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The burnout economy: poverty and mental health

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on extreme poverty and human rights, Olivier De Schutter, in accordance with Human Rights Council resolution 44/13.

Report of the Special Rapporteur on extreme poverty and human rights, Olivier De Schutter

The burnout economy: poverty and mental health

Summary

The Special Rapporteur on extreme poverty and human rights, Olivier De Schutter, identifies the mechanisms that expose people in poverty to a heightened risk of mental health conditions, and he examines how, despite the extraordinary resilience of many people in poverty, mental ill-health in turn can perpetuate poverty. He calls on States to move from a biomedical approach to mental health, which treats it as a problem of the individual, to an approach that addresses its social determinants: in order to combat the global tide of depression and anxiety, more should be done to fight poverty and inequality, and to address economic insecurity.

In addition to increasing investments in mental healthcare, he identifies addressing the psychosocial risks caused by the casualization of labour, strengthening social protection by providing an unconditional basic income, destigmatizing mental health conditions, and facilitating access to green spaces allowing to reconnect to nature, as priority interventions. The vicious cycles connecting poverty to mental health problems are the price we pay for the current focus on stimulating competition and performance, in a society obsessed with increasing total economic output: these cycles can be broken, provided we put well-being above the endless quest for economic growth.

I. Introduction

1. In his most recent report to the Human Rights Council, the Special Rapporteur called for expanding the toolbox against poverty to identify how the eradication of poverty could be made less dependent on increasing economic output, measured as the gross domestic product (GDP). He noted that the obsessive quest for increasing the GDP -- what he described as "growthism" -- could become counterproductive. Beyond a certain point in the development process, or when economic growth is extractive and exploitative, its negative impacts outweigh its benefits: as societies become more affluent in general, environmental pressures increase and consumption patterns change, resulting in new forms of social exclusion and inequalities.[1]

2. One of the reasons why growth can thus become "uneconomic" is that the focus on increasing material consumption and on competition threaten mental health.[2] In this report, the Special Rapporteur explores the vicious cycles that exist between poverty and poor mental health. Poverty causes mental health conditions, which in turn constitutes an obstacle to the escape from poverty: in order to understand how these cycles can be broken, we need to understand how they work.

3. The World Health Organization defines mental health as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community".[3] Mental health is, the WHO recalls, "a basic human right", "crucial to personal, community and socio-economic development".[4] Today however, 970 million people globally (11 per cent of the world's population) live with a mental health condition[5], over 280 million people worldwide suffer from depression and 301 million people face anxiety.[6] Every year, 700,000 people commit suicide, which is the fourth leading cause of death in young people aged 15–29 years.[7] The prevalence of depression and anxiety increased by 25% during the first year of the Covid-10 pandemic, moreover, due to increased social isolation and economic fears.[8] Climate change and related disruptions, as well as biodiversity loss and pollution, may further worsen mental health outcomes.[9]

4. The implications are huge both for those concerned, and for societies as a whole. Globally, mental health conditions cause losses of one trillion USD annually, with depression being the leading cause of ill-health and disability; the returns on investing in treating depression and anxiety would therefore be considerable.[10] In OECD countries, between one-third and one-half of all new disability benefit claims are for reasons of mental ill-health, and among young adults that proportion was estimated to go up to over 70%.[11]

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[1] A/HRC/56/61.

[2] Jules Pretty, et al., "Improving health and well-being independently of GDP: dividends of greener and prosocial economies", *International journal of environmental health research*, 26(1)(2016), pp. 11–36. https://doi.org/10.1080/09603123.2015.1007841; B.-C. Han, *Burnout Society* (Stanford Univ. Press, 2015).

[3] WHO, Mental Health (Factsheet), 17 June 2022, at: https://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response

[4] Id.

[5] https://www.who.int/health-topics/mental-health#tab=tab_2 (last consulted on 24 June 2024).

[6] "Mental health and brain health" (World Health Organisation), https://www.who.int/observatories/global-observatory-on-health-research-and-development/analyses-and-syntheses/mental-health/global-strategic-direction#:$%7Bsim%20%7D$:text$=$Mental (last consulted on 24 June 2024).

[7] *Suicide worldwide in 2019* (Geneva: WHO, 2021), pp. 4 and 7.

