HHR
Health and Human Rights Journal

Mental Health as a Basic Human Right and the Interference of Commercialized Science

LISA COSGROVE AND ALLEN F. SHAUGHNESSY

Abstract

Although there is consensus that a rights-based approach to mental health is needed, there is disagreement about how best to conceptualize and execute it. The dominance of the medical model and industry's influence on psychiatry has led to an over-emphasis on intra-individual solutions, namely increasing individuals' access to biomedical treatments, with a resultant under-appreciation for the social and psychosocial determinants of health and the need for population-based health promotion. This paper argues that a robust rights-based approach to mental health is needed in order to overcome the effects of commercial interests on the mental health field. We show how commercialized science—the use of science primarily to meet industry needs—deflects attention away from the sociopolitical determinants of health, and we offer solutions for reform.

Lisa Cosgrove, PhD, is Professor of Counseling Psychology in the Department of Counseling and School Psychology at the University of Massachusetts-Boston, USA.

Allen F. Shaughnessy, PharmD, MMedEd, is Director, Master Teacher Fellowship and Professor and Vice Chair of Family Medicine for Research, Tufts University School of Medicine, Malden, USA.

Please address correspondence to Lisa Cosgrove. Email: lisa.cosgrove@umb.edu.

Competing interests: None declared.

Introduction

> *Mental health and well-being cannot be defined by the absence of a mental health condition, but must be defined instead by the social, psychosocial, political, economic and physical environment that enables individuals and populations to live a life of dignity, with full enjoyment of their rights and in the equitable pursuit of their potential.*[1]

Human rights are not only entitlements that have a legal and ethical force but also "fundamental pillars of justice and civilization."[2] The United Nations (UN) Committee on Economic, Social and Cultural Rights adopted its general comment on the right to health 20 years ago. Officially adopting this comment solidified states' obligation to make the right to health a priority. Over the last two decades, mental health has become recognized as a critical component of the right to health and one that must be addressed for this right to be realized. As the first director-general of the World Health Organization (WHO) noted, "without mental health there can be no true physical health."[3]

However, there are numerous challenges to bringing a rights-based approach to mental health to fruition. This approach necessitates a critical evaluation of the assumptions about mental illness and traditional models of care. The hegemony of the medical model and the over-reliance on organized psychiatry as the main policy maker has undermined the development of mental health policy "as a robust cross-sectoral issue."[4] As a result, there has been an over-emphasis on biomedical interventions aimed at the individual rather than at population-based health promotion, even though the latter is just as important as individual health treatment.[5] The focus on biomedical interventions is particularly disconcerting because of the ways in which industry influence has compromised the scientific evidence base in medicine.

This paper argues that a rights-based approach to mental health is needed in order to overcome the effects of commercial interests on the mental health field. Specifically, we show how commercialized science—the use of science primarily to meet industry needs—deflects attention away from the psychosocial and sociopolitical determinants of health and undermines several key elements of a rights-based approach to mental health, such as the right to participation, the right to acceptable health care, and the importance of population-based health interventions.

Commercialized science: Why it undermines a rights-based approach

> *The mix of science and commerce continues to erode the ethical standards of research and diminish public confidence in its results.*[6]

Collaborations between academe and industry are credited with sparking innovation and have resulted in benefits to overall health (for example, treatments for malaria and the vaccine to prevent meningitis). However, the pressures of capitalism have resulted in a corrupting of the scientific evidence base, the medical education system, and even the lens through which human wellness and illness are viewed. Indeed, research has consistently shown that commercial influence is a pernicious problem in all of health care.[7] Although there is disagreement about the extent of bias, there is consensus among researchers, clinicians, scientific communities, and medical organizations that the scientific evidence base has been compromised.[8] Research has consistently shown that financial conflicts of interest shape prescribing practices, medical education, guideline recommendations, and editorial decisions.[9] In 2009, the Institute of Medicine (IOM, now the National Academy of Medicine) published *Conflicts of Interest in Medical Research, Practice, and Education*, which offered recommendations for restoring integrity in medicine. A decade later, an international group of researchers and clinicians assessed the progress made and concluded that there is continued "widespread financial dependence on industry [which] brings commercial bias into research evidence, medical education and clinical practice."[10]

