Chapter 9
Social Progress, Globalization, and the Development of Mental Health: A Human Right Perspective

Christopher G. Hudson

Social Progress, Globalization, and the Development of Mental Health as a Human Right: Introduction

Mental health as a human right has emerged out a fundamentally transformed understanding of mental illness. It is one that departs from traditional deficit models in which service needs are seen as discretionary, and is instead based on the values of interdependency, human dignity, and entitlement. Central to it is the recognition that mental health requires the shared responsibilities of communities, and as such is most effectively addressed by a community mental health service strategy that is undergirded by the guarantee of human rights. Mental health is not a right that, as of yet, is widely recognized, but is one that has been developing alongside a range of other human rights, particularly the right to health care. It is one of several rights that have emerged as a part of several long-term societal changes involving social progress, globalization, and social development initiatives, including the global mental health movement. This chapter will, therefore, explore what such rights practically mean, and explore their roots in the context of globalization and the global mental health movement.

Social Progress

Central to globalization and the development of mental health rights is the notion of social progress (Hudson, 2020). This is an idea that has for many years been both extolled and demeaned, and in both cases it has served as an organizing ideal. The

C. G. Hudson (✉)
School of Social Work, Salem State University, Salem, MA, USA
e-mail: c.hudson@salemstate.edu

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sociologist Robert Nesbit concluded that, 'No single idea has been more important than … the Idea of Progress in Western civilization for three thousand years' (1980). It represents one of several competing perspectives on history and social change. These can be broadly categorized as involving (i) a continuous period of stasis or the variant of cyclical change; (ii) degeneration from a golden age; (iii) random processes involving both degeneration and development; or (iv) sustained and continuous social development. While ideas of social progress were once rarely held, since the Enlightenment they have come to dominate, and at that time, they were idealized and seen to include a range of social changes. The term progress is believed to have originated from the Latin term progressus, derived from progrědi, meaning "to walk forth, to advance" (Coccia & Belleto, 2018). Teodor Shanin (1997) epitomizes the concept as consisting of "a movement from badness to goodness and from mindlessness to knowledge, which gave this message its ethical promise, its optimism and its reformist 'punch'" (Shanin, 1997).

An alternative definition, which eschews the use of concepts of happiness, mental health, and quality of life is that of Gunther Stent (1978) who argues for a notion that highlights the 'will to power', or progress as the achievement of control of external events and the environment. Those who seek to characterize its breadth typically list its essential dimensions as advancements in science, technology, economic growth, energy, and democratization" (Coccia & Bellitto, 2018). Alternatively, Nathaniel Keohane (1982) breaks social progress down into four components: increased human knowledge about the world, increased human power over the world, increased human virtue deriving from this knowledge, and sometimes increased happiness as a consequence of the preceding. Often it has not been seen as involving human flourishing, and particularly, the enhancement of mental health.

As pervasive as the belief in social progress had become by the start of the twentieth century, a range of events in the first half of the century, most notably the two world wars, led to a widespread questioning and rejection of the progress narrative. Many critics have questioned the reality of social progress, but more often they have cast doubt on its effects on broadly improving the human condition. Specifically, many have wondered whether a narrow technological conception of progress could translate into greater human happiness and mental well-being. Other critics have focused on unintended effects, for example, social fragmentation and higher suicide rates in developed societies. The environmental movement highlighted issues of sustainability, whether economic growth can continue in the face of finite natural resources. Others have emphasized the amorality of its inherent materialism and a weakening of the individual (Horkheimer & Adorno, 1947). Still others have argued that the progress narrative is too often used by repressive regimes and social classes for their legitimization and perpetuation (Nisbet, 1980). Finally, some have complained about its linearity and assumed inevitability (Farrenkopf, 1993).

In recent decades, particularly since the early 1990s, there has developed a widespread reexamination and questioning of what many have concluded has been an excessively pessimistic assessment of social progress as reflected in the various critiques advanced over much of the twentieth Century. This trend has attributed to the publication of Francis Fukuyama's *The End of History and the Last Man* (1992)

which argued that with the demise of communism, history may have entered its final phase. Others have more optimistically seen the end of communism as the end of ideological deadlock, freeing both private and public resources for social development. In recent decades the United Nations has formulated and monitored the world's accomplishment of a variety of millennium social development goals, such as the worldwide reduction of extreme poverty and progress with enhancing mental health. The increasing availability of both data pertinent to international social development, as well as advances in computational hardware and analytical software involving techniques such as 'data mining', has fueled an expanded popular, theoretical, and empirical literature that has reexamined and sought to resurrect social progress, both current and past.