[8] *Mental Health and COVID-19: Early evidence of the pandemic's impact: Scientific brief* (WHO/2019-nCoV/Sci_Brief/Mental_health/2022.1, 2 March 2022).

[9] *The impact of the triple planetary crisis on mental health in low- and middle-income countries* (United for Global Mental Health, 2024).

[10] "Mental health and brain health"; for estimates, Dan Chisholm, et al., "Scaling-up treatment of depression and anxiety: a global return on investment analysis", *The Lancet Psychiatry*, 3(5)(2016), pp. 415-424.

[11] OECD, *Sick on the Job? : Myths and Realities about Mental Health and Work* (Paris: OECD, 2012), https://doi.org/10.1787/9789264124523-en.

5. As a result, the prescription of psychiatric drugs explodes, as if the problem were only attributable to the chemical imbalances of the brain or limited to individual suffering. However, while it can help to reduce blame and serves pharmaceutical companies, this biomedical approach distracts from more systemic solutions.[12] Rather than to the functioning of neurotransmitters such as serotonin and dopamine, the mental health pandemic is attributable to the increased pressures towards higher productivity and the constant quest for more.[13]

II. Mental health conditions and decision-making under scarcity

6. Since this report addresses the links between poverty and mental health, its focus is different from the separate but related issue of the constraints in decision-making that people in poverty might encounter.

7. People facing scarcity find themselves in a paradoxical situation.[14] On the one hand, scarcity leads them to focus on what matters most to fulfil their needs, for instance paying attention to prices or to opportunities to reduce avoidable expenses; and to make more consistent choices aimed at paying less: they are, in that sense, "hyperrational" and skilled at comparing options. On the other hand, however, scarcity may operate as a "cognitive tax", making it more difficult for people facing scarcity to make the choices that would serve them best; and it may result in a tendency to neglect a wider range of options, to focus too much on the short-term, or to be excessively risk-averse, leading to decisions different from those more privileged people would take.

8. Strictly speaking, the impacts of scarcity on cognitive bandwidth and on the ability to make fully reasoned choices, that do not excessively discount long-term impacts, are separate from the mental health impacts of poverty. The argument of the authors having studied decision-making under scarcity is *not* that "poor people have less bandwidth", it is instead that "*all people, if they were poor*, would have less effective bandwidth".[15] This distinction matters. Not all failures of people living in poverty to make the right decisions can be attributed to the mental health impacts of poverty; some are attributable to the fact of poverty itself, which leads the person facing scarcity to a particular framing of the situation in which she find herself.

9. At the same time, such failures in decision-making may fuel negative stereotypes against people in poverty (what the Special Rapporteur labelled "povertyism" in an earlier report[16]), which in turn can lead, at best, to paternalism, and, at worse, to discrimination. Moreover, the impacts of failed decision-making may be similar, whether they stem from the more restricted cognitive bandwidth of people facing scarcity or whether they have their source in mental ill-health such as depression or anxiety. Finally, some policy recommendations included in this report that address the vicious cycles linking poverty to mental health are also relevant to improving the ability for people in poverty to make the right choices, despite the "cognitive tax" scarcity imposes on them.

[12] See A/HRC/44/48, para. 23; and Brett Deacon and Grayson Baird, "The Chemical Imbalance Explanation of Depression: At What Cost?", *Journal of Social and Clinical Psychology*, 28(4)(2009), pp. 415-435.

[13] A/HRC/41/34, para. 81; A/HRC/44/48, para. 9; and James Davies, *Sedated: How Modern Capitalism Created Our Mental Health Crisis* (London: Atlantic Books, 2021).

[14] S. Mullainathan and E. Shafir, *Scarcity. The New Science of Having Less and How It Defines our Lives* (New York, Holt & Co., 2013). See also Anandi Mani, Sendhil Mullainathan, Eldar Shafir and Jiaying Zhao, "Poverty Impedes Cognitive Function", *Science* 341(6149)(2013), pp. 976-980, doi:10.1126/science.1238041; and Ernst-Jan de Bruijn and Gerrit Antonides, "Poverty and economic decision-making: a review of scarcity theory", *Theory and Decision* 92(2022), pp. 5–37, https://doi.org/10.1007/s11238-021-09802-7.

[15] Mullainathan and Shafir, *Scarcity* (2013), p. 66.