The public health implications of the bias resulting from undue industry influence, especially when taken in aggregate, are staggering.[11] Although all medical specialties have to grapple with commercial bias and its resulting harm to

patients, psychiatry is particularly vulnerable because of the lack of biological markers for any mental health disorders. In the field of psychiatry, commercialized science crowds out an appreciation for epistemic diversity (that is, an appreciation of diverse idioms of distress) by reinforcing a reductive biomedical disease model. In turn, this results in the "professionalization of suffering" that sustains the authority of psychiatrists and other mental health professionals over people with lived experience.[12] The right to participation and autonomous decision-making, including the right to refuse a proposed treatment, are all too easily glossed over in the service of enhancing "adherence to treatment." The heavily marketed disease model of mental illness has contributed to a range of systemic measures that have inadvertently entrenched discrimination in health care services, such as forced hospitalization when there is no immediate danger to one's self or others. Disease rhetoric and disease measures (for example, the disability-adjusted life year) are used to emphasize the economic burden of mental illness, particularly in low- and middle-income countries. The following section briefly discusses the commercialization of psychiatric science in four key areas: psychiatric taxonomy, psychotropic drug trials, clinical care guidelines, and medical education.

How has commercialized science resulted in biased research, practice, and education in psychiatry?

Limiting mental distress to a biomedical model

> *There is a boundary between the normal and the sick. There are discrete mental illnesses … It is the task of scientific psychiatry, as a medical specialty, to investigate the causes, diagnosis, and treatment of these mental illnesses.*[13]

The early versions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) were heavily influenced by the prevailing psychoanalytic zeitgeist of the early 20th century. As a result, *DSM I* and *DSM II* had a descriptive focus and did not make clear demarcations between specific disorders. However, a paradigm shift occurred in 1980 with the publication of the *DSM III*, when the American Psychiatric Association, the book's developer, adopted a medical framework and used a "symptom checklist" approach. The conceptualization of emotional distress (and mental health conditions such as schizophrenia) codified in the third edition and continuing with each new iteration of the *DSM* encourages a view of people as patients with identifiable, quantifiable mental illnesses. This paradigm shift facilitated standardization (for example, are symptom criteria met for a mental illness?), but it also deflected attention away from asking questions about how structural interventions at the population level could enhance emotional well-being. Moreover, embracing a disease model solidified organized psychiatry's status within the mental health field.

The *DSM's* categorical approach, with its focus on identifying discrete symptomatology and expansion of diagnostic boundaries, reinforces the logic of "a pill for every ill." Although it was not the intention of organized psychiatry to develop a diagnostic taxonomy that was an industry-friendly instrument, Robert Spitzer, the chair of the *DSM III*, later acknowledged that "[t]he pharmaceuticals were delighted" with the medical model adopted by the *DSM*.[14] The fact that the majority of *DSM IV* and *DSM V* panel members had financial ties to the manufacturers of psychotropic medications used to treat the disorders described in the manual has raised concerns about industry exerting an undue influence on it.[15]

Setting the agenda and swaying the evidence via psychotropic drug trials

In addition to aligning the very definitions of mental illness with its commercial needs, the pharmaceutical industry also controls much of the current evidence base. Although the US National Institutes of Health and government agencies in other countries fund basic science studies, much of the clinical research relied on by clinicians and policy makers is funded by industry. This "ghost management" not only sets the research agenda but also normalizes academic-industry relationships.[16]

