Mental Health

An AFI Changemakers Report to the United Nations

ACKNOWLEDGEMENTS

May 2015

ISBN: 978-0-9964523-2-8

Report written by Dominic King (Chair), Poonam Bhar (Rapporteur), Rory Evans, Catherine White and Megan Smith.

AFI Changemakers "Right to Health and Access to Medicines" Summit conceived, organised and facilitated by Ariel Foundation International, Dr. Ariel Rosita King.

Special Thank You to:

Dr. Ariel King for dedicating so much of her life to providing young people with a platform to have their voices heard.

AFI Changemakers 2015 Summit Co-chairs Michael Fox, Catherine White and Megan Smith.

All participants of the AFI Changemakers Summit on "the Right to Health and Access to Medicines".

CONTENTS

FOREWORD

"There is no health without mental health"

Mental health disabilities and the lack of globally available treatment for them is a major, yet invisible, crisis. Average annual global spending on mental health is less than $2 per person and in low-income countries is less than 25¢[i]. For years, the global community has been collaborative in its efforts to combat the most prevalent threats to the physical wellbeing of its citizens. Yet those with mental disabilities are often left vulnerable, forgotten and invisible.

This report looks in detail at the legal framework in place to support people with mental health disabilities, the significant barriers to adequate mental health care from a medical perspective and the educational issues around awareness and acceptance of those who suffer. These three areas of concern encapsulate many of the most serious barriers to those with mental health disabilities being able to access treatment and live a life free from discrimination.

We want to recognise the crucial role that young people must play in any dialogue about mental health. In the United Kingdom, for example, more than half of adults with mental health disabilities were diagnosed in childhood and less than half of those were treated appropriately at the time[ii]. The inclusion of young people in the dialogue on mental health is essential to ensuring that responses to mental health disability in this age group are appropriate and sensitive. Tackling mental disability in youth, both through educational awareness and appropriate treatment, presents a golden opportunity not just for future mental health, but also for a new generation free from the mental health stigma of the past and present.

ABOUT THIS REPORT

0.1 This report is the result of the AFI Changemakers Summit on "the Right to Health and Access to Medicines" and participation in the Human Rights Council Social Forum on "Access to Medicines" by young people. The Summit saw youth, aged between 18 and 35, from all over the world come together to discuss issues relating to "the Right to Health and Access to Medicines" and proposing concrete policy recommendations that should be enacted to create lasting change to the global healthcare landscape. A complimentary report detailing a summary of the summit as a whole is also available.

0.2 Participants were shocked that during the course of the social forum mental health was only referenced once, only specifically in relation to autism and no other mental health disabilities, and that this statement came from a member of civil society. Mental health was entirely absent from the agenda. This year, 2015, is a crucial year with regards to the future of global development. The transition from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs) presents a vital opportunity to see the realisation of the right to mental health. We are determined to push mental healthcare and awareness up the agenda to ensure the correct, equal and appropriate treatment of those with mental health disabilities, whether their conditions are permanent or transient.

KEY ASPECTS OF MENTAL HEALTH

Definition

0.3 The World Health Organisation (WHO) defines mental health as a "state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community[iii]." This positive definition of mental health is furthered within the WHO's Constitution; "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[iv]."

Terminology

0.4 In writing this report we were aware that it was crucial that appropriate and consistent terminology was used. In legal terms this is an issue that we will address more fully later. We have taken guidance from a report by Paul Hunt, Special Rapporteur on the Right to Health to the United Nations Commission on Human Rights from August 2002 to July 2008;

> *"When discussing mental health and mental disability, a complicating factor is the absence of agreement on the most appropriate terminology. Mental illness, mental disorder, mental incapacity, psychiatric disability, mental disability, psychosocial problems, intellectual disability, and several other terms are all used with different connotations and shades of meaning.*
>
> *Having taken extensive advice, the Special Rapporteur has decided to adopt the generic term "mental disability". In this report the umbrella term "mental disability" includes major mental illness and psychiatric disorders, e.g. schizophrenia and bipolar disorder; more minor mental ill health and disorders, often called psychosocial problems, e.g. mild anxiety disorders; and intellectual disabilities, e.g. limitations caused by, among others, Down's syndrome and other chromosomal abnormalities, brain damage before, during or after birth, and malnutrition during early childhood. "Disability" refers to a range of impairments, activity limitations, and participation restrictions, whether permanent or transitory[v]."*

Summary of Recommendations

1.1 Ensure the consistent use of terminology at the United Nations level.

1.2 Clarify the scope of State Parties' obligations under the CRPD regarding the rights of individuals with transitory mental disabilities.

1.3 Ensure that those with transitory mental disabilities are protected by national mental health laws and policies.

1.4 Revoke or revise the Mental Illness Principles, with the direct involvement of civil society.

2.1 Mental health professionals should receive effective training in basic hygiene practices and hospitals should be thoroughly inspected with frequency.

2.2 Member States should be assisted in building stronger systems for the reporting of abusive behaviour.

2.3 Bring an end to use of restraints as a treatment for disability in all forms.

2.4 Assist Member States in implementing national psychiatric training mechanisms based on pyramid style schemes, to increase national capacity to treat those with mental disabilities.

3.1 An individual Sustainable Development Goal for the post-2015 agenda must focus directly on increasing mental health spending in all member states by 100% of their current levels.

3.2 A large scale international media campaign should be launched to raise awareness of mental health disabilities and remove stigma.