As a result there have been proliferations of books that count the many ways that progress has been occurring. Each of these focus on somewhat different trends, with a range of explanatory frameworks used. For example, Richard Baldwin (2016) focuses on the dramatic economic catchup that the developing nations have achieved in recent years relative to those considered to be developed, a phenomenon now known as the 'great convergence'. Close to twenty such books have appeared in English since the publication in 2000 of *It's Getting Better All the Time: 100 Greatest Trends of the Last 100 Years* by Stephen Moore and Julian Simon (2000). These include books by Nobel laureates which highlight the positive developments featured in their titles – *Progress* (Norberg, 2017), *The Progress Paradox* (Easterbrook, 2004), *Infinite Progress* (Reese 2013), *The Infinite Resource* (Ramez, 2013), *The Rational Optimist* (Ridley, 2010), *The Case for Rational Optimism* (Robinson, 2017), *Utopia for Realists* (Bregman, 2017), *Mass Flourishing* (Phelps 2013), *Abundance* (Diamandis & Kotler, 2012), *The Improving State of the World* (Goklany, 2007), *Getting Better* (Kenny, 2012), *The End of Doom* (Bailey, 2015), *The Moral Arc* (Shermer, 2015), *The Big Ratchet* (DeFries, 2014), *The Great Escape* lain (Deaton, 2013), *The Great Surge* (Radelet, 2015), *The Great Convergence* (Baldwin, 2016). Two of the most significant such works are Hans Rosling's *Factfulness. Ten Reasons We're Wrong About the World – and Why Things Are Better Than You Think* (2018) and Steven Pinker's *Enlightenment Now: The Case for Reason, Science, Humanism, and Progress* (2018). Both of these works provide details on scores of trends ranging from poverty reduction, birth control, education, political organization, violence, culture, and health and mental health, much of which is derived from United Nations statistical sources. In both cases, the authors document their conclusions that social progress has been dramatic and pervasive, encompassing most fields of interest over extended time spans, though not without select gaps.

The constellation of trends that have been cited by Pinker, Rosling, and other researchers represents a substantial body of evidence that the world continues to see ongoing social development, but with some important exceptions. Most notable are the inadequate responses to climate change and to evidence of rising economic inequality, both of which could, when extrapolated decades into the future, undo many of the positive trends covered. In addition, both the critics and promoters of the social progress narrative, have paid scant attention to its quality of life,

subjective well-being, and mental health dimensions, however, this also has been changing in recent years. Furthermore, the new embrace of the social progress narrative has largely ignored the complexities introduced by globalization, an essential context for the development of mental health rights, two subjects to which we will now turn.

Globalization

The term globalization refers to a set of loosely linked international trends, all of which have involved the development of increasing interdependencies among societies; both economic and social (see Hudson, 2010; Zajda & Vissing, 2021; Zajda, 2021). Globalization is not new as there have been several earlier versions of it, for example, during the onset of the industrial revolution and during the progressive era (Baldwin, 2016). According to the Oxford dictionary, the word 'globalisation' was first employed in 1930. It was widely used by economists, sociologists and policy analysts in the 1960s. Furthermore, Marshall McLuhan, a Canadian professor of English at the University of Toronto, who analysed the media and used the term 'the medium is the message' in his cutting-edge book *Understanding Media: The Extensions of Man*, published in 1964. He also coined the term 'global village' (Zajda & Majhanovich, 2021).

However, its newest rendition since the demise of the Cold War, at the beginning of the 1990s, has been one of the most dramatic. The earlier trends involving deindustrialization, servicetization, and the development of the information economy have increasingly come to be thought of as a part of globalization. Globalization is a broad and controversial set of trends. Specifically, it is regarded as including one or more of the developments that are outlined in Table 9.1.

A variety of driving forces behind globalization have been cited, with the most common being technological innovation, democratization, and the spread of neoliberal trade ideologies, leading to deregulation, including lowered costs of manufacturing and trade due to increasing automation, ease of travel, communication, and shipping. Numerous theories have been advanced as to how such conditions have operated. Perhaps most notable is that of Richard Baldwin (2016) who suggests that globalization has been driven by the progressive separation of production and consumption, which has been enabled by the falling costs of moving goods, people, and ideas brought about by deregulation and advancing technology. This has led to greater economic specialization across geographic regions, not only moving production of goods to developing nations, but concentration of research, development, and high-end professional activities in select cities in the developed world, in what has come to be referred to as "spiky globalization" (2008).

Deindustrialization has come to be supplemented with servicetization, the development of the service economy, mainly in developed nations, but increasingly manifested as growing middle classes in developing nations such as India and China (see Hudson, 1998). Technology, especially computerization and automation, has