This entanglement affects the interpretation of the data and research that is produced.[17] For example, in all fields of medicine, it has been shown repeatedly that published outcomes of industry-sponsored studies "tend to favour sponsors' products, creating a 'sponsorship bias'."[18] In psychiatry, studies that reported financial conflicts of interest were almost five times more likely to report positive results.[19] The use of disease-oriented outcome measures and a reliance on statistical—rather than clinical—significance contribute to this "funding effect." Indeed, industry funding of phase III randomized clinical trials for psychotropic drugs consistently results in the publication of pro-industry findings, overestimation of efficacy, and underreporting of harms.[20] The funding effect can be manifest in subtle but powerful ways. For example, Veronica Yank et al. found that trial authors with financial conflicts of interest tend to write favorable conclusions even in the absence of positive trial results.[21] This finding demonstrates that the commercial interference is likely to be rooted in implicit bias and in the development of "pro-industry habits of thought."[22]

Spreading the agenda via clinical care guidelines

Commercial influence over guideline development occurs when authors have financial conflicts of interest or when the pharmaceutical or medical device industry funds the development process (directly or indirectly). Guild interests can also exert an influence when the development group is not sufficiently multidisciplinary and when the group does not include methodologists who can help ensure that the interpretation of the evidence is not influenced by a professional society's interests. The fact that 90% of the authors of three major guidelines produced by the American Psychiatric Association for major depressive disorder, bipolar disorder, and schizophrenia had ties to the companies that manufactured the medications recommended as treatments for these disorders raises questions about undue industry influence.[23] More recently, a new guideline for the treatment of depression was published in a peer-reviewed psychiatric journal and heavily marketed to physicians and psychiatrists (for example, it was featured on Medscape and as a continuing medical education course).[24] The authors of this guideline recommended expensive on-patent medications even though generic options were available and did not provide empirical support for their recommendation. An independent review of the guideline found that it *did not meet a single IOM standard* for trustworthy guidelines and that most of the guideline authors had ties to the manufacturer whose product was recommended as a first-line treatment.[25]

Solidifying the hegemony via medical education

In addition to supporting great swaths of research in medical schools, the pharmaceutical industry starts early in medical training to create a non-critical, welcoming atmosphere among medical students. Most medical students will interact with the pharmaceutical industry at some point, with these interactions ranging from meals to gifts to books or study aids. As a result, favorable attitudes toward industry are cultivated.[26] Cultivation of either indebtedness or entitlement continues in residency training and follows physicians into their practices, where relationships with industry are further developed, resulting in the prescribing of new medicines with little or no advantage over older, less expensive ones.[27]

Commercial support of continuing medical education (CME) is also a pernicious problem. Despite efforts by the accrediting body to minimize the influence of industry on content, almost three-fourths of the top 500 providers of CME receive commercial support.[28] Not surprisingly, industry-funded CME has been criticized for containing marketing messages that are neither balanced nor accurate.[29] The Accreditation Council for Continuing Medical Education sets standards in an attempt to "ensure that CME activities are independent and free of commercial bias," but there is still a need for greater oversight and transparency. For example, physicians should be told that despite the council's oversight, it is possible that there will still be commercial interference in terms of the content of the educational activity.[30] Because of the concern that medical education has effectively become a marketing tool, the National Academy of Medicine

has called for a complete severing of ties between industry and CME providers.[31] Unfortunately, this call has gone unheeded.

Solutions for reform

> *Will we have to wait for someone to run a randomised controlled trial with an economic evaluation to support the intervention of befriending, supported decision making, inclusion in the work-place, or decent housing before we acknowledge these as being worthy investments for health-care systems? Moral arguments continue to be dismissed or undervalued in priority setting in global health … [and] the primary locus of interventions for healthcare problems is narrowly defined technological fixes.*[32]

Using a human rights lens to understand emotional suffering revives ethical discussions about mental health because the impetus for addressing well-being is grounded in a moral and not economic argument. As Gillian MacNaughton and Diane Frey note, framing a right as an economic good "undermines its content and positions it as a component in an economic equation rather than as part of a fulfilling life."[33] In contrast, casting well-being in a moral framework facilitates a deeper understanding of the relationship between human rights and the social determinants of health, for we must consider the immediate psychosocial context out of which symptoms emerge. A robust human rights approach can thus address key aspects of this relationship in order to enhance the well-being of populations. Indeed, Amartya Sen's capabilities approach—a moral framework that understands that the opportunity to develop capabilities is central to human freedom and dignity—clearly shows that rights and capabilities must be seen as interdependent entities.[34] In an attempt to respond to that interdependence and ensure that access to care and health equity are not conflated, we offer the following suggestions.