GLOBAL FACTS AND FIGURES

- One in four people in the world will be affected by mental or neurological disabilities at some point in their lives[vi].

- Nearly two-thirds of people with a known mental disability never seek help from a health professional[vii].

- Schizophrenia, depression, epilepsy, dementia, alcohol dependence and other mental, neurological and substance disorders make up 13% of the global disease burden, surpassing both cardiovascular disease and cancer[viii].

- Life expectancy of people with schizophrenia is 15-20 years shorter than the general population[ix].

- An estimated 804,000 suicide deaths occurred worldwide in 2012[x].

- Suicide accounts for 17.6% of all deaths among young adults aged 15-29 in high-income countries[xi].

- Among African nations, of the adults who suffer from diagnosed mental disabilities, 75% of them are found to have developed them in their youth[xii].

- Over 8,000 children aged under 10 years old suffer from severe depression[xiii].

Section 1: THE LEGAL FRAMEWORK

The Use of Terminology

1.1 One key obstacle to ensuring that all individuals suffering from mental disabilities are guaranteed legal protection of their fundamental human rights is the lack of consistent and agreed upon terminology in this area on both a national and international level. A variety of terminology is used, including mental illness, mental disorder, mental incapacity and others that encompass differing meanings and implications [xiv] . The use of certain terminology or concepts relating to mental health have a crucial and direct impact upon issues concerning the rights of persons with mental disabilities both nationally and internationally.

Recommendation 1.1: In order to ensure the global protection of all individuals suffering from mental health disabilities, the issue of terminology must be brought to the forefront of the discourse. This conversation should involve all key stakeholders, including Member States, international agencies and civil society. There should be consistent use of terminology, reflecting that of the former Special Rapporteur, in all official United Nations publications.

The Scope of State Parties' Obligations under the Convention on the Rights of Persons with Disabilities

1.2 It is submitted that the current terminology in the Convention on the Rights of Persons with Disabilities [xv] (CRDP) impacts the clarity of State Parties' obligations under the Convention and the general knowledge of concerned individuals as to whether they are guaranteed protection under international law.

1.3 The CRDP is the most comprehensive and only legally binding international instrument protecting the rights of the mentally disabled. The Convention applies to persons with disabilities including those with; "long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others"[xvi]. The precise wording of the CRPD may be compared to the use of terminology in other United Nations reports, including the "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health[xvii]". It is stated by the former Special Rapporteur that the term 'mental disability' "refers to a range of impairments, activity limitations and participation restrictions, whether permanent or transitory"[xviii].

1.4 It has been noted that the wording of Article 1 CRPD "does not mean persons with short term or intermittent impairments

are excluded, but that the Convention emphasizes those whose impairments are long-term [xix] ." Moreover, UN Enable clarifies that "[t]he reference to "includes" assures that this need not restrict the application of the Convention and State Parties could also ensure protection to others, for example, persons with short-term disabilities or who are perceived to be part of such groups[xx]."

1.5 The use of the terms "need not" and "could" in this clarification are ambiguous. It appears to imply that State Parties, which have ratified the Convention [xxi] , are not obliged to ensure protection of those with short-term disabilities, as opposed to those explicitly referred to in the text of Article 1; "does not" and "should", would denote such an obligation.

1.6 The question and ambiguity highlighted may have been settled and clarified at international and national levels. However, a prerequisite for ensuring access to justice is that individuals are able to be informed of their rights and the State's corresponding obligations under international law. It has become clear from our own research that it is currently very difficult for individuals, without a very high-level of knowledge of the CRPD and its translation into national laws, to ascertain whether the Convention obliges State Parties to ensure the protection of rights within the Convention for those suffering from transitory mental disabilities.

1.7 This issue is particularly vital to individuals and civil society organisations in those countries [xxii] that have ratified the Optional Protocol to the CRPD, which permits individual complaints to be submitted to the CRPD by individuals, groups of individuals or third parties on their behalf. There is currently nothing in the jurisprudence of the Committee that clarifies the scope of the State Parties' obligations under the Convention or its application to transient mental disabilities. Moreover, there is no reference to transitory mental disabilities or a clarification of State obligations in relation to this in the Committee's Concluding Observations.

Recommendation 1.2: The Committee on the Rights of Persons with Disabilities, as a body of independent experts, should clarify the existence or extent of State Parties' obligations under the Convention regarding individuals with transitory mental disabilities. This clarification may stem from a preliminary discussion during a Committee Session or in response to a State Party report, in which the content relates to transitory disabilities. In a 2011 Concluding Observation, the Committee urged Spain to "expand the protection of discrimination on the grounds of disability to explicitly cover multiple disability, perceived disability and association with a person with a disability"[xxiii]. This illustrates the ability and willingness to urge State Parties to expand the scope of the protection of the Convention rights past that explicitly mentioned in Article 1 CRPD. This ability should be built upon and it is submitted that the Committee should use its Concluding Observations not only to urge State Parties to expand the scope of protection but also to clarify their legal obligations.

