Mental health policies and services in 21st century: the need for paradigm shift

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International Meeting “The right [and the opportunity] to have a [whole] life”
Trieste, November 17, 2017

Momentum

- Importance of mental health – increasingly recognized
- Agenda 2030 and SDGs: “to promote mental health and well-being”. Good opportunity to place mental health from margins to center of health and development agenda globally.
- What does it mean “to promote mental health and well-being”? The need to find wise balance, based on values and evidence, within so many different issues and approaches
- States are urged to invest more in mental healthcare
- To invest more in mental healthcare services - as they are (status quo) or **do we need a shift of paradigm?**
- Unacceptable situation with violations of human rights of persons who need and who use mental health services. Is this just because of lack of resources?
- All stakeholders should rethink their position on important issues and their role

Mental health promotion

- Social and environmental determinants of mental health (including psychosocial/emotional environment)
- All forms of inequalities and violence have negative impact to mental health
- States need to invest in enabling non-discriminatory and non-violent environments in all settings (family, school, workplace, community, healthcare services, society at large)
- Full implementation of a human rights based approach is an obligatory pre-condition of effectively investing in mental health (including promotion, prevention, treatment, rehabilitation, recovery)
- Crucial role of civil society

The right to mental health normative framework

- Freedoms and entitlements
- Participation
- Non-discrimination
- Healthcare (AAAQ)
- Social determinants
- Obligations
- Accountability
- International cooperation

Biomedical model vs. Human rights framework: imbalances and power asymmetries

- Classical biomedical paradigm: patients with diagnoses and professionals with solutions. Huge asymmetry of power.
- Human rights framework: the person as a subject and owner of rights. Informed consent. First do no harm. Disability framework: post-CRPD era.
- Over 60 years of convincing human rights critique of situation in mental health care, especially concerning non-consensual measures and overuse of biomedical model.
- Despite existence of mechanisms of monitoring and protection of human rights in mental healthcare, decision-making process is dominated by monopoly exercised by medical profession. This allows to over-ride principle of informed consent, and such exceptions in practice tend to turn into the rule and pave the way to human rights violations
- E.g., circular argument is used, according to which a person reluctant to undergo psychiatric hospitalization and treatment may be qualified as being not able to appreciate his own condition and the risk of its potential worsening – which is qualified as another reason for applying non-consensual measures.

Lessons from history

- Important paradigm shifts in history of psychiatry during last centuries (including shifts from “mindless brain” to “brainless mind” and other way around).
- History of psychiatry is marked with serious violations of human rights, often done with very good intentions. E.g., lobotomy.
- World Health Report (WHO, 2001) sent a clear message - field of mental health needs to be liberated from isolation and stigma. Many recommendations from that report are not being implemented
- CRPD – now 11 years. Many principles not seriously addressed and even ignored by stakeholders in all regions.
- The need for reconsidering balance between biomedical and social models/interventions, promotion/prevention vs. treatment, and other balances.
- Mental health policies and services need to be guided by modern public health approach and human rights based approach
- Relations between psychiatry (mental healthcare) and human rights movement has always been complicated. Good news is that these relations were gradually improving, as psychiatry was learning from painful lessons of human rights abuses. Still, there remains are need to move ahead. Paradigm shift needed?

Operationalization of the right to mental health: challenges and obstacles. Regional issues. Case of Central and Eastern Europe

- Different historical legacies in regions and sub-regions. Example from Europe; still huge differences between sub-regions
- Culture of mental health services in eastern part of Europe remains different from western part of Europe. Some paradigm shifts are still to happen, including serious attitude to human rights and ethics, de-institutionalization, investing in mental health promotion and psychosocial interventions
- Unacceptably high number of children and adults with intellectual and psychosocial disabilities are living in large residential institutions. Europe has largest number of beds in psychiatric hospitals and people living in residential institutions.
- Independent monitoring of human rights in mental health facilities is still not in place in many countries
- Independent experts express concern over different forms of violation of human rights in mental healthcare services. These violations persist even after mental health services receive additional financial support (e.g., EU funds strengthened the system of segregated large psychiatric institutions in the new EU member states)
- What message do the middle- and low-income countries receive from high-income countries? What should be recommended to high- middle- and low-income countries? What about developments in Africa

Issues for serious debate and search of rights-compliant solutions

- If there is no hierarchy of rights, and if a right to receive effective treatment and a right to be free from violence and deprivation of liberty are equally important, how then to proceed in situation of so called psychiatric emergencies?
- Is the argument of applying non-consensual measures because of "dangerousness" strong enough?
- Is the argument of applying non-consensual measures because of "medical necessity" strong enough?
- Supported vs. substitute decision making
- What could be a new role and mission of psychiatry in the new paradigm of right-compliant mental health services?
- WHO Comprehensive mental health plan 2013-2020
- WHO Quality rights initiative

How this challenge should be addressed by psychiatric profession and other stakeholders?