[16] A/77/157.

III. How poverty and inequality cause mental health conditions

10. In 2012, when it endorsed the Guiding Principles on Extreme Poverty and Human Rights in resolution 21/11, the Human Rights Council identified as "a clear example of the vicious circle of poverty" the mechanisms through which "persons experiencing ill health are more likely to become poor, while persons living in poverty are more vulnerable to accidents, diseases and disability".[17] In what follows, the Special Rapporteur describes these links, before examining how they can be addressed.

A. Proven correlations

11. The link between poverty and mental ill-health is well documented. A 2011 study covering around 35,000 adults in the United States found that mental conditions were more common among those making less than US$ 40,000 per year than among those making more than US$ 70,000 USD.[18] Moves into poverty cause more than 6 per cent of common mental conditions among the working-age population in the United Kingdom.[19] And the relationship is also strong in low- and middle-income countries.[20]

12. The reasons for this link are obvious enough. People living on low incomes generally contact psychiatric services later than those from higher income households, both because of limited access to such services and because they may be less well informed about whatever services are available and affordable.[21] Yet, the economic insecurity they experience is a permanent source of stress, detrimental to mental well-being: the WHO's Comprehensive Mental Health Action Plan 2013–2030, updated in 2021, identifies households living in poverty among the vulnerable groups most likely to experience mental health problems.[22] Moreover, there is a correlation between education levels and income, and better education generally translates into better physical and mental health.[23]

13. More than *absolute* poverty or material deprivation as such, however, it is *relative* poverty or inequality, as well as economic insecurity, that cause mental conditions.[24] A sample of 43,824 respondents collected by the European Social Survey (ESS) 2006/2007 in 23 European countries found that individuals in countries with greater income inequalities reported more depressive symptoms, although this could be mitigated by coping resources such as social support, self-esteem and optimism.[25] In 2009, depression was found to be the main cause of loss of healthy years of life in Mexico (affecting 6.4 per cent of the population), a phenomenon researchers related to high inequality and to the feelings of despair, fear and impotence that result from economic insecurity.[26] In the Brazilian city of São Paulo, living in

[17] Guiding Principles on Extreme Poverty and Human Rights, para. 81.

[18] J. Sareen, et al., "Relationship Between Household Income and Mental Disorders: Findings From a Population-Based Longitudinal Study", *Arch Gen Psychiatry,* 68(4)(2011), pp. 419–427.

[19] Rachel M. *Thomson, et al., "Effects of poverty on mental health in the UK working-age population: causal analyses of the UK Household Longitudinal Study", International Journal of Epidemiology 52(2022): 512 - 522.*

[20] Lund C, Breen A, Flisher AJ, Kakuma R, Corrigall J, Joska JA, et al., "Poverty and common mental disorders in low and middle income countries: a systematic review", *Soc Sci Med.* 71(3)(2010), pp. 517–28.

[21] V. Murali and F. Oyebode, "Poverty, social inequality and mental health", *Advances in Psychiatric Treatment* 10(3)(2004), pp. 216-224. doi:10.1192/apt.10.3.216.

[22] *Comprehensive Mental Health Action Plan 2013–2020* (WHO, 2021), para. 10.

[23] C.R. Belfield and H.M. Levin, *The Price We Pay: Economic and Social Consequences of Inadequate Education* (Washington, DC: Brookings Institute Press, 2007).

[24] R. Wilkinson and K. Pickett, *The Spirit Level. Why More Equal Societies Almost Always do Better* (London: Penguin Books, 2009); W.S. Ribeiro, et al., "Income inequality and mental illness-related morbidity and resilience: a systematic review and meta-analysis", *The Lancet. Psychiatry*, *4*(7)(2017), pp. 554–562. https://doi.org/10.1016/S2215-0366(17)30159-1; A/HRC/41/34, para. 41.