First and foremost, greater inclusivity of individuals who have been assigned psychiatric diagnoses or who identify as individuals with psychosocial disabilities is needed in order to develop policies, programs, and standards of care that appreciate diverse idioms of distress. Participation must be seen not as an add-on but as an "efficient and effective strategy to improve health care systems and services"; such participation will help expand proposed solutions beyond the biomedical realm.[35] That is why people with lived experience should play a central role in the decision-making, design, and dissemination of mental health research and practice standards. Such inclusion will also help ensure that commercial interests do not compromise the integrity of guidelines.

Also, in terms of addressing stigma, the enhanced participation of stakeholders will help us better understand and challenge the *institutional* structures through which the stigmatization of individuals with psychosocial disabilities is perpetuated.[36] In order to avoid what Flick Grey has termed a process of "benevolent othering," anti-stigma approaches must be rooted in a more nuanced sociological understanding of stigma that sees it as social, relational, and structural.[37] For example, in Australia, the Queensland Mental Health Commission analyzed legislation and identified laws that were potentially stigmatizing, described why, and made specific recommendations for their revision or elimination.[38] A rights-based orientation can thus interrupt the stigmatizing process because it is premised on the universality of human dignity.[39]

Moreover, assessments of states' and duty bearers' compliance with a rights-based approach should not be limited to the availability of psychotropic medications. Interventions that fail to consider the social determinants of health would thus not be compliant with the right to health and not aligned with scientific evidence.[40] Population-based health must be put on equal footing with intra-individual treatments because improvements in the mental health status of populations cannot be improved simply by increasing access to medical and psychological treatments and services.[41] For example, the Special Rapporteur on the right to health has consistently urged action on structural factors that produce distress and has called on states to fund health promotion activities and not simply focus on scaling up access to psychiatric diagnosis and treatment.[42] Certainly, addressing

structural violence (that is, the ways in which institutions and social arrangements hurt populations and individuals) will undoubtedly be an uphill battle: population-based interventions do not serve industry the way biomedical interventions do.[43] However, as the Special Rapporteur has urged, we should not remain wedded to a narrow metric of an essential medicines list when evaluating states' human rights compliance; we need to expand assessments of compliance to include psychosocial interventions.[44]

Finally, we need analyses that deepen our understanding of the constitutive role of power in the broader determination of health. The current Special Rapporteur on the right to health pointed out early on in his tenure that there needs to be a shift in conversations and policies about mental health—from talking about chemical imbalances to addressing power imbalances.[45] The resulting power asymmetries that occur because decision-making power remains concentrated in financially conflicted organized psychiatry and industry disempowers the people who need the care the most.

Conclusion

> *Scaling up of psychiatry in low income countries risks becoming scaled down to an "administrative psychiatry" whose primary objective is the prescription of psychotropic drugs and the reduction of symptoms rather than addressing the social and psychological factors which contribute to mental breakdown and recovery.*[46]

What are the conditions for the possibility of a robust human rights approach to mental health? While that question eludes easy answers, a necessary starting point is recognizing that the precarious epistemological foundations of psychiatry allow the mental health field to be manipulated by industry. Therefore, although it is clear that many people throughout the world are not getting the health care they need and deserve, it is also evident that the uncritical exportation of the biomedical disease model will not provide optimally effective mental health interventions at either the individual or population level. Indeed, scaling up mental health treatments in the absence of conceptual and structural competence may very well lead to unintended human rights violations (such as forced treatment).[47] Challenging though it may be, addressing the entrenched problem of commercial influence on the scientific evidence base is essential if we are to bring a rights-based approach to fruition.[48]

Acknowledgments

We would like to thank Chia Po Cheng for his editorial assistance and helpful feedback on earlier drafts and Justin Karter, Zenobia Morrill, Rebecca Troeger, Jackie Hogan, Evan Valdes, Michelangela Yusif, and Christine Tosti for their assistance, comments, and suggestions.