1.8 If State Parties are not legally obliged to ensure that those with transient mental disabilities are guaranteed the rights enshrined within the CRPD, the scope of individuals potentially affected by this is

wide. Examples of short-term or intermittent mental disabilities include adjustment disorders[xxiv], brief psychotic disorders[xxv], and anxiety disorders. The severity of such mental disabilities should not be underestimated. For example, statistics show that suicidal behaviour is prominent among individuals with adjustment disorder and up to one fifth of adolescent suicide victims may have such a disorder[xxvi]. Moreover, within five years of an adjustment disorder diagnosis, approximately 20-50% of the sufferers go on to be diagnosed with psychiatric disorders that are more serious in nature[xxvii]. Considering this, the possible absence of a State obligation to ensure the effective implementation and protection of the rights enshrined within the CRPD may directly contribute to the development of more serious disorders in such case.

1.9 During the Eighth Session of the Ad Hoc Committee[xxviii] on the International Disability Caucus (IDC), a group of more than 70 international, national and local disability organisations openly opposed the use of the terms "long-term" and "persistent" within the CRPD. The ICD stated that either term would "still allow State Parties to take a decision at a national level whether or not to use the "qualifier"[xxix]. If this is the case, the ability of State Parties to use the term "long-term" as a "qualifier" may have had a substantial impact on the implementation of the obligations set out in the CRPD. For example, Article 13 imposes a duty to ensure "effective access to justice...on an equal basis with others" which includes "the provision of procedural and age-appropriate accommodation". It is currently unclear, from the guidance provided, whether State Parties are obliged under international law to provide such procedural accommodation to individuals suffering from transitory mental disabilities. This has the potential to have a direct impact on such individuals to access the justice they are entitled to[xxx].

Recommendation 1.3: If the State Parties that have ratified the CRPD do not have a binding obligation regarding individuals with transitory mental disabilities, this must be addressed. The difficulty in ensuring that Conventions such as the CRPD permits sufficient flexibility within terminology in order to accommodate the varied national laws and approaches is appreciated. It is submitted, however, that the effects of national and international mental health laws and policies that apply exclusively to "long-term" impairments, are too grave to ignore.

This may be addressed by the Committee of the Convention on the Rights of Persons with Disabilities in its Concluding Observations, similar to that discussed previously[xxxi]. It is also submitted that the WHO should consider and integrate the issue of individuals with transitory mental disabilities into its work under the WHO Project on Mental Health and Human Rights, particularly when assisting countries in developing and implementing national mental health legislation. Ensuring that mental health laws are as holistic and inclusive as possible must be a priority.

The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

1.10 The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care [xxxii] (herein the MI Principles) outline non-binding minimum standards that national mental health systems should meet and rights that those with diagnosed mental disabilities should hold. The MI Principles were adopted by the United Nations General Assembly in 1991 and were drafted without consultation of key stakeholders. The MI Principles have faced increasing criticism and controversy, mainly from civil society and, in light of this, it is now accepted that they must be read in light of the CRPD. Nevertheless, it is submitted that this is not sufficient to combat the potential negative effects of the MI Principles.

1.11 The MI Principles, in comparison to the CRPD, do not take a human rights based approach to the issue of mental illness. An example of this is the deployment of the word "patient" throughout the principles; this is used to refer to all individuals receiving mental health care and those admitted to a mental health facility. As discussed, the use of correct and sensitive terminology in this context is vital to eliminating stigmas and negative stereotypes of mental illness; this solely medical approach does not contribute to the achievement of this aim.

1.12 Another key issue refers to the treatment of involuntary patients. Principle 11 states that "No treatment shall be given to a patient without his or her informed consent", except as provided for in paragraphs 6, 7, 8, 13 and 15. Paragraph 6 then states that treatment may be given to a patient without their informed consent if that individual is an 'involuntary patient'. This practice would expose many individuals (both those with a diagnosed mental disability and those erroneously treated as such for civil, political or other reasons) to fundamental human rights violations including the right to freedom of movement[xxxiii], to liberty of the person[xxxiv] and to be free from torture or cruel, inhuman and degrading treatment or punishment[xxxv].

1.13 It is appreciated that the current international framework, made up of various international instruments is effective in that all instruments reinforce each other. Yet the MI Principles are not, as they stand, conducive to the realisation of the right to health and other fundamental rights of the mentally disabled.

Recommendation 1.4: The Mental Illness Principles must either be revoked or revised in order to bring them in line with the protections guaranteed by the CRPD and other related human rights instruments. If the Mental Illness Principles are revised, they should follow the human rights based approach of the CRPD and the word "patient" should be removed from throughout its text. Those that fall within the scope Mental Illness Principles must be referred to as "persons".

Since key stakeholders including international and national non-governmental

organisations, individuals and groups directly or indirectly affected by mental disabilities and mental health care, were omitted from the consultation procedures that produced the Principles, it is imperative that they are involved in their revision

SECTION 2: MEDICAL PERSPECTIVE

Institutional Hygiene

2.1 In many cases, the general hygiene of institutions that provide mental health treatment is a major problem, especially in low-income countries. By entering psychiatric hospitals, patients run a substantial risk of contracting nosocomial infections. According to the World Health Organization (WHO), poor hand hygiene of health workers is a leading factor in hospital-acquired infections (HAI). In developed countries, HAI concerns 5-15% of hospitalised patients and can affect 9-37% of those admitted to intensive care units (ICUs)[xxxvi].