- One way is to disqualify position of CRPD committee expressed in its General Comment N.1 and to use influence of medical/psychiatric profession over policy makers to keep status quo in psychiatry
- Another way is to accept this challenge and crisis of prevailing paradigm as a unique opportunity for change and for shift of paradigm:

To recognize that psychiatry is facing serious crisis, and to rethink position of profession with regard to overriding human rights, promoting non-consensual measures, neurobiological paradigm, concepts of “dangerousness”, “medical necessity” and other conventional wisdoms.

To form effective alliances with those willing to develop innovative approaches and to lead the process of modernizing philosophy and practice of what modern mental health policies and services are and what they should and should not be.

Shift of focus is needed not only in policies and services, but also in medical and mental health education and mental health research

This shift of paradigm is not possible to achieve without involvement of psychiatric profession

Report of the Special rapporteur to UN Human Rights Council – June 2017

- Global burden of obstacles highlighted – as alternative view to medicalized concept of "global burden of diseases"
- Three main groups of obstacles identified. They need to be seriously addressed:

- Dominance of biomedical model and overuse of biomedical interventions

- Huge power asymmetries

- Biased use of knowledge and evidence

Report to UN HRC - key messages and recommendations

- The **failure of the status quo** to address human rights violations in mental health-care systems **is unacceptable**. As mental health emerges as a policy priority, it is crucial now to assess the failure to chart a better way forward, reaching consensus on **how to invest and how not to invest.**
- The SR **calls for leadership to confront the global burden of obstacles and embed rights-based mental health innovation** in public policy. That includes **State champions** in international policy efforts, **the leadership of professional psychiatry** in assessing constructively its approach to the necessity for change, **managers of mental health services** leading change by example and municipal officials championing grassroots innovation. These champions must work in partnership with their constituents, including persons with intellectual, cognitive and psychosocial disabilities and with autism.
- To reach parity between physical and mental health, mental health must be integrated in primary and general health care through the participation of all stakeholders in the development of public policies that address the underlying determinants. **Effective psychosocial interventions in the community should be scaled up and the culture of coercion, isolation and excessive medicalization abandoned.**
- The SR seeks **to develop**, through an inclusive and participatory process and open dialogue, **guidelines on human rights and mental health to support all stakeholders in the implementation of rights-based mental health policies** in their respective areas of work. He **welcomes contributions and suggestions in this respect**.

Report to UN HRC - key messages and recommendations

- Ensure that users are involved in the design, implementation, delivery and evaluation of mental health services, systems and policies;
- Stop directing investment to institutional care and redirect it to community-based services;
- Invest in psychosocial services, that are integrated into primary care and community services to empower users and respect their autonomy;
- Scale up investment in alternative mental health services and support models;
- Develop a basic package of appropriate, acceptable (including culturally) and high-quality psychosocial interventions as a core component of universal health coverage;
- Take targeted, concrete measures to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement;
- Seek technical assistance from the WHO QualityRights initiative to assess and improve the quality of mental health care.

Actions to be prioritized on the way to moving towards elimination of non-consensual measures

- (a) Mainstream alternatives to coercion in policy with a view to legal reform;
- (b) Develop a well-stocked basket of non-coercive alternatives in practice;
- (c) Develop a road map to radically reduce coercive medical practices, with a view to their elimination, with the participation of diverse stakeholders, including rights holders;
- (d) Establish an exchange of good practices between and within countries;
- (e) Scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals.

Urgent need for the shift of paradigm

- Human rights imperative
- Address adversities in childhood and adolescence
- Prevent medicalization of human diversity and misery
- Mainstream mental health and discontinue investments in segregated psychiatric institutions (also when providing international assistance)
- Prioritize culturally appropriate psychosocial interventions
- Replicate good practices that provide non-coercive mental health services
- Address imbalances and biased knowledge in medical (health related) education and research