References

1. D. Pūras, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/HRC/41/34 (2019).

2. S. P. Mann, V. J. Bradley, and B. J. Sahakian, "Human rights-based approaches to mental health: A review of programs," *Health and Human Rights Journal* 18/1 (2016), pp. 263–276.

3. C. Brock, *Outline for a study group on World Health and the survival of the human race: Material drawn from articles and speeches* (Geneva: World Health Organization, 1951). Available at https://apps.who.int/iris/bitstream/handle/10665/330666/MH.276.51-eng.pdf.

4. D. Pūras, *Statement by Mr. Dainius Pūras Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health at the 35th session of the human rights council* (June 2017). Available at https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=22052&LangID=E.

5. J. Hannah and T. Sadiq, "Relationships are human rights determinants in mental health," *Health and Human Rights Journal* (June 2019). Available at https://www.hhrjournal.org/2019/06/relationships-are-human-rights-determinants-in-mental-health/.

6. S. Krimsky, *Science in the private interest: Has the lure of profits corrupted biomedical research?* (Lanham, Maryland: Rowman and Littlefield, 2004), p. 4

7. E. G. Campbell, J. S. Weissman, S. Ehringhaus, et al., "Institutional academic–industry relationships," *Journal of the American Medical Association* 298/15 (2003), pp. 1779–1786.

8. J. P. A. Ioannidis, "Why most published research findings are false," *PLos Medicine* 2/8 (2005), p. e124.

9. A. Lundh, J. Lexchin, B. Mintzes, et al., "Industry sponsorship and research outcome," *Cochrane Database of Systematic Reviews* 2 (2017).

10. R. Moynihan, L. Bero, S. Hill, et al., "Pathways to independence: Towards producing and using trustworthy evidence," *BMJ* 367 (2019), p. 16576.

11. H. B. Perry, "Understanding financial conflict of interest: Implications for information literacy instruction," *Communications in Information Literacy* 12/2 (2018), pp. 215–225; New York State Health Foundation, *Follow the money: Pharmaceutical manufacturer payments and opioid prescribing patterns in New York state* (New York, 2018). Available at https://nyshealthfoundation.org/wp-content/uploads/2018/06/following-the-money-pharmaceutical-payments-opioid-prescribing-june-2018.pdf.

12. A. Kleinman and J. Kleinman, "Moral transformation of health and suffering in Chinese society," in A. M. Brandt and P. Rozin (eds), *Morality and health* (New York: Routledge, 1997).

13. G. Kelerman, "The evolution of scientific nosology," in J. Shershow (ed), *Schizophrenia: Science and practice* (Cambridge, MA: Harvard University Press, 1978).

14. J. Ronson, "Bipolar kids: Victims of the 'madness industry'," *New Scientist* 210/2815 (2011), pp. 44–47.

15. L. Cosgrove, S. Krimsky, M. Vijayaraghavan, et al., "Financial ties between DSM-IV panel members and the pharmaceutical industry," *Psychotherapy and Psychosomatics* 75/3 (2006), pp. 154–160; L. Cosgrove and S. Krimsky, "A comparison of DSM-IV and DSM-5 panel members' financial associations with industry: A pernicious problem persists," *PLoS Medicine* 9/3 (2012), p. e1001190.

16. S. Sismondo, "Ghosts in the machine: Reply to McHenry (2009)," *Social Studies of Science* 39/6 (2009), pp. 949–952.

17. J. Abramson, "The reliability of our medical knowledge as a product of industry relationships," *Hofstra Law Review* 35 (2006), pp. 691–698.