2.2 Outbreaks of infectious diseases in mental institutions are very different from those in intensive care units or acute medical-surgical units. Agents circulating in the community most often cause outbreaks in mental institutions. Patients residing in mental health facilities have unique characteristics that differentiate them from patients in acute medical facilities. They usually have fewer comorbidities and indwelling devices in place than patients admitted to intensive care units or medical floors. They are typically ambulatory, and they mingle freely on many wards[xxxvii]. There are some similarities between the long-term care residential environment and the mental health care environment: both groups of residents tend to stay for long periods of time, and they attend congregate events, such as group or recreational therapy. As patients are less often weakened from physical illness while placed under psychiatric care, handwashing and other sanitation procedures are often less stringently enforced and observed.

2.3 Mentally disabled patients have a high incidence of chronic infection relating to substance abuse and socioeconomic factors, including human immunodeficiency virus (HIV) infection, hepatitis B and C, and tuberculosis[xxxviii]. This is also a common problem in middle and low-income where healthcare workers are often poorly paid and suffer from a lack of effective training. Institutions lack time for staff training and structures for compliance monitoring are weak or non-existent.

Recommendation 2.1 Good institutional hygiene is vital to prevent HAIs. Mental health professionals should receive effective training in basic hygiene practices and hospitals should be thoroughly inspected with frequency to ensure conditions are acceptable. The early 1980s saw a dramatic increase in Long-term Care Facilities (LTCF) infection control activities in the United States of America[xxxix]. There were

LTCF infection control program structures, infection control professional (ICP)[xl], and epidemiologists in every hospital. Member states should be encouraged to establish bodies that monitor and provide guidelines for hygiene and who should also be responsible for inspections. Hygiene procedures that apply in general hospitals should also apply to psychiatric facilities.

Abuse of the mentally disabled by health workers

2.4 In all countries, regardless of socio-economic status, there are cases of patients in psychiatric institutions being abused physically, emotionally and sexually. Those with mental health disabilities are vulnerable individuals, particularly if they are in the sole care of one person, or if they have been detained in a psychiatric unit and are therefore unable to leave. In one survey, conducted in the United Kingdom, 18% of respondents admitted to psychiatric care reported serious abuse or assault, including rape[xli]. Often, systems in place for reporting abuse are inadequate, including insufficient awareness among patients that systems are in place, a lack of access to these systems as the abuser is often present, or a lack of anonymity or ability for the patient to be transferred or separated from their abuser.

2.5 Poor understanding of mental health treatment, including a belief in traditional, unscientific methods, can lead to the abuse of the mentally disabled. For example, one traditional folk practice in Somalia involves the mentally disabled individual being chained up in a cage with a hyena, purportedly to ward off evil spirits[xlii]. Somalia has one of the highest rates of mental illness in the world due to the psychological challenges of ongoing conflict and extreme poverty, with the WHO estimating that 33% of Somalis have a mental health disability[xliii].

Recommendation 2.2 Stronger systems in place for the reporting of abusive behavior, and a legal framework recognizing the right of hospital patients and vulnerable people to a life free from abuse. Legal action should be taken against anyone who violates their duty of care to a patient. We recommend Increased funding for the training of psychiatric medical staff to combat inappropriate and abusive treatment methods and educate on mental health disability *(see recommendation 2.4)*.

Inappropriate and excessive use of control interventions

2.6 According to the Ontario Mental Health Reporting System[xliv], the various types of control interventions are as follows:

i. Acute control medication: Psychotropic medication is administered as an immediate response to control harmful behaviour.
ii. Mechanical restraint: A person is placed in mechanical restraints and is unable to ambulate (restrained to

bed) or the person is placed in mechanical restraints but is unable to ambulate (wrist restraints only)

iii. Physical restraint: A person is physically held to restrict his/her movement for a brief period of time, in order to restore calm to the individual.

iv. Seclusion: A person is placed in a room that confines him or her. This is often referred to as solitary confinement.

2.7 The use of restraints is very common in mental institutions. The National Alliance on Mental Illness (NAMI) tracked reports of restraints and seclusion abuse, producing a report of 58 incidents across two years in the United States. Based on data obtained under the Freedom of Information Act, there have been 39,883 recorded incidents of physical restraint in mental health institutions during 2011-2012 in the United States, resulting in at least 949 injuries to people with mental health disabilities[xlv]. According to NAMI[xlvi] the use of involuntary mechanical or human restraints or involuntary seclusion is only justified as an emergency safety measure in response to imminent danger to a patient or others. These extreme measures can be justified only so long as, and to the extent that, an individual cannot commit to their own safety or the safety of others. Restraint and seclusion have no therapeutic value and should be used only as an emergency safety measure by order of a physician with competency in psychiatry or a licensed independent mental health professional (LIP). A physician trained in psychiatry or an LIP should see the patient within one hour after restraints are initiated.

2.8 Restraints should be continued only for periods of up to one hour at a time and a face-to-face examination of the patient by the physician or LIP must occur prior to each time a restraint order is renewed. Alternatives to the use of restraint and seclusion should be used whenever possible. De-escalation techniques and debriefings should be used after each restraint and seclusion incident. Based on The Canadian Journal of Psychiatry, there are numerous adverse effects associated with physical restraints. This includes, restraint asphyxia, death by aspiration, blunt trauma to the chest, catecholamine rush, rhabdomyolysis, thrombosis as well as worsening of psychological state as restraints remind patients of past abuse or trauma[xlvii].

Recommendation 2.3 Immediately bring an end to the use of restraint as a treatment for mental disability in all forms. Restraint to be recognised only a method of ensuring patient or staff safety in the most extreme circumstances, and must only be enforced when a patient shows genuine threat to their own safety or the safety of others. Once restraints have been applied, their application should be reviewed hourly. They should only ever be applied by an LIP. Restraints must only be applied when all other methods of calming a patient have been exhausted, and once applied, appropriate methods of calming a patient should be continued. The indefinite or prolonged use of restraints on mental health patients must be recognised internationally as a violation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[xlviii].