Table 9.1 The globalization mega-trend: major themes and sub-trends

Growing economic and social interdependency: The once largely independent economies of the various nations have grown increasingly interdependent due to the increasing ease of free trade, brought about by laissez-faire trade treaties, deregulation, improved transportation and communications, and new finance mechanisms
Increased economic specialization: Because of the enhanced interdependencies, the economies of various nations and regions are becoming more specialized. With a wider and more competitive economies, corporate survival has forced many companies to narrow their focus, and to outsource many tasks to other localities, companies, or individuals
Proliferation of multinational and transnational corporations: Although most organizations are still rooted in particular nations, this is increasingly less so. As of 2018, there were estimated to be 60,000 multinational corporations, with nearly one-half million affiliates (CIA)
Reduction of trade barriers and deregulation: For several decades now, a major trend has been to encourage trade and free market competition through the minimization of trade barriers, such as duties and tariffs, often through the use of regional trade agreements, as well as deregulation in other sectors, such as environmental protection
Resource fluidity: The above trends have been associated with an increased fluidity of capital investments, as well as other resources, including labor. It has been noted that "the elements of globalization—greater and freer flow of information, capital, goods, services, people, and the diffusion of power to non-state actors of all kinds—will challenge the authority of virtually all governments. At the same time, globalization creates demands for increased international cooperation on transnational issues." While this his made economies more responsive to changing local conditions, it has introduced a new dimension of social instability
Privatization and outsourcing: Whereas national governments have increasingly sought to delegate, often through contracting, a variety of responsibilities to private companies, private companies in turn have sought to outsource their work to other organizations and individuals, often to gain greater control over the performance of this work, as well as for minimizing overhead and fringe benefit social costs. Outsourcing has been both local, but increasingly it is international, for example, many customer service jobs in information technology are being outsourced to South Asia. Both these trends have manifested through commodification, marketization, and the corporatization of much economic activity. In health care and the human services, there have been recurrent efforts to redefine many services as commodities to be aggressively marketed
Deterritorialization: Given the increasing interdependencies and the enhanced role of both market forces, as well as international regulatory bodies, many observers have noted a reduction in the power of national governments
Westernization and cultural homogenization: Some commentators argue that increasing economic interdependencies, as well as western imperialistic tendencies, have brought with it the indiscriminate spread of western culture. However, there has been considerable debate about the extent of this process, with many in second and third world nations insisting that social development, linked with globalization, need and should not mean westernization and the eclipse of local culture

Source: Adapted from: Hudson (2010). *Complex Systems and Human Behavior*, Lyceum Books

led to considerable pressures placed on employment opportunities for working classes, particularly those minimally educated, contributing to homelessness.

Globalization has elicited much controversy given its breadth and multiple outcomes, both positive and negative. It has been pointed out that the same time globalization has lifted billions out of the most extreme forms of poverty in the developing world, the lower middle classes in developed nations have suffered considerable

economic and social hardship, including unemployment, demoralization, substance abuse, and increased suicide rates. This phenomenon has been identified by the economist Branko Milanović (2016) who introduced an "elephant graph" of changing economic inequality, that shows the bulk of humanity gaining (the elephant's body), as well as the richest of the rich (the raised tip of the trunk), a smaller group of working classes in developed nations facing substantial economic stress (the trunk). At the same time that there has been improving economic conditions, there has been rising inequality with many adversely affected populations.

Globalization, thus, has represented some of the complex and diverse outcomes of the most recent generation of social progress, modernization, and specifically social development. The array of ongoing changes represents a mixture of those that are naturally occurring as a result of minimally regulated competition, as well as some intentional and planned policies aimed at facilitating social and economic development. Several of these have originated from the policies of multi-national organizations such as the World Bank, the International Monetary Fund, and the European Union.

While the notion of social development has been in use since the 1920s when it was first introduced in Africa as a literacy campaign, in subsequent years it had been promoted by U.N. agencies that worked in close cooperation with centralized governmental agencies in the developing world that implemented a statist approach, one that fell by the wayside by the 1970s (Mia, 2008). As these governments faced massive cutbacks, social development came to be pursued more so through bottom-up community organization and entrepreneurial strategies by non-government organizations (NGOs). However, since the turn of the century, there have been efforts to integrate the traditional statist with the community and entrepreneurial strategies. For example, James Midgely (1997) has advocated for a balanced integration of the three approaches in what he termed an "institutional strategy". Such commentators on social development have focused on moving the field to be less reliant on economic and infrastructure development – whether planned or laissez-faire – however, they have only gradually come to advocate for a more balanced inclusion of quality of life initiatives, including the development of health and mental health care.

Emergence of Global Mental Health

In parallel with social development initiatives, developments in mental health have only gradually become a global movement. Beginning in the 1950s in the U.S. and later in Europe, the spread of psychiatric deinstitutionalization has increasingly been supplemented with the development of community mental health services. Over the last 20 years, upwards of 45.1% of the world's nations have come to participate in these trends (Hudson, 2016). At the same time the World Health Organization (WHO) has developed its mental health program, focusing on global research, consultation, advocacy, and training. Its efforts have included the publication of the *Mental Health Atlas* (2001, 2005, 2014, 2017), dissemination of the

WHO Assessment Instrument for Mental Health Systems (WHO-AIMS), and the launching of the Mental Health Gap Action Programme (mhGAP), and the Movement for Global Mental Health in 2008 (see WHO, 2010).

