshney and others, "Violence and mental illness: what is the true story?" in *Journal of Epidemiology & Community Health*, vol. 70, No. 3 (2016), pp. 223–225.

cognitive and intellectual disabilities – are still being left behind. The global community should prioritize sustainable systems that enable and adopt a human rights-based approach to the promotion of mental health. Human beings, in all their diversity, are rights holders and should not be seen as subjects of diagnosis or a disease burden. Modern mental health policies should foster empowerment, meaningful participation and resilience among all persons, including those with mental health conditions.

94.   **The Special Rapporteur recommends that States:**

(a)   **Include the promotion of mental health and well-being as a cross-cutting issue in the participatory development and implementation of all public policies, and place societal well-being at the centre of development and assistance decisions that aim to implement the 2030 Agenda for Sustainable Development;**

(b)   **Take immediate steps to develop a cross-sectoral strategy for the promotion of mental health that includes a review of public policies with a view to social, labour and economic reforms that prevent inequality, discrimination and violence in all settings, promote non-violent and respectful relationships between members of societies and communities, and increase mutual trust between authorities and civil society;**

(c)   **Develop holistic strategies and policies for societal well-being and scale up sustainable resources for interventions that strengthen protective factors, harnessing the resilience of people and communities throughout their life and across all settings: the home, schools, workplaces and the broader community;**

(d)   **Fund and enable civil society and user-led groups to support monitoring and service provision in the promotion of societal well-being.**

95.   **With regard to international cooperation and assistance, the Special Rapporteur recommends that States, and relevant development and international stakeholders:**

(a)   **Balance development efforts to close the treatment gap by investing equally in promotion activities that are free from discriminatory approaches and respect both evidence and holistic rights-based approaches that build well-being in societies, not just health-care sectors; and fund assistance for global mental health advocacy;**

(b)   **Ensure transparent and participatory decision-making processes in the development of strategies and funding priorities for global mental health action, and develop rights-based indicators for the monitoring and review of investment;**

(c)   **Resource and support civil society engagement and user-led advocacy, particularly for those who are in the most marginalized situations due to existing systems of mental health services.**

96.   **With regard to the promotion of non-violent, healthy relationships, the Special Rapporteur recommends that States:**

(a)   **Develop policies and resource measures that promote effective interventions to promote positive relationships throughout life, particularly scaling up such measures to support healthy holistic development in childhood and adolescence;**

(b)   **Develop effective infrastructure for child protection and family support to improve the quality of relationships between parents and children, thereby protecting children from experiencing any form of violence in the family and avoiding the use of institutional care as a way of bringing up children;**

(c)   **Take steps towards the full elimination of institutional care for children, with a special focus on eliminating the institutionalization of young children, with or without disabilities;**

(d)   **Ensure that policies and services supporting families empower children and adolescents, recognizing their capacities; these policies should respect and protect**

the human rights of all members of a family and should exclude measures that undermine the rights of any individual;

(e) Address bullying with an ecological, public health approach that values and fosters non-violent relationships and engages children, schools, families and communities to end this harmful practice;

(f) Adopt prevention strategies to address depression and suicide through a modern public health approach that focuses on tackling determinants, enhancing life skills and resilience, promoting social connection and healthy relationships, and avoiding excessive medicalization;

(g) Assign high priority to developing accessible public health interventions to prevent or reduce violence in all its forms, including as part of a core package of services provided within universal health coverage;

(h) Address the fact that violence, institutionalization and other forms of coercion are unacceptably widespread in mental health-care systems, often in the name of treatment, in the case of persons who are diagnosed with mental health conditions, doing more harm than good;

(i) Refrain from and prevent xenophobic action and rhetoric inciting intolerance against persons in vulnerable situations, including people on the move and persons who are discriminated against by law and in practice.

97. With regard to the promotion of accountability and measuring progress, the Special Rapporteur recommends that States develop a more holistic set of indicators to measure progress in the full realization of the right to mental health, including:

(a) Performance indicators on the reduction of coercion, institutionalization and excessive medicalization, and on the sustainable funding of rights-based alternatives to a biomedical framework and the use of coercion;

(b) Participatory indicators on the funding of user-led and other civil society initiatives;

(c) Cross-sectoral indicators on the coordination and integration of the promotion of mental health in education, housing and employment.