Inadequate Access to trained mental health professionals

2.9 With reference to the Mental Health Atlas 2011 by the WHO[xlix], at a global level, there are more graduates with degrees in nursing (5.15 per 100,000 population) than in any other health profession working in the field of mental health. After nurses, the most common health professional graduates are medical doctors (3.38 per 100,000 population). Comparatively, there is a much smaller pool of psychologists, psychiatrists and social workers that graduate on a yearly basis.

2.10 Human resources with adequate and appropriate training are necessary for scaling up all health interventions and especially for mental, neurological and substance use (MNS) conditions, since care for these conditions relies heavily on health personnel rather than on technology or equipment. Most countries with low and middle incomes have few trained and available human resources, and often face distribution difficulties within countries or regions[l] (e.g. too few staff in rural areas or too many staff in large institutions)

2.11 This problem has been exaggerated by the migration of trained professionals from developed to developing countries because of economic incentives. Infrastructures and facilities for continuous training of health workers in many low-income countries are lacking. A better nurse to patient ratio is a must for psychiatric hospitals. The greater the decrease in quality care, the higher the chances of adverse events, such as inpatient suicides, suicide attempts and violence.

2.12 Due to the lack of human resources and funding, patients do not receive the right medication and the right doses. Such negligence can cause deterioration in patients and it can also be fatal.

Recommendation 2.4 Almost half the world's population lives in a country where there is less than 1 psychiatrist per 200,000 people. We recommend support for a volunteer program of psychiatrists who train existing doctors in the developing world with basic psychiatric skills so they can better identify and treat those that are suffering as a complimentary health service alongside their other health provisions. As part of the program, those who have received the training become mental health ambassadors and train others in local communities so that the knowledge spreads exponentially and the program is sustainable, eventually becoming an entirely national project. The pyramid nature of this scheme has been used by NGOs in many different areas from law to farming, and the three-month training aspect has been used in Somalia specifically in the area of mental health[li]. We'd like to see these two ideas combined and expanded. Ultimately, we'd like to see an increase in the number of fully qualified specialist psychiatrists, however this can only be possible following an increase in awareness of mental disabilities and better provisions, which we hope would follow the roll-out of this initial scheme

SECTION 3: AWARENESS & ACCEPTANCE

Lack of awareness of mental health issues by members of the public

3.1 One of the greatest barriers to effective mental health diagnosis and treatment is a lack of awareness, both among health professionals and the general public. The stigma attached to mental health disabilities is particularly surprising given the large proportion of people who will suffer from a mental health disability at some point during their lives. 25% of people in Great Britain will experience a mental health disability at some point during any given year, and 17% will experience suicidal thoughts during their lifetime[lii].

3.2 A lack of awareness of mental disabilities can be particularly damaging for several reasons:

i. Those directly affected by mental disabilities fail to recognise symptoms and therefore do not seek treatment, exacerbating their problems.
ii. Medical professionals are not correctly trained to care for the psychiatrically unwell, and mental disabilities go ignored as a priority. For example a World Health Organisation Report from Palestine notes that in the West Bank in the whole of 2013 there was not a single hospital referral for psychiatric illness[liii]. This kind of statistic is also indicative of the unequal allocation of resources to the treatment of mental health.
iii. Those suffering from mental health disabilities experience social stigma. This can include discriminatory media reporting that treats the problems of mental health sufferers as amusing or even entertaining, rather than as a serious health issue.
iv. The problematic encouragement of social norms that create an environment in which individuals do not feel able to speak out when suffering from a mental health disability. This culture of silence creates a society in which there is an erroneously low impression of the number of people suffering, reinforcing stigma on those who make their mental health issues known.

3.3 Furthermore, there is a lack of recognition or willpower to tackle the reality that cultural attitudes, behavior and practices can directly lead to mental health problems in societies, both in the developed and developing world. Awareness that culture is integral to understanding mental health disabilities and cannot be detached from the ways in which they manifest themselves in individuals can be demonstrated best through comparison; in the United Kingdom, suicide is far more prevalent in young adults, and rare in the elderly; in South Korea, the opposite is true[liv]. Some cultural factors that contribute to mental health issues at a regional level include:

i. The presentation of idealised images of the human appearance can result in negative body image that leads to eating disorders or body dysmorphic disorders. In the United Kingdom, for example, 60% of adults report that they feel ashamed of the way they look[lv], while in the United States over half of teenage girls and a third of teenage boys use unhealthy weight control methods like skipping meals, fasting, smoking, vomiting or taking laxatives[lvi]. In India, the skin-whitening cream industry was worth $432m in 2010 and was growing by 18% a year[lvii].

ii. In conflicted societies, Post-Traumatic Stress Disorder (PTSD) is a common problem; one study from Juba in South Sudan suggested 36% of the sampled population met the criteria for PTSD and 50% for depression[lviii]. While it is often assumed that victims of war will require treatment for PTSD, they often also require much longer term care for depression and anxiety. This demonstrates the need for mental health treatment to be tailored not just on a culturally relative level, but at an individual level. A greater understanding of preferential methods of effective communicative therapy in different areas would help mental health practitioners better tailor their services to the individuals and societies they serve, instead of simply a one-size-fits-all policy being exported from the developed and imposed upon the developing world.

iii. The marginalization of minority ethnic groups, including economic disempowerment; studies have suggested that latino youths in the United States experience disproportionate rates of anxiety, behavioral disorders, depression and drug addiction compared to their white counterparts[lix].

iv. Cultural beliefs that do not lend themselves to the open expression of feelings or the conveying of disabilities to request assistance. South Korea has one of the highest suicides rates in the world; 40 South Koreans kill themselves every day, and suicide rates doubled between 1999 and 2009. Some sociologists have suggested that Korea's cultural history being underpinned by values that emphasise diligence, stoicism and modesty have created a climate in which mental health sufferers remain quiet[lx].