Since the dissemination of its *Mental Health Atlas*, WHO has continued to refine its data collection instrument on national mental health systems, and this is now known as the Assessment Instrument for Mental Health Systems (WHO-AIMS 2.2). It covers the six domains included in the *Atlas* – policy and legislative framework; mental health services; mental health in primary care; human resources; education of the public at large; and monitoring and research – and is designed to facilitate cross-country comparisons. As much as this initiative represents an important advance in the study of national mental health systems, critiques in the literature have emphasized several limitations, most notably the neglect of the politics of mental health policy development, underestimation of the role of culture in mental health care utilization, and questionable measurement validity (Hamid et al., 2008).

The accumulating body of research on world mental health, both the epidemiological data from the World Mental Health Initiative, as well as the *Mental Health Atlas* and the WHO-AIMS instrument, have led to a decision by WHO, in October of 2008, to launch an advocacy initiative, known as the Mental Health Gap Action Programme (mhGAP). This effort, based on the idea that "There is no health without mental health", aims to recruit international donors to help scale up services for mental, neurological, and substance use disorders, particularly in countries with low and middle incomes (WHO, 2018). The program emphasizes that with proper care, psychosocial assistance, and medication, many millions could be treated for depression, schizophrenia, and epilepsy, prevented from suicide, and led to lead normal lives, even with minimal resources.

The global expansion of the community mental health movement, supported by the various initiatives of WHO and other international organizations, has paralleled other critical trends in mental health. A critical part of community mental health has been the recovery movement, involving widespread advocacy on the part of mental health consumers aimed at introducing a more realistic acceptance of the possibilities of recovery and community integration into the approaches of mental health providers. This has included a rejection of the notion of the chronicity of mental illness and the associated marginalization of mental health patients and ex-patients, sometimes referred to as 'psychiatric survivors'. At the same time, the positive psychology movement has spread and come to complement more traditional approaches such as the cognitive, behavioral, and psychoanalytic psychology, as well as neuropsychology. Positive psychology specifically is concerned with enhancing high-end levels of psychological functioning, including creativity, problem solving, wisdom, and self-actualization. While work on improving services – whether inpatient or community oriented – for the most severely mentally ill, suffering from conditions such as schizophrenia and bipolar disorder, continue to be of critical importance, increasing efforts are being made to develop such services within the context of a balanced service system that includes needed services for those with lesser disabilities. A key value informing these efforts has involved the normalization of services, involving community integration that minimizes stigmatization. All of these efforts

have increasingly sought to enhance the quality of life and subjective well-being, based on the recognition that mental health is a shared characteristic of communities and not only one of discrete individuals.

Impact of Globalization on Mental Health

Globalization has typically been hypothesized as having an upstream, or early and indirect effect on mental health, and as such, there is limited solid data on its specific impact. Most of the research results have stimulated somewhat speculative interpretation of components of this possible relationship to make the required connections. Based on research findings that globalization is associated with increased economic inequality, some researchers have sought to link inequality with declining mental health. Most notably, Pickett, James, and Wilkinson (2006) demonstrated a strong linear associated between income inequality and rates of mental illness. More recently, the author (Hudson & Doogan, 2019) demonstrated a moderately strong correlation between inequality and the prevalence of mental disability in the United States' three thousand counties using two stage least squares regression with instrumental variables. Nonetheless, this relationship is controversial (Bhavsar, 2008). While Subramanian and Kawachi (2004, p. 89) do report better health and lower mortality in egalitarian societies, Deaton and Lubotsky (2003, p. 1147) found no evidence to support such an association. It is believed that greater levels of relative inequality clearly aggravate the negative effects of absolute poverty, partly through more insidious personal comparisons that characterize more unequal societies.

A particularly pertinent line of research has investigated the impact of globalization on labor markets, often using micro economic data. For instance, Autor et al. (2013) explore the effect of growing Chinese import competition between 1990 and 2007 in the U.S. They report that rising imports led to higher unemployment, diminished labor force participation, and lower wages in affected local labor markets. McManus and Schaur (2016) explore how the extent of international trade affects occupational safety in US manufacturing companies. Using Chinese import growth in 1996–2007 as a shock of competition, they reported that import competition increased work place injuries, especially at small companies that are most affected by foreign imports.

In an earlier national study in the U.S. of disparate rates of homelessness throughout the nation's counties, Hudson (1998) estimated a structural equation model – an "interdependency model of homelessness" – that showed that both deindustrialization and servicetization had powerful impacts on such rates, mainly through their impact on unemployment and the decreasing reliance on labor which disproportionately has affected those with minimal levels of education.

Two well-known features of globalization – employment fluidity and migration – have been implicated in increasing rates of mental illness. Research in China by Li (2006, pp. 5–13) has documented identifiable effects of globalization on the

mental health of migrants, this was based on qualitative interviews with internal Chinese migrants in Beijing. Global migration has been associated with large migrant populations, ones that face pressures to adapt to the culture of their host community (Schwartz et al., 2010). The acculturation processes, particularly involving those in the first generation, are well known to be easily subverted and contributory to mental illness. Nonetheless, research on the impact of migration is inconclusive, failing to show definitive impacts on income inequality in the U.S (Putnam, 2020).