[25] Ioana van Deurzen, Erik van Ingen, Wim J. H. van Oorschot, "Income Inequality and Depression: The Role of Social Comparisons and Coping Resources", *European Sociological Review*, 31(4)(2015), pp. 477–489, https://doi.org/10.1093/esr/jcv007

[26] S. Berenzon, H. Sentíes and E. Medina-Mora, "Mental health services in Mexico", *Int. Psychiatry*, 6(4)(2009), pp. 93-95.

areas with medium and high-income inequality increases the risk of depression, relative to low-inequality areas.[27] Similarly, a study covering 26 countries during the period 1975-2011 showed a statistically significant correlation between incidence rates for schizophrenia and income inequality, leading researchers to suggest that chronic stress associated with living in highly disparate societies places individuals at risk of schizophrenia because of the impacts of income inequality on social cohesion and on the erosion of social capital.[28] Another cross-country comparison covering 50 countries and 249,217 individuals showed that various forms of psychoses (leading to hallucinations, delusions of thought control, and delusional mood) are correlated with income inequality, controlling for average income per capita.[29]

14. Various explanations have been proposed to link income inequality to mental conditions in general, and to depression in particular. Based on data from the European Quality of Life Survey containing information from 30 countries and over 35,000 individuals, researchers concluded that the chief reason for this link is that social capital (what binds people together) is higher in more equal countries.[30] Indeed, social capital provides a more supportive environment to individuals, thus allowing them to cope better with stress. It allows communities to resort to collective action in order to hold governments accountable and, as a result, to improve the provision of healthcare services. And it may help to reduce risky behaviours, such as addictions.[31] Another reason for inequality being linked to mental conditions is because it may increase status anxiety, the fear of falling behind, and, therefore, levels of stress.[32] A cross-national survey of more than 34,000 individuals carried out in 2007 in 31 European countries showed that status anxiety was highest in the more unequal countries at all points on the income rank curve.[33]

15. In sum, while GDP growth per capita increases life satisfaction in low-income countries, beyond a certain level of average affluence it is income inequality that matters the most. Indeed, the richer the country is on average, the more distribution of income across population groups explains mental health outcomes. It then operates like a "virus", affecting all the population negatively (as it is associated with more mental conditions and drug use), and not only the lowest income groups.[34]

16. The respective roles of extreme deprivation (absolute poverty) and high inequality (relative poverty) in explaining mental ill-health will vary from country to country, not least because how inequalities are perceived and whether they are seen as a failure of the individual or instead as a challenge for society as a whole may be a major explanatory factor.[35] In

[27] A.D. Chiavegatto Filho, et al., "Does income inequality get under the skin? A multilevel analysis of depression, anxiety and mental disorders in Sao Paulo, Brazil", *Journal of epidemiology and community health*, 67(11)(2013), pp. 966–972, https://doi.org/10.1136/jech-2013-202626.

[28] J.K. Burns, et al., "Income inequality and schizophrenia: Increased schizophrenia incidence in countries with high levels of income inequality", *International Journal of Social Psychiatry*, 60(2)(2014), pp. 185-196. doi:10.1177/0020764013481426

[29] S.L. Johnson, E. Wibbels and R. Wilkinson, "Economic inequality is related to cross-national prevalence of psychotic symptoms", *Soc Psychiatry Psychiatr Epidemiol* 50(2015), pp. 1799–1807, https://doi.org/10.1007/s00127-015-1112-4

[30] Richard Layte, "The Association Between Income Inequality and Mental Health: Testing Status Anxiety, Social Capital, and Neo-Materialist Explanations", *European Sociological Rev.*, 28(4)(2012), pp. 498-511, https://doi.org/10.1093/esr/jcr012

[31] I. Kawachi and L. Berkman, "Social cohesion, social capital and health", in Berkman and Kawachi (eds), *Social Epidemiology* (Oxford:Oxford University Press, 2000).

[32] R.G. Wilkinson, "Health, hierarchy, and social anxiety", *Annals New York Academy of Sciences*, 896(1999), pp. 48–63.

[33] Richard Layte and Christopher T. Whelan, "Who Feels Inferior? A Test of the Status Anxiety Hypothesis of Social Inequalities in Health", *European Sociological Review*, Volume 30, Issue 4, August 2014, Pages 525–535, https://doi.org/10.1093/esr/jcu057

[34] L. Bouffard and M. Dubé, "L'inégalité de revenus : un « virus » qui affecte la santé mentale et le bonheur" [Mental income inequality: a "virus" which affects health and happiness], *Santé mentale au Québec*, 38(2)(2013), pp. 215–233. https://doi.org/10.7202/1023997ar

[35] In South Africa, cross-district comparisons did not show a correlation between depression and inequality levels, although this may be because inequality is rather high in all districts (K. Adjaye-Gbewonyo, et al., "Income inequality and depressive symptoms in South Africa: A longitudinal analysis

addition, these two explanations are not mutually exclusive: while inequality increases the risks of mental health conditions across all groups of society, people in poverty may be the most vulnerable, because of their more limited access to healthcare and because they may have fewer supportive networks, as poverty can increase social isolation.