3.4 A lack of understanding of LGBT+[lxi] people has led to the miscategorisation of gender and sexual identities as mental illnesses, despite scientific consensus that this characterization is erroneous[lxii]. The WHO removed homosexuality from the International Statistical Classification of Diseases and Related Health Problems in its 11th revision (ICD-11) in 1990[lxiii]. While the incorrect recognition of homosexuality as an illness is not legally recognised, this viewpoint is frequent enforced unofficially, meaning that homosexuals are subjected to discrimination, ranging from an unrecognised legal status to incarceration and even the death penalty.

3.5 This lack of awareness of the nature of homosexuality results in discrimination that inhibits and impedes the achievement of the right to health, as LGBT+ individuals face legal sanctions if they attempt to access treatment[lxiv]. Frequently, LGBT+ individuals seek treatment from unqualified physicians claiming to be able to change their sexuality in so-called 'conversion therapy', despite the fact that this practice is rejected by the medical community[lxv] and has no basis in science. Discrimination against LGBT+ people contributes to serious mental health issues amongst this group, with gay men more than twice as likely to attempt suicide [lxvi] because of a lack of social acceptance. In the United Kingdom, 46% of transgender individuals under the age of 26 have attempted suicide, compared to 6% of 16-24 year olds[lxvii].

Lack of Social Acceptance of Mental Health Sufferers

3.6 We must accept that only with an increase in awareness can come a lack of acceptance. People with mental health disabilities face discrimination and marginalization in all societies, and only through a greater awareness of mental health disabilities can the public come to understand an appropriate way to behave towards these people. As has already been discussed, legal discrimination at a national and international level that leaves disabled people unprotected is a major problem.

Recommendation 3.1 Mental health to be included in the Sustainable Development Goals (SDGs). Goal 3.4 of current proposals reads: "by 2030 reduce by one-third premature mortality from non-communicable diseases (NCDs) through prevention and treatment, and promote mental health and wellbeing". We see mental health as an afterthought in this proposal. We would like to see an entirely separate SDG that focuses on mental health and wellbeing and underlines strong mental health as being essential to all human life. There is no health without mental health. We understand the challenge of setting specific targets in relation to mental health when compared to physical health, but this is not a reason to maintain the status quo. This is the platform on which to make formal calls made by international leaders on mental health "to increase the amount invested in the mental health budget by 100% by 2020 in each low and middle-income country[lxviii]".

Recommendation 3.2 A large-scale international UN media campaign to promote mental disabilities and remove stigma. For maximum impact this could have an internationally recognised celebrity ambassador who has suffered from mental disabilities themselves. This could replicate the success of the 'He for She' campaign for gender equality.

Concluding Remarks

The effects of poor mental health are grave and far-reaching. Mental disabilities can hinder an individual's ability to participate fully in society on an equal basis with others. They act as a basis for discrimination, which can in turn lead to a lack of access to healthcare, housing, employment, education and justice. Ill treatment and discrimination against those with mental disabilities also has socio-economic consequences upon the world's countries. In 2015, a crucial year for future development, mental health cannot go ignored and cannot continue to be an end note to the need to guarantee physical health. It is essential that the international community, utilising the strength of civil society, place the realisation of mental health for all its citizens at the forefront of the agenda.

Dominic King
Poonam Bhar
Rory Evans
Megan Smith
Catherine White

About the Authors

Dominic King, 21, UK
Dominic assisted in drafting a report on the state of children's rights in England for the UN Committee on the Rights of the Child when he was fourteen. He has had input into major publications and made public presentations in the field of human rights. Over the last year he has been working in strategic communications and has previously co-ordinated a UK wide children's rights partnership, been a Trustee for one of the world's largest human rights alliances and developed a public speaking course for a school in Uganda.

Poonam Bhar, 24, Malaysia
Poonam is currently enrolled at medical school in Moscow, graduating in June 2015. She is involved in a variety of influential medical projects within Russia, including providing medical help to small towns and delivering much needed support to rural orphanages.

Catherine White, 21, UK
Catherine is an English and French student at the University of Warwick and hopes to pursue postgraduate study in human rights. Being half Jamaican and half English, she has been sensitive to discrimination from a young age; this has led her to pursue overseas internships and volunteering opportunities, including being a translator in Guadeloupe, a research assistant in Madagascar and teaching English in Uganda. Catherine was a Co-Chair of the AFI Changemakers 'Right to Health and Access to Medicines' Summit.

Megan Smith, 22, UK
Megan is studying Law with European Legal Studies at King's College London, and is currently spending a year at Leiden University in the Netherlands. She has worked with various human rights and civil liberties organisations in the UK and abroad. She is currently pursuing her keen interest in International Humanitarian Law with a focus upon ending sexual violence in conflict. Megan was a Co-Chair of the AFI Changemakers 'Right to Health and Access to Medicines' Summit.