18. B. Als-Nielsen, W. Chen, C. Gluud, et al., "Association of funding and conclusions in randomized drug trials: A reflection of treatment effect or adverse events?," *Journal of the American Medical Association* 290/7 (2003), pp. 921–928; T. Jefferson, "Sponsorship bias in clinical trials – growing menace or dawning realization?," *JLL Bulletin: Commentaries on the History of Treatment Evaluation* (2019). Available at https://www.jameslindlibrary.org/articles/sponsorship-bias-in-clinical-trials-growing-menace-or-dawning-realisation/. See also Ioannidis (see note 8).

19. R. H. Perlis, C. S. Perlis, M. Be, et al., "Industry sponsorship and financial conflict of interest in the reporting of clinical trials in psychiatry," *American Journal of Psychiatry* 162/10 (2005), pp. 1957–1960.

20. J. E. Bekelman, Y. Li, and C. P. Gross, "Scope and impact of financial conflicts of interest in biomedical research: A systematic review," *Journal of the American Medical Association* 289/4 (2003), pp. 454–465; T. Bodenheimer, "Uneasy alliance," *New England Journal of Medicine* 342/20 (2000), pp. 1539–1544; B. Djulbegovic, M. Lacevic, A. Cantor, et al., "The uncertainty principle and industry-sponsored research," *Lancet* 356/9230 (2000), pp. 635–638; I. Pitrou, I. Boutron, N. Ahmad, et al., "Reporting of safety results in published reports of randomized controlled trials," *Archives of Internal Medicine* 169/19 (2009), pp. 1756–1761.

21. V. Yank, D. Rennie, and L.A. Bero, "Financial ties and concordance between results and conclusions in meta-analyses: Retrospective cohort study," *BMJ* 335/7631 (2007), pp. 1202–1205.

22. J. Lexchin, L. Bero, B. Djulbegovic, et al., "Pharmaceutical industry sponsorship and research outcome and quality: Systematic review." *BMJ* 326.7400 (2003), pp. 1167–1170.

23. L. Cosgrove, H. J. Bursztajn, S. Krimsky, et al., "Conflicts of interest and disclosure in the American Psychiatric Association's Clinical Practice Guidelines," *Psychotherapy and Psychosomatics* 78/4 (2009), pp. 228–232.

24. S. M. Stahl, D. A. Morrissette, G. Faedda, et al., "Guidelines for the recognition and management of mixed depression," *CNS Spectrums* 22/2 (2017), pp. 203–219.

25. L. Cosgrove, A. F. Shaughnessy, and T. Shaneyfelt, "When is a guideline not a guideline? The devil is in the details," *BMJ Evidence-Based Medicine* 23/1 (2018), pp. 33–36.

26. K. E. Austad, J. Avorn, and A. S. Kesselheim, "Medical students' exposure to and attitudes about the pharmaceutical industry: A systematic review," *PLoS Medicine* 8/5 (2011), p. e1001037.

27. A. Fugh-Berman and S. Ahari, "Following the script: How drug reps make friends and influence doctors," *PLoS Medicine* 4/4 (2007), p. e150.

28. Accreditation Council for Continuing Medical Education, *Accreditation rules* (revised edition, February 2014). Available at https://www.accme.org/accreditation-rules; A. Fugh-Berman and A. Hogenmiller, "CME stands for commercial medical education: And ACCME still won't address the issue," *Journal of Medical Ethics* 42/3 (2016), pp. 172–173.

29. B. Lo and C. Ott, "What is the enemy in CME, conflicts of interest or bias?," *Journal of the American Medical Association* 310/10 (2013), pp. 1019–1020; A. Meixel, E. Yanchar, and A. Fugh-Berman, "Hypoactive sexual desire disorder: Inventing a disease to sell low libido," *Journal of Medical Ethics* 41/10 (2015), pp. 859–862; M. A. Rodwin, "Drug advertising, continuing medical education, and physician prescribing: A historical review and reform proposal," *Journal of Law, Medicine and Ethics* 38/4 (2010), pp. 807–815.

30. L. Golestaneh, "Transparency in continuing medical education–Author's reply," *Lancet* 391/10137 (2018), p. 2324.

31. M. J. Field, and B. Lo (eds), *Conflict of interest in*

medical research, education, and practice (Washington, DC: National Academies Press, 2009).