B. Manufacturing insecurity: employment and social protection

17. Changes in the world of employment and in the organisation of social security play a major role in the increase of mental health conditions, particularly affecting people living on low incomes.

18. What these factors have in common is that they are associated with the quest for competitiveness and, in the name of innovation, a form of acceleration of life which results in an insecure environment[36]. Individuals are recruited into a fearful competition against each other, and the most politically disempowered and economically disenfranchised face the heaviest "allostatic loads", i.e., bodily reactions to the stress of having to cope with insecurity.[37]

19. People literally age faster as a result of the stress from this uncertainty, conflict and competition, lack of control and lack of information.[38] These impacts are measurable: during the financial crisis of 2009-2011, young adults in Greece faced significantly higher levels of depression and anxiety than young adults in Sweden, to the point that hair samples showed that the protective response to stress (the production of cortisol) was debilitated among the former group.[39] Stress-hormone levels among children from low-income households in Canada were found to be much higher than average, a sign that parental stress from economic insecurity has biological impacts on children.[40]

1. The new world of work

Economic insecurity

20. Economic shocks have a major impact on the rates of depression and suicide. In India, for temperatures above 20°C, a 1°C rise causes about 70 additional suicides per day, particularly during the agricultural growing season, since such climate shocks lead to a loss of harvests.[41] In Indonesia, reduced agricultural output and income due to extreme rainfall caused increased rates of depression and suicide among farmers, though cash transfers could mitigate such impacts.[42]

21. In more advanced economies, economic insecurity caused by globalization and economic restructuring is a major cause of psychological distress, affecting disproportionately people in poverty or those who are most at risk of falling into poverty: those facing such insecurity seek comfort in the use of drugs or alcool, and they run a higher risk of committing suicide -- they are the "deaths of despair" described by Anne Case and

of the National Income Dynamics Study", *Health & place*, 42(2016), pp. 37–46. https://doi.org/10.1016/j.healthplace.2016.08.013).

[36] D. Stuckler, et al., "The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis", *Lancet* 374(2009): 315–323.

[37] Gabor Maté, *The Myth of Normal* (London: Penguin Books, 2022), p. 276.

[38] E.R. De Kloet, "Corticosteroids, Stress, and Aging", *Annals of the New York Academy of Sciences* 663(1992), pp. 357-371.

[39] Åshild Faresjö, et al., "Higher perceived stress but lower cortisol levels found among young Greek adults living in a stressful social environment in comparison with Swedish young adults", *PLoS One* 8(9)(2013):e73828. doi: 10.1371/

[40] S.J. Lupien, et al., "Child's stress hormone levels correlate with mother's socioeconomic status and depressive state", *Biological psychiatry*, 48(10)(2000), 976–980. https://doi.org/10.1016/s0006-3223(00)00965-3

[41] Tamma Carleton, "Crop-Damaging Temperatures Increase Suicide Rates in India", *Proceedings of the National Academy of Sciences* 114 (33)(2017), pp. 8746–8751.

[42] Cornelius Christian, Lukas Hensel and Christopher Roth, "Income Shocks and Suicides: Causal Evidence From Indonesia," *Rev. Econ. Stat.*, December 2019, 101 (5)(2019), pp. 905–920.

Angus Deaton, who note how working-class white men without a college degree are especially affected.[43] A study on plant closures in Austria in 1999-2001 thus showed that men significantly increased expenditures for antidepressants and related drugs, as well as for hospitalizations due to mental health problems.[44] Similarly, researchers who assessed the impacts of increased global competition on the counties in the United States most exposed (where the risks of closures of industial plants was higher) reported higher rates of suicide and related causes of death, especially white males, from that change[45].