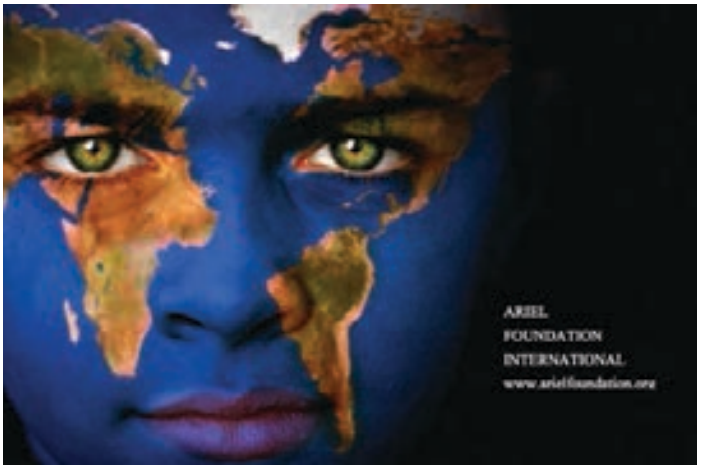
Rory Evans, 23, UK
Rory is a Religious Studies graduate from London, specialising in the relationship between religion and contemporary issues. He has experience working in digital media for a food security charity operating in eastern Africa and has volunteered in the West Bank on a youth media project bringing the Palestinian struggle to an international audience. Rory has previously represented AFI Changemakers at the informal intersessional meeting for the Working Group on the Right to Development at the United Nations Geneva.

References

[i] http://www.commonwealthhealth.org/wp-content/uploads/2013/07/Mental-Health-Overview_CHP13.pdf
[ii] http://www.youngminds.org.uk/training_services/policy/mental_health_statistics
[iii] http://www.who.int/features/factfiles/mental_health/en/
[iv] Ibid
[v] Economic and Social Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,* Paul Hunt, 11 February 2005, E./CN.4/2005/51, para. 18-19.
[vi] World Health Organisation, *Mental disorders affect one in four people,* accessible at http://www.who.int/whr/2001/media_centre/press_release/en/.
[vii] Ibid
[viii] World Health Organisation, *The Global Burden of Disease: 2004 Update* (2008)
[ix] Hennekens CH., Hennkens AR., Hollar D., Casey DE., Am Heart J., *Schizophrenia and increased risks of cardiovascular disease*, Am Heart J 2005 Dec: 150(6): 1115-21, accessible at http://www.ncbi.nlm.nih.gov/pubmed/16338246.
[x] World Health Organisation, *Preventing Suicide, A Global Imperative, Executive Summary* (2012), accessible at http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/, p. 2.
[xi] World Health Organisation, Regional Office for Europe, *Data and Statistics,* accessible at http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-statistics.
[xii] Kleintjes, S., Lund, C. and Flisher, A.J., 2010. MHAPP Research Programme Consortium. "A situational analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia." *African Journal of Psychiatry,* 13, pp. 132–139.
[xiii] Green, H., McGinnity, A., Meltzer, H., et al. (2005). *Mental health of children and young people in Great Britain 2004*. London: Palgrave. http://www.youngminds.org.uk/training_services/policy/mental_health_statistics
[xiv] As noted in the Economic and Social Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,* Paul Hunt, 11 February 2005, E./CN.4/2005/51, para 18.
[xv] UN General Assembly, *Convention on the Rights of Persons with Disabilities: resolution/adopted by the General Assembly,* 24 January 2007, A/RES/61/106, available at: http://www.refworld.org/docid/45f973632.html.
[xvi] Ibid, article 1
[xvii] Economic and Social Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,* Paul Hunt, 11 February 2005, E./CN.4/2005/51
[xviii] Ibid, para 19
[xix] As noted in the Economic and Social Council, Report of the Special Rapporteur on the right to everyone of the highest attainable standard of physical and mental health, Paul Hunt, 11 February 2005, E./CN.4/2005/51, para. 18
[xx] UN General Assembly, Convention on the Rights of Persons with Disabilities: resolution/adopted by the General Assembly, 24 January 2007, A/RES/61/106, http://www.refworld.org/docid/45f973632.html
[xxi] Ibid, article 1
[xxii] Economic and Social Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, 11 February 2005, E./CN.4/2005/51
[xxiii] Ibid, para 19
[xxiv] Ibid
[xxv] Not lasting longer than a period of six months
[xxvi] Not generally lasting longer than a period of one month
[xxvii] Bisson JI, Sakhuja, D. "Adjustment disorders.", *Psychiatry* 5 (7) (2006), pp. 240-242.
[xxviii] The Eighth Session of the Ad Hoc Committee on a Comprehensive and Integral International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities
[xxix] International Disability Caucus (IDC), *Proposed Text on Definitions,* available for download at www.un.org/esa/socdev/enable/rights/ahc8docs/ahc8**idc**deftext.doc
[xxx] As guaranteed by Article 8, UN General Assembly, *Universal Declaration of Human Rights,* 10 December 1948, 10 December 1948, 217 A (III), available at http://www.refworld.org/docid/3ae6b3712c.html.
[xxxi] See endnote 21 and corresponding text.
[xxxii] UN General Assembly, *The Protection of persons with mental illness and the improvement of mental health care: adopted by the General Assembly, 17 December 1991, A/RES/46/119,* accessible at http://www.un.org/documents/ga/res/46/a46r119.htm.
[xxxiii] [xxxiii] As guaranteed by Article 13, UN General Assembly, *Universal Declaration of Human Rights,* 10 December 1948, 10 December 1948, 217 A (III), available at http://www.refworld.org/docid/3ae6b3712c.html.
[xxxiv] As guaranteed by Article 3, UN General Assembly, *Universal Declaration of Human Rights,* 10 December 1948, 10 December 1948, 217 A (III), available at http://www.refworld.org/docid/3ae6b3712c.html.

