

**Statement of Tlaleng Mofokeng,**

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

Exploring and sharing positive experiences in reforming mental health systems guided by a human rights-based approach in order to move from practice to policy.

Delivered at

Intersessional Consultation on Mental Health and Human Rights

(RES 43/13)15 November 2021

**Distinguished Guests,**

It is an honour to address you today.

I wish to thank the Office of the High Commissioner for Human Rights for organising this consultation and for inviting me to this panel.

Globally, almost all contexts share the need for a paradigm shift in mental health, although what that shift looks like in practice is a matter of much debate.

As my predecessor, Danius Puras, noted: “there is no health without mental health and there is no good mental health and well-being without embracing a human rights based approach.”

**Distinguished guests,**

**The position of the mandate I hold, is that any reform of mental health must embrace a human rights approach.**

As such, **a human rights approach to mental health reform demands being aware of the existing inequalities and differences** within and between low-middle- and high-income countries **and how these and the legacy of coloniality** shape mental health systems.

Adverse health outcomes are not only about individual predisposition or genetics, but also about oppressive systems that established hierarchies, which enable enduring social discrimination continue to perpetuate health inequalities.

The starting point of millions of people around the globe is unequal and this inequality affects an individual’s access to the underlying and social determinants of health, to the detriment of mental health. Also, the impact of colonialism is evident in some countries that have an entrenched colonial psychiatric system, whereas others have no formalized psychiatric system at all. Efforts to reform mental health systems should not uncritically export models from global North to the South and should address the root causes and the symptoms of structural inequalities in health systems. There must be an end to demonisation and belittling of indigenous and traditional health systems and knowledge. Many community led and immediately available assistance and facilities to many people around the world are non-western and such, there must be an integration in public health systems.

Poverty, social injustice, inequality, discrimination and violence can and do produce mental distress. We must remain aware of how a global world order in which people are persecuted for their race, gender, sexuality, religious affiliation, social class, or disability impacts on mental health as a result of social exclusion, marginalisation and exploitation. In a society where such anti-social systems control the fate of people who have little recourse to correct it, a commitment to achieving good mental health must coincide with a commitment to eradicating the systems of inequality that impact on people’s overall health.

**Distinguished guests,**

From the perspective of the mandate I hold, **reforming mental health systems also entails the adoption of a human rights-based approach where everyone that requires mental health support is recognized first and foremost, as a person, with equal rights, and equal recognition before the law**; where every person’s autonomy, integrity and dignity are guaranteed; where we invest in mental health systems in the community.

Reforming mental health systems requires as well placing **right holders in all their diversity**, **at the forefront of efforts and decisions for a rights-based change and reform of mental health systems**. Persons with mental health illness, various conditions, including persons with disabilities must also participate in the planning, monitoring and evaluation of services, in system strengthening and in research.

**Human rights based models of mental health policy** should emphasize a holistic support to the individual and provide recovery and treatment jointly defined with the affected individual. Coercion, involuntary treatment and forced placement are incompatible with a human rights based approach to mental health.

I cannot overemphasize enough the importance I place, as the Special Rapporteur on the right to health, to human dignity, individual autonomy and the right to control one’s health and to be free from non-consensual medical treatment. These principles and entitlements recognized under the right to health also apply to mental health as further clarified by the Convention on the rights of persons with disabilities, which provides critical guidance in this regard. I would like to echo my predecessor in noting that: “The combination of a dominant biomedical model, power asymmetries and the wide use of coercive practices together keep not only people with mental health conditions, but also the entire field of mental health, hostage to outdated and ineffective systems”.

Over time, the right to health mandate has identified **alternative models of mental health services as a good alternate option to traditional mental health systems too heavily reliant on a biomedical paradigm**. These alternative models are particularly relevant for those who have not been helped or who have been failed or harmed by traditional mental health systems, that still help many.

In this connection, I wish to commend WHO vision and work with the **WHO Quality Rights global initiative** on improving the quality of mental health care and services. If this initiative is scaled up and implemented in all countries, it will contribute to ensuring that persons with disabilities and with mental health conditions globally can exercise their rights. The work of my predecessor has also helped identify other good alternative models of mental health, such as **systems-level community health reforms in Brazil and in Italy**, or highly localized innovations in different resource settings around the world, such as **Soteria House, Open Dialogue, peer-respite centres, medication-free wards, recovery communities and community development models**.

Importantly, the mandate has also identified the dominance of medicalization and the overreliance on medications for mental health as a significant obstacle to the realization of the right to health. “**Medication-free” treatment wards identified in Norway and a rights-based pilot project in Sweden**, where the use of peers has been employed to confront power asymmetries and support dialogical, non-coercive approaches, are good practices to be guided from, highlighted in the 2020 report of the former Special Rapporteur to the Human Rights Council.

I would also like to echo and concur with the recommendation of my predecessor with regard to mental health medication, and request WHO to review its essential medicines list and remove the mental health medications for which there is no evidence of adequate risk/benefit and to work towards developing a new, holistic list of essential psychosocial and population-based interventions, informed by evidence and supported and developed by rights-based principles, which can more appropriately guide States towards full compliance with the right to health.

I would also like to conclude by encouraging Member States to promote mental health by prioritizing mental health and well-being over gross domestic product following the steps of New Zealand “world-first” well-being budget and by increasing financial support to sustainable, cross-cutting programmes that reduce poverty, inequalities, discrimination on all grounds and violence in all settings, so that the main determinants of mental health are effectively addressed.

I cannot overemphasize that **everyone has a right to health and to be treated with respect, dignity and equality** - regardless of health status such as mental health, gender, sexuality, race, nationality, legal status or drug use. **Leaving no one behind means reaching first those who are furthest behind**, those in most vulnerable or most marginalized situations.

We **must** work together to ensure compassionate, inclusive and human rights based approaches to mental health that are integral and take into account intersectional vulnerabilities, and provides programmes that help achieve better health.

Thank you