Several commentators have written about the potentially negative effects of the global mental health movement, especially in the global south (Fermando, 2014; Roberts, 2020; Sharma, 2016). The concern is that western medical models are being indiscriminately promoted in developing nations, and indigenous healing practices are being displaced. Part of this concern involves an over-reliance on psychopharmacology. WHO research has documented remarkable low rates of community mental health services and mental health practitioners in most developing nations (see WHO *Mental Health Atlas*, 2006–2017), and thus, there has been a concerted initiative to focus on the training and support of primary medical practitioners, typically through information and training on the use of psychotropics.

One of the few empirical studies that has specifically examined the impact of globalization on rates of mental illness in a multi-national study is that conducted by Maria Cervini and Vallacinencio (2019). Published as a working paper in *Economix*, this study examined the various correlations between both economic and social indices of globalization with rates of anxiety and depression, using data on mental disability from the Global Burden of Disease project, for 67 nations for the 1990–2016 period. They found that, on the aggregate country level, that the relationship depended on the particular dimension of globalization examined. Specifically, they reported that the results were driven by social globalization which was strongly and positively related to mental distress, but unexpectedly, this was not true for economic globalization. They also researched the differences between emerging and advanced countries, and found that higher globalization is associated with greater rates of mental problems in the advanced countries. This was not the case in developing nations. In these nations, higher economic globalization is correlated with lower anxiety and depression, suppressing the negative impact of social globalization. In the advanced countries, in turn, there is no effect of economic globalization; we only observe that higher social globalization is associated with greater mental problems. These results appear to be consistent with the 'elephant graph' interpretation proposed by Milanović (2016) that emphasized by negative impacts on economic inequality of the working classes in the developed world. This study, however, should be considered as far from definitive, given the lack of statistical controls, proper weighting for population, and in general, problems of potential endogeneity.

Human Rights in Mental Health

The recognition of human rights has historically been a fragile one, dependent on its endorsement by ruling powers, public consensus, and their enactment in national and international laws. Although historically many rights have been rooted in religious beliefs, the development of most rights has been a function of an evolving social consensus since the Enlightenment, essentially, a social contract among increasingly widening groups with recognized societal standing. Many of the earliest declarations of human rights, such as the Magna Carta [1215], The English Bill of Rights [1689], the French Declaration on the Rights of Man and Citizen [1789], and the U.S. Bill of Rights [1791] were necessarily framed in very general terms to enable their adoption. For instance, the U.S. Declaration of Independence [1776] that promulgated "the right to life, liberty, and the pursuit of happiness" has left considerable latitude for interpretation, yet has been a powerful source of derivative rights, such as that of privacy. Because human rights are seen as social obligations directed at individuals, resistance to their adoption has been considerable with many exceptions and qualifications advanced for any possible right.

Many proposed rights, such as those involving health and mental health, have frequently been rejected because such health issues are often seen as primarily individual responsibilities rather than social obligations. Nonetheless, the adoption of some rights, including those involving mental health, have been progressively but slowly realized in limited instances and jurisdictions. Some rights of mental patients, such as participation in decision making in matters of treatment, are much better established, but still debated (see Szumkler & Bach, 2015). Yet others, such as the right to treatment and the right to mental health itself (Trestman, 2018), remain poorly defined and thus have infrequently been enacted into law. The remainder of this chapter will explore the ongoing struggles in the development of mental health rights, particularly those for mental health services and mental health itself, beginning with the Universal Declaration of Human Rights (UDHR) (United Nations, 1948), in the context of the global mental health movement alongside the broader globalization developments.

The contemporary history of mental health as a human right begins with the UDHR, enacted by 56 member states of the United Nations on Dec. 10, 1948. The atrocities of two world wars and the subsequent rebuilding created an urgency for the establishment and protection of fundamental rights that transcend national boundaries. This document, sometimes referred to as the international Magna Carta, established that how a government treats its citizens is a matter of international concern, and not simply a domestic issue. It declares that, "All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood." (Article 1). The declaration enumerates 30 rights, falling into five categories: Economic, social, cultural, civil, and political. Under its Article 25, the UDHR establishes that:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary

> social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (Article 25).

Although the field of mental health has enjoyed little visibility during the immediate post-war period, the recognition of the right for health care and social services has provided the foundation of the subsequent recognition of mental health rights. References to and further elaboration of health and mental health rights have been included in a range of treaties and other documents since the passage of the UDHR. As the United Nations and its constituent organizations, such as the World Health Organization (WHO), have developed these rights, an increasing number of nations have subsequently adopted some version of them. These include conventions aimed at preventing and prohibiting abuses like torture and genocide and the protection of vulnerable populations, such as refugees (Convention Relating to the Status of Refugees, 1951), women (Convention on the Elimination of All Forms of Discrimination against Women, 1979), and children (Convention on the Rights of the Child, 1989).