Unemployment and underemployment

22. Mental health conditions are also strongly associated with unemployment. As long as sixty years ago, it was shown that unemployment in Great Britain almost quadrupled the likelihood of substance abuse and drug dependence (even after controlling for other socio-demographic variables), and more than doubled the odds of depression, anxiety and obsessive–compulsive disorder.[46] More recent studies confirm this association,[47] especially since unemployment is often associated with reduced social participation.[48] Indeed, a study covering 3,170 respondents in New Haven (United States) showed that the effects of poverty were substantially reduced when controlling for degree of isolation from friends and family. This suggests that rather than the loss of income alone associated with unemployment, it is the resulting social isolation that explains the relationship between social and physical statuses and major depression.[49]

23. Whether or not unemployment increases the risk of depression significantly depends, however, on the nature of the compensation provided. Whereas the risk does not increase significantly when the unemployed receives unemployment compensation or benefits from other entitlement programs based on social insurance (deriving from prior earnings and work history), the index of depression is much higher among unemployed persons receiving welfare benefits or no benefits.[50] A study on 4,842 participants (18-65 years) from Germany in 2011-2014 showed unemployment to be a risk factor for impaired mental health where the unemployed receive means-tested social benefits, even adjusting for differences in sociodemographic factors, net personal income and risk of social isolation.[51] This may be due to the stigmatizing impacts of social assistance, which is associated with images of laziness, dependency and unwillingness to work, whereas entitlement-based benefits in social

[43] A. Case and A. Deaton, *Deaths of Despair and the Future of Capitalism* (Princeton Univ. Press, 2020).

[44] Kuhn, Andreas, Rafael Lalive, and Josef Zweimüller, "The public health costs of job loss," J. Health Econ., December 2009, 28 (6), 1099–1115.

[45] Justin R. Pierce and Peter K. Schott, "Trade Liberalization and Mortality: Evidence from US Counties." *American Economic Review: Insights*, 2 (1)(2020): 47-64. Specifically, the research assessed the impacts of the granting of Permanent Normal Trade Relations (PNTR) to China in October 2000, a chenge that dfferentially exposed U.S. counties to increased international competition via their industry structure.

[46] Meltzer, H., Gill, B., Hinds, K., & Petticrew, M. (1995). *OPCS Surveys of Psychiatric Morbidity in Great Britain: Report 1: The Prevalence of Psychiatric Morbidity Among Adults Living in Private Households*. HM Stationery Office.

[47] P. Acevedo, A.I. Mora-Urda and P. Montero, "Social inequalities in health: duration of unemployment unevenly effects on the health of men and women", *European Journal of Public Health*, 30(2)(2020), 305–310.

[48] L. Kunze and N. Suppa, "Bowling alone or bowling at all? The effect of unemployment on social participation", *Journal of Economic Behavior & Organization*, 133(2017), pp. 213–235.

[49] M.L. Bruce and R.A. Hoff, "Social and physical health risk factors for first-onset major depressive disorder in a community sample", *Social psychiatry and psychiatric epidemiology*, *29*(4)(1994), pp. 165–171. https://doi.org/10.1007/BF00802013

[50] E. Rodriguez, K. Lasch and J.P. Mead, "The potential role of unemployment benefits in shaping the mental health impact of unemployment", *International journal of health services : planning, administration, evaluation*, *27*(4)(1997), pp. 601–623.

[51] Andrea E. Zuelke, Tobias Luck, Matthias L. Schroeter, A. Veronica Witte, Andreas Hinz, Christoph Engel, Cornelia Enzenbach, Silke Zachariae, Markus Loeffler, Joachim Thiery, Arno Villringer, Steffi G. Riedel-Heller, "The association between unemployment and depression–Results from the population-based LIFE-adult-study", *Journal of Affective Disorders*, 235(2018), pp. 399-406, https://doi.org/10.1016/j.jad.2018.04.073.

insurance programs are considered to be an "earned" right.[52] This should be seen as a warning sign, since recent welfare state reforms in developed countries have included the increased use of welfare-to-work-policies, reduced population coverage of unemployment benefits, stricter entitlement criteria and more obligations for fulfilling unemployment benefits.

