A Rights-Based Global Mental Health

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Social medicine is the beating heart of global mental health for there is no human ailment which is as inseparably intertwined with social conditions as mental illness. Adversities in one's social world contribute immensely to the risk of mental illness and are amongst their most damaging consequences. Moreover, as I have observed over the course of my career working in both wealthy and less-resourced countries, unlike most other human ailments, all countries have singularly failed to address the vicious cycle between social adversities and poor mental health.

My earliest encounters of the interface of social medicine and mental health were in my clinic as a trainee psychiatrist in London, England, where the mutually reinforcing narratives of social suffering and mental illness were central to almost every patient story. Ironically, even though George Brown and Tirril Harris' classic treatise on the Social origins of Depression (1978) had been based on their research with women in the same community in which I worked, it had been relegated to a historical footnote during my residency at the Maudsley Hospital (at the time, the Mecca of biological psychiatry), and I was only to discover its full significance much later in my career. During the final year of my residency, I opted for an opportunity to work in Sydney, Australia where I was posted in a less than salubrious western suburb, as the psychiatrist in a community mental health team serving a neighborhood comprising a large aboriginal population. The shocking levels of deprivation and the profoundly traumatic history of the peoples I was treating compelled me to question whether the biomedical tools I was deploying, essentially a handful of symptom-based diagnostic categories and medicines, could be remotely adequate or appropriate to address what seemed like an unimaginably complex mix of cruel history, unjust circumstances and neglected mental and physical health.

This early experience whetted my appetite to challenge all that I had been trained to do, even its very legitimacy for the poor and for non-European societies. Inevitably, I found myself immersed in medical anthropology and the only books I had packed in my suitcase when I boarded the flight from Heathrow to Harare in February 1993 to begin a two-year fellowship at the University of Zimbabwe Medical School were "Patients and Healers in the Context of Culture" (Kleinman, 1980) and an edited volume of essays on "Culture and Depression" (Kleinman and Good, 1985). Looking back, it seems as if my joining the Department was inevitable and, when I finally did so in 2017, it felt like I was coming home! But my work in Zimbabwe upended my assumptions that mental health problems, as conceptualized by modern psychiatry, were a figment of contemporary European culture, for I witnessed very similar encounters in my clinics in Harare, and in those of my traditional healer colleagues, as I had in London and Sydney. While the cultural contexts of each of these communities were so very different, the inescapable truth was that mental health problems were universal, their core experiences were similar and, most importantly, social suffering was a constant bed-fellow.

When the "World Mental Health Report" (Desjarlais, Eisenberg, Good & Kleinman) was published in 1995, reframing mental health as a global development issue, I leant on it as my vademecum for the next phase of my career, in India, which ultimately contributed to the emergence of the discipline of global mental health. The powerful influence of structural violence on mental health was a central theme: the impoverishment of large numbers of people through colonialism and neo-liberal economic policies, the systematic subjugation of groups such as women in patriarchal societies, the trauma and loss experienced by millions affected by conflicts fueled by commercial or sectarian interests, and the historic marginalization and dispossession of peoples such as indigenous peoples and persons with disabilities were examples of the essential elements of the 'social epidemiology' of mental health problems.

Around this time, I had been particularly anguished by the harrowing, and completely preventable, suffering and death experienced by people with AIDS in southern Africa and India and moved by the way the language of rights propelled access to life-saving medicines and empowerment of people living with HIV. I was deeply inspired by the leadership of people living with HIV who ensured, through unrelenting sacrifice and activism, the enshrining of the rights to care and freedom from discrimination as the moral foundations of the global AIDS response in the late 1990s. I saw parallels between this crusade and what needed to be done in my own field of global mental health and embraced a rights-based approach to addressing the consequences of structural violence on mental health and on the lives of people with mental illness.

Initially, my attention was focused on the right to care which went beyond a narrow biomedical prism of 'doctors, diagnoses and drugs' to address the injustice experienced by people with mental illness of the denial of access to quality care that could support their recovery. Much of my work focused on leveraging community resources to deliver psychosocial interventions, imitating the approaches adopted by colleagues in other areas of medicine in India, documented in the book People's Health in People's Hands (Antia & Bhatia, 1994). Unknown to me at that time was that this approach, now widely referred to as 'task-sharing', was also being championed by Partners in Health; when I did discover this, I was captivated by Paul Farmer's framing of the role of the community health worker as 'accompanying' a person on their journey to recovery. Today, the large and compelling body of implementation science that supports the effectiveness of community health worker-delivered psychosocial interventions for the full range of mental illnesses has laid the foundation for a transformed vision of mental health care in which communities that were previously labelled as being hopelessly under-resourced because they lacked expensive and scarce specialized human resources could be empowered to leverage the resources all communities have-people who care-towards mental health tasks.

As I expanded my efforts towards addressing the 'right to care', it quickly became evident that there were a number of other fundamental basic rights that were systematically denied to persons with mental illness: the rights to freedom, dignity and inclusion. And, of course, the right to be heard. These are the rights that have been championed by the movements of persons with disability and mental health problems ("psychosocial disability") who have shone the spotlight on the cruel and inhumane ways in which people with intellectual disabilities and severe mental health problems have been treated across history and geography – right up to modern times where incarceration, involuntary and coercive treatment in both traditional and psychiatric care facilities, exclusion from social spaces, and the denial of civil rights continue to be perpetrated in many countries. Even in the most progressive societies, people with mental illness experience scandalous levels of premature mortality, much of it due to the structural violence they have to bear in their daily lives, including lack of access to fair employment and housing and to quality medical care for chronic conditions.

It is clear to me that the right to care must be aligned with the right to freedom, dignity, agency and inclusion, and it is through the realization of these rights that the elephant in the room, the stigma and discrimination experienced by people with mental illness, will ultimately be put to rest.