Of particular importance are two treaties designed for the goal of enforcing the UDHR. These treaties were signed initially in 1966 by 74 signatories, and effective as of 1976, and by 2021, 170 nations had adopted them. One of these is the International Covenant on Civil and Political Rights (ICCPR) which focuses on the right to life, freedom of speech, religion, and voting. The other one, more important for health and mental health, is the International Covenant on Economic, Social and Cultural Rights (ICESCR) that is concerned with rights to food, education, health, and shelter. A common theme of both treaties is the prohibition of discrimination. Part 3, Article 12, of the ICESCR establishes the right of everyone to the "enjoyment of the highest attainable standard of physical and mental health". It goes on to enumerate several steps required for achieving the full realization of this right shall that include:

> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
> (b) The improvement of all aspects of environmental and industrial hygiene;
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

These are considered "illustrative, non-exhaustive examples", rather than a complete statement of the parties' obligations. The right to health is regarded an inclusive right that applies not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions.

Beginning in the 1990s, the right to health care was further defined and extended, sometimes to include mental health. The Convention on the Rights of the Child (1990) states that the parties to the convention recognize the right of the child to the highest attainable standard of health. In the following year, the U.N. General

Assembly adopted *The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (MI Principles)* which made explicit the rights of persons with mental illness in 1991. And shortly thereafter, the General Assembly also adopted *Standard Rules on the Equalization of Opportunities for Persons with Disabilities*.

In 2000, the Committee on Economic, Social and Cultural Rights, which oversees the ICESCR, published *General Comment 14*, a document that provides a detailed interpretation of the ICESCR. It explains that "[t]he right to health is not to be understood as a right to be *healthy*" and that [t]he right to health contains both freedoms and entitlements." The entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health. It mentions mental health several times, for instance, it states that member states recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Comment 14 was followed up with the Convention on the Rights of Persons with Disabilities (CRPD) in 2006. This convention affirmed the right to the highest attainable standard of health, including access to habilitation and rehabilitation services and inclusion in the community for persons with both physical and mental disabilities. Given the continuing Conventions and their varying interpretations, it was not unexpected that in 2013, the World Health Organization would include mental health as a global health priority in its comprehensive mental health action plan.

Since the early 1980s, several regional organizations have included health and mental health rights in their founding documents, all of which serve to extend the Universal Declaration of Human Rights. For instance, in 1981, the African Charter on Human and People's Rights declared that, "every individual shall have the right to enjoy the best attainable state of physical and mental health." Similarly, Muslim states created their own Charter of Human and People's Rights (1981). Other regional organizations in Europe, the Americas, and Asia have also incorporated the right to health and mental health into key documents.

It is clear that a range of declarations, treaties, conventions, and statements of principals have advanced the right to health care, and mental health care in international law, progress with individual nations has also been continuing. A 2013 study (Heymann et al., 2013) found that only a minority of U.N. member states guarantee the rights to public health (14%), medical care (38%) and overall health (36%) in their constitutions in 2011. Furthermore, free medical care was constitutionally protected in only 9% of the countries examined. Thirteen percent (13%) of nations' constitutions guaranteed children's right to health or medical care, 6% did so for persons with disabilities, and 5% for the elderly and the same for the socioeconomically disadvantaged. Examples of nations that have established a right to health include Brazil and South Africa (Gable & Gostin, 2009).

Considerably less information is available on the extent that the world's nations specifically guarantee mental health care, often included as part of a nation's health care provisions. WHO reports, through its *Mental Health Atlas* (2017) that 43% of countries do not have any mental health legislation. Legislation, itself, provides no

guarantees of such care. One of the few countries that has recently come to explicitly include guarantees of mental health care in its constitution is India (Kelly et al., 2020). India commenced what is effectively the world's largest experiment in rights-based health care with its Mental Healthcare Act of 2017, which took effect on May 29, 2018, granting a legally binding right to mental health care to the nation's population of over 1.3 billion people (Nagaraja & Math, 2008). Specifically, the legislation declares that, "every person shall have a right to access mental health care and treatment from mental health services run or funded by the appropriate Government." The legislation aims to eliminate all discrimination of any description in the implementation of this right.

In contrast, there are 86 countries whose constitutions do not guarantee its citizens health protection, of which the United States is a noted example (UCLA, 2013). Although both health and mental health care in the United States is provided to the majority of its population through its multi-payer system of healthcare, both types of care remain largely and legally discretionary and subject to resource availability, with few exceptions. Rather than being understood as universal rights, health and mental health care are instead regarded in the United States as entitlements, dependent on a variety of conditions such as citizenship, age, poverty status, and contributions to public or private insurance plans. The nation's Patient Protection and Affordable Care Act, enacted by the Obama Administration in 2012, provides care for 89.1% of its population as of 2019 through its efforts to orchestrate a variety of public a private insurance plans using its multi-payer strategy (Tolbert et al., 2020). Exceptions to the largely discretionary provisions under this plan, include those who are involuntarily psychiatrically committed and incarcerated for whom health and mental health care is treated as a constitutional right rather than a discretionary benefit or qualified entitlement. The right of committed mental patients to treatment was established in the 1970s on the basis of the idea that it was unconstitutional to restrict mental patient's liberties unless an appropriate quid-pro-quo involving needed services is offered when a person's liberties are restricted (Wyatt vs. Stickney, 1973, Ala.). In recent years, a range of legal cases have attempted, with limited success, to extend such a right. One which has achieved limited success is the Olmstead Act (1999) which seeks to guarantee mental health care in the community for voluntary patients on the basis of the Americans with Disabilities Act of 1990.