[xxxv] As guaranteed by Article 5, UN General Assembly, *Universal Declaration of Human Rights,* 10 December 1948, 10 December 1948, 217 A (III), available at http://www.refworld.org/docid/3ae6b3712c.html.
[xxxvi] WHO guidelines on hand hygiene in healthcare http://www.who.int/gpsc/5may/tools/who_guidelines-handhygiene_summary.pdf
[xxxvii] *Infections in Psychiatric Facilites, with an Emphasis on Outbreaks* http://www.medscape.com/viewarticle/776871
[xxxviii] Rothbard AB, Blank MB, Staab JP, et al. Previously undetected metabolic syndromes and infectious diseases among psychiatric inpatients. *Psychiatr Serv* 2009;60:534–537. *See also:* Goff DC, Cather C, Evins AE, et al. Medical morbidity and mortality in schizophrenia: guidelines for psychiatrists. *J Clin Psychiatry* 2005;66:183–194.
[xxxix] http://www.apic.org/Resource_/TinyMceFileManager/Practice_Guidance/id_APIC-SHEA_GuidelineforICinLTCFs.pdf
[xl] The ICP is most commonly a registered nurse. The qualifications of an ICP can be found at http://www.cbic.org/certification
[xli] http://www.theguardian.com/society/2002/apr/24/mentalhealth
[xlii] http://www.bbc.co.uk/news/magazine-24539989
[xliii] Ibid
[xliv] Ontario Mental Health Reporting System https://secure.cihi.ca/free_products/Restraint_Use_and_Other_Control_Interventions_AIB_EN.pdf
[xlv] The data obtained under the Freedom of Information Act can be verified here: http://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf
[xlvi] Usage of restraints according to the National Alliance of Mental Illness http://www2.nami.org/Content/ContentGroups/Policy/Issues_Spotlights/NAMIs_Position_on_Seclusion_and_Restraints.htm
[xlvii] https://ww1.cpa-apc.org/Publications/Archives/CJP/2003/june/mohr.asp
[xlviii] General Assembly Resolution 39/46
[xlix] Mental Health Atlas 2011 by the World Health Organisation (WHO) http://whqlibdoc.who.int/publications/2011/9799241564359_eng.pdf?ua=1
[l] *Mental Health Gap Action Programme* - http://www.who.int/mental_health/mhgap_final_english.pdf
[li] http://www.who.int/mental_health/mogadishu_south_central_somalia_who_aims_report.pdf
[lii] 'How many people have mental health problems', Mind, http://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/
[liii] '*Right to Health: Crossing barriers to access health in the occupied Palestinian territory, 2013',* World Health Organisation, 2014
[liv] Kim, Seong Yi, Myoung-Hee Kim, Ichiro Kawachi, and Youngtae Cho, 2011, 'Comparative Epidemiology of Suicide in South Korea and Japan: Effects of Age, Gender and Suicide Methods", *Crisis: The Journal of Crisis Intervention and Suicide Prevention* (pp. 5-14)
[lv] Centre for Appearance Research, 2012
[lvi] Neumark-Sztainer, D. (2005), 'I'm, Like SO Fat!', New York, The Guildford Press, pp.5
[lvii] BBC News, 'Has skin whitening in India gone too far?', http://www.bbc.co.uk/news/magazine-18268914
[lviii] Roberts B, Damundu EY, Lomoro O, Sondorp E. 'Post Conflict Mental Health Needs: a cross-sectional survey of trauma, depression and associated factors in Juba, Southern Sudan', BMC Psychiatry. 2009, 9:7
[lix] 'Mental Health: Culture, Race and Ethnicity Supplement", *US Surgeon General's Report on Mental Health,* 1999
[lx] BBC News, 08.11.2011, http://www.bbc.co.uk/news/world-asia-pacific-15331921
[lxi] Lesbian, Gay, Bisexual, Transgender and all other self-defined sexual and gender idenitities
[lxii] http://www.who.int/bulletin/volumes/92/9/14-135541.pdf
[lxiii] Ibid
[lxiv] http://www.hrw.org/news/2014/05/14/uganda-anti-homosexuality-act-s-heavy-toll
[lxv] http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=17703
[lxvi] http://www.theguardian.com/theobserver/2010/aug/22/gay-attitude-depression-isolation
[lxvii] http://www.theguardian.com/society/2014/nov/19/young-transgender-suicide-attempts-survey
[lxviii] http://pressroom.ifred.org/newsroom/news/international-leaders-unite-under-fundamentalsdg-to-create-global-movement-in-inclusion-of-mental-health-in-the-united-nations-un-post-2015-development-agenda

The AFI Mental Health Working Group presenting their ideas to the delegation.



ISBN 9780996452328
90000 >
9 780996 452328