32. V. Patel and P. E. Farmer, "The moral case for global mental health delivery," *Lancet* 395/10218 (2020), p. 108.

33. G. MacNaughton and D. Frey, "Challenging neoliberalism: ILO, human rights, and public health frameworks on decent work," *Health and Human Rights Journal* 20/2 (2018), p. 43.

34. T. Pfister, "Citizenship and capability? Amartya Sen's capabilities approach from a citizenship perspective," *Citizenship Studies* 16/2 (2012), pp. 241–254; A. Sen, *Development as Freedom* (Oxford: Oxford University Press, 1999).

35. K. H. Kenyon, L. Forman, and C. E. Brolan, "Deepening the relationship between human rights and the social determinants of health: A focus on indivisibility and power, " *Health and Human Rights Journal* 20/2 (2018), pp. 1–10.

36. F. Mahomed, "Stigma on the basis of psychosocial disability: A structural human rights violation," *South African Journal on Human Rights* 32/3 (2016), pp. 490–509.

37. F. Grey, "Benevolent othering: Speaking positively about mental health service users," *Philosophy, Psychiatry, and Psychology* 23/3 (2016), pp. 241–251; M. L. Hatzenbuehler, and B. G. Link, "Introduction to the special issue on structural stigma and health," *Social Science and Medicine* 103 (2014), pp. 1–6.

38. K. Lancaster, K. Seear, and A. Ritter, "Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use," (Brisbane: Queensland Mental Health Commission, 2017); J. D. Livingston, *Mental illness-related structural stigma: The downward spiral of systemic exclusion* (Calgary: Mental Health Commission of Canada, 2013).

39. D. Rose, "Service user/survivor-led research in mental health: Epistemological possibilities," *Disability and Society* 32/6 (2017), pp. 773–789; S. Schrader, N. Jones, and M. Shattell, "Mad pride: Reflections on sociopolitical identity and mental diversity in the context of culturally competent psychiatric care," *Issues in Mental Health Nursing* 34/1 (2013), pp. 62–64. See also Lo and Ott (see note 29); Meixel et al. (see note 29); Rodwin (see note 29).

40. D. Pūras, "Challenges in promoting the interdependence of all human rights," *Health and Human Rights Journal* (December 2019). Available at https://www.hhrjournal.org/2019/12/challenges-in-promoting-the-interdependence-of-all-human-rights/.

41. A. R. Chapman, *Global health, human rights, and the challenge of neoliberal policies* (Cambridge: Cambridge University Press, 2016).

42. D. Pūras, Report of the Special Rapporteur on the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/HRC/35/21 (2017).

43. P. E. Farmer, B. Nizeye, S. Stulac, et al., "Structural violence and clinical medicine," *PLoS Medicine* 3/10 (2006), p. e449.

44. See Rose (see note 39); Schrader et al (see note 39).

45. D. Pūras, *Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health Mr. Dainius Pūras* (April 2017). Available at https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21480&LangID=E.

46. R. G. White, "'Global mental health spreads like bush fire in the global South': Efforts to scale up mental health services in low-and middle-income countries," in R. G. White et al. (eds), *The Palgrave handbook of sociocultural perspectives on global mental health* (London: Palgrave Macmillan, 2017).

47. H. Hansen and J. Metzl, "Structural competency in the US healthcare crisis: Putting social and policy interventions into clinical practice," *Journal of Bioethical Inquiry* 13/2 (2016), pp. 179–183; J. M. Karter, and S. R. Kamens, "Toward conceptual competence in psychiatric diagnosis: An ecological model for critiques of the DSM," *Critical Psychiatry* (2019), pp. 17–69; J. M. Karter, "An ecological model for conceptual competence in psychiatric diagnosis," *Journal of Humanistic Psychology* (2019).

48. D. Pūras, Right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Note by the Secretary-General, UN Doc. A/72/137 (2017).