Discussion

Success in establishing mental health as a right has been slow and still incomplete, lagging substantially behind general health care. Mental health has been described by Paul Hunt, the former United Nationals Special Rapporteur on the Right to Health, as "among the most grossly neglected elements of the right to health" (Gable & Gostin, 2009). Reasons for this are many and these include common myths about

mental illness, economic and political considerations, and insufficient development of treatments and other interventions for mental illness.

Most myths regarding mental health revolve around the stigma of mental disorders. One account cites the myth of incompetency, involving the false assumption that persons with mental disabilities cannot competently make decisions or grant consent. A common myth is that of the dangerousness of mentally ill persons, notwithstanding data indicating that the vast majority of persons so afflicted are no more dangerous than the general population. Many view mental illness through a moral lens, believing that persons become mentally ill due to unwise and immoral personal choices. Resistance to providing care for the mentally ill, or at least substantially limiting it more so than medical care, has arisen out of the view that mental illness is often hopeless and represents an unfillable blackhole in respect to an insatiable demand for services. And finally, both the pain invoked in people who witness others suffering from mental disabilities is sometimes accompanied with the attitude, 'out of sight, out of mind', involving the community exclusion of mentally ill and the isolation of many mentally ill patients in mental hospitals and more recently, in nursing homes and jails.

Such myths serve to undermine the development of a shared understanding of social responsibilities for the mentally ill, and thus a recognition of the rights of the mentally ill. There are a variety of rights which have come to be accepted by many providers, but these are highly qualified by the condition of any individual in question. In institutions, these include discrete rights, such as the right to make calls, to have visitors, to be treated with respect and dignity, for explanations of care provided, the right to uncensored private communication, informed consent, and privacy. In nations with mental health codes, patients often have the right to consent to and refuse treatment unless strict criteria are present, such as dangerousness to self or others, a substantial mental disorder, and the availability of a no less restrictive alternative in the community. Depending on the nation, they may have the right to due process and judicial review if any such right is declined. Unfortunately, too often such review is in name only, given negative presumptions regarding the decision-making capabilities of most individuals proposed for psychiatric commitment.

Thus, the right to refuse mental health care remains a critical issue, one side of the coin of mental health rights, the other side of the coin being the right to mental health care, and even mental health itself (see Szmukler, 2019). Traditionally, the right to mental health care has been viewed as contingent on the professional judgment of providers regarding the need and availability of treatments, as well as the prognosis and willingness of the potential patient to be engaged, and invest the requisite time and resources into the treatment process, whether inpatient or outpatient. Such conditions have generally obscured any considerations of a right to mental health care.

Among calls for mental health rights, there is a hierarchy among these rights, based on how they are understood and defined. At the most basic level are those discrete rights of mental patients mentioned above, such as the right to be treated with respect and dignity, privacy, to consult with an attorney, and the like. These

tend to be based on local statutes, and are variously interpreted by caretaking professionals. In some countries they are also defined by case law, and professional practices.

In some cases, such as in many western European nations and India, the right to mental health care has been established, at least officially. This can, of course mean many things, but on the whole, it refers to a basic standard of care involving permissible selections from a menu or basket of services, that the professionals involved can decide to offer and is subject to appeal if refused. A critical issue is cost reimbursement; unless there is some guarantee of reimbursement when the patient cannot afford the services, any such declared right remains an empty one.

Mental health rights may also include the idea that people have a right to the requisite conditions for mental health. One author suggests that "it could mean a right to conditions that protect health in the population" such as civil and political rights and access to population-based personal health care services (Kinney, 2001). Another commentator, critical of any absolute right to mental health, argues that mental health rights include rights of access to a range of "protective environmental services, prevention and health promotion and therapeutic services as well as related actions in sanitation, environmental engineering, housing and social welfare." (Leary, 1994). Such views emphasize the interdependency of the range of human rights and services. The recent motto of the WHO mental health program, "No health without mental health" (2018), echos this perspective.

A closely related conceptualization of the right to mental health involves the notion that people have a right to the 'highest attainable standard" of mental health. This approach was first introduced in the preamble to Constitution of the World Health Organization in 1946, and subsequently reaffirmed by the ICESCR in 1966 which declared "the right of everyone to the … highest attainable standard of physical and mental health." This was followed by Comment 14, in 2020, which explained that the entitlement to mental health "includes the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health." Whether this standard, as well as that involving the conditions of mental health, is stronger or weaker than the right to mental health care is debatable, especially given its lack of definition. On one hand, it is more encompassing and aspirational as it includes mental health care, as well as many related social conditions requisite for well-being, but on the other hand, it is undefined, and thus, hardly enforceable. While the right to mental health clearly requires not only the right to services when need is demonstrated, but also a range of other conditions – income, food, housing, medical care, sanitation, social justice – the challenges of enforcing the guarantee of such conditions remains daunting.

The right to mental health itself, thus, is yet to be fully defined and realized. This right was first introduced in 1978 when the Hague Academy of International Law and the United Nations University organized a multi-disciplinary workshop on The Right to Health as a Human Right with participants from the fields of law, medicine, economics and international organizations. It established the phrase "right to health" within the context of international human rights and drew attention to sources of the right. This phrase is, at a minimum, regarded as a shorthand expression used to

emphasize the link of health status to issues of dignity, non-discrimination, justice, and participation. The expression has had its critics who complain that it is obviously absurd "to presume that government or international organizations or individuals must guarantee a person's good health" (Leary, 1994). Likewise, the ICESCR states that "[t]he right to health is not to be understood as a right to be *healthy.*" For this reason, this interpretation is generally not used in respect to either the right to health or mental health. Rather, most commentators regard the right to health and mental health as established short-hand terms for some combination of the right to mental health services, and the social conditions required for achieving the highest attainable standard of mental health.

Continued development of a social consensus around the right to mental health arguably requires further clarification of its meaning. As long as it remains nebulous, especially if it includes a hint of absurdity, there are unlimited opportunities for naysayers. If it does not literally refer to a guarantee of mental health, then by this 'shorthand expression' do we mean the guarantee of some minimum level of services? A level of services, along with an array of social protections for guarding against the well-known threats to mental health such as lack of income, housing, food, and social justice? Framing mental health in terms of individual rights is clearly needed. It has been pointed out by Ronald Dworkin (1977) that rights essentially trump the language of social goals, and as such, they immediately take priority over various discretionary social goals, that is "a special importance, status, priority, is implied in categorizing something as a right." In fact, at the same time that the language of mental health rights has been advanced, the promotion of mental health and well-being as also achieved a new status. Mental health is increasingly referred to as a type of "mental capital", placing it on par with social and economic capital. Furthermore, it has been included as one the goals under "ensuring healthy lives and promotion of well-being for all at all ages' in the UN's Sustainable Development Goals (SDGs) (WHO, 2020). Despite the inclusion of mental health in the SDGs, the single indicator that they use for evaluating a country's progress is the suicide mortality rate.

Partly because of their ambiguities, resistance to the rights of the mentally ill is substantial. This are rooted, in large part, in discrimination and stigma, in those myths cited earlier, particularly the notion that the mentally ill are especially dangerous, that it is a moral rather than a public health issues, and that service demand is regarded as a blackhole requiring special restrictions moreso than those that ordinary medical care is subject to. Resistance to mental health service provision, especially that involving community services, is also subject to considerable resource competition, especially with groups more favorably viewed, such as children, older adults, the medically ill.

For these reasons there is a continuing need for advocacy for such rights, especially for mental health care. This is much more easily defined as an understandable and achievable right, more so than any guarantee of mental health. It includes both services and supports, not only for the seriously mentally ill with persistent conditions, but also those with acute conditions. Care is inclusive of both services and a variety of other supports, such as housing and food. Furthermore, determining a

required minimum standard of service provision, a menu or basket of services that must be available when needed, is not only feasible, but often done. With considerable work having been accomplished in identifying best practices, and especially empirically-based services, there is a recognized knowledge base available for this task, though considerable work is still required in this respect.

Conclusion

Both the idealization and the questioning of the notion of social progress has inevitably contributed to a diversity of approaches as to how social development can best be facilitated. These have ranged from highly centralized top-down approaches to neo-liberal laissez-faire strategies of deregulation. The latter, which has come to be widely promoted since the demise of communism, along with continued technological innovation, has driven globalization, the most recent rendition of social progress and modernization. Globalization, as a loosely interconnected set of economic, social, and cultural trends, has had a diversity of positive and negative impacts, most notably the widening of economic inequalities, involving both the lifting of many out of extreme poverty in the developing world, and economic and social stagnation among the working classes of developed nations. Although the full impact of such changes is yet to be fully documented in respect to patterns of global mental health, preliminary indicators suggest that the mixed economic effects of globalization have had equally mixed effects on the mental health of the various populations involved, ones that represent its winners and losers. Very importantly, the growing international interdependencies and the social dimensions of globalization are contributing to psychiatric deinstitutionalization and the growth of community mental health on a worldwide basis, with some evidence of displacement of indigenous support systems and healing practices in the developing world. All of these changes, as well as the overall development of human rights law, have set the stage for and enabled the continued implementation of the right to mental health, one which is most practically understood as the right to mental health care, including the requisite social and health conditions, and the attainment of the highest possible standard of mental health.

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