24. Underemployment -- being forced to work part-time because of a lack of full-time jobs – also increases the likelihood of psychological distress. A British Household Panel Survey covering more than 8,000 individuals over a period of 18 years showed that transitioning from full-time employment to underemployment leads to an increase in distress levels, only 10 per cent of which could be explained by job earnings and perceptions of job security: the key explanatory factor was instead the individual's feeling that their contribution to society was not sufficiently valued.[53]

Mental health risks at work

25. Employment itself entails a range of psychosocial risks. Such risks are magnified by the post-Fordist organisation of work. High workload and pressures to improve productivity at work, as well as a lack of control over task performance, are associated with increased stress and ill-health.[54] Indeed, some studies suggest that having a poor-quality job (with limited levels of control, high demands and complexity, job insecurity, and unfair pay) leads to even worse mental health outcomes than being unemployed.[55]

26. The 2022 WHO Guidelines on Mental Health at Work identified such risks, which may result from how work is designed (fragmented or meaningless work, and work in which skills are underused increase the risks), workload and time pressures, work schedules, lack of control in the work organisation, poor environmental conditions of work, organizational culture, interpersonal relationships at work (including social or physical isolation, bullying, harassment or microagressions), how roles are defined at work, career development, or a limited ability to combine work and personal life or to have dual careers.

27. While all these psychosocial risks should be considered, work scheduling in particular stood out in the consultations led by the Special Rapporteur in preparation of this report. In an increasingly tertiary economy operating on a 24/7 basis, in which precarious work and the "just-in-time" organisation of the production process become the norm, and in which work schedules are determined by workforce management algorithms to closely align staffing with demand, schedules are increasingly unstable and unpredictable, with variable work hours, short advance notice of weekly schedules, and frequent last-minute changes to shift timings. In 2014, 54 per cent of workers paid by the hour in the United States received less than two weeks' advance notice of their work schedule, and 41 per cent received less than one week's notice.[56]

28. This unpredictability increases household economic insecurity. It also leads to more work-life conflicts[57], to diminished sleep quality and to increased psychological distress. A survey of 27,792 retail and food service workers employed at 80 large companies across the United States in 2016-2017 showed a strong relationship between variable work schedules or rotating schedules and psychological distress. Workers with fewer than three days' notice

[52] Clare Bambra, "Yesterday once more? Unemployment and health in the 21st century". *Journal of epidemiology and community health*, 64(3)(2010), pp. 213–215. https://doi.org/10.1136/jech.2009.090621

[53] V. Mousteri, et al., "Underemployment and psychological distress: Propensity score and fixed effects estimates from two large UK samples". *Social science & medicine*, *244(*112641)(2020). https://doi.org/10.1016/j.socscimed.2019.112641.

[54] Ted Schrecker and Clare Bambra, *How Politics Makes Us Sick. Neoliberal Epidemics* (Springer, 2015), p. 53.

[55] P. Butterworth, et al., "The psychosocial quality of work determines whether employment has benefits for mental health: results from a longitudinal national household panel survey", *Occupational and environmental medicine*, *68*(11)(2011), 806–812. https://doi.org/10.1136/oem.2010.059030

[56] Susan Lambert, Peter Fugiel and Julia Henly, "Precarious Work Schedules among Early-Career Employees in the US: A National Snapshot", Research brief (University of Chicago, 2014).

[57] J.R. Henly and S.J. Lambert, "Unpredictable Work Timing in Retail Jobs: Implications for Employee Work–Life Conflict", *ILR Review*, *67*(3)(2014), pp. 986-1016. https://doi.org/10.1177/0019793914537458

and workers with just three to six days' notice fared significantly worse than those with more than two weeks' advance notice of their schedules, especially where workers have no control over the working schedules. Similarly, the survey respondents who worked a variable schedule expressed reduced life satisfaction compared to those who worked a regular day shift, and those with zero or just a few days of advance notice were significantly less happy than those with at least one weeks' notice. Remarkably, the impacts of variable and unpredictable work schedules on psychological distress, sleep quality and happiness were even more significant than the impacts of low incomes. Although part of the mental health impacts of variable and unpredictable work schedules are attributable to greater household economic insecurity (as weekly and monthly incomes will vary depending on the number of hours worked), the main explanation for these impacts is the difficulties such work scheduling practices have on the worker's ability to combine work and private life -- i.e. to be present for the family, to adequately deal with family or personal problems, or to handle family needs.[58]

29. These various factors -- unemployment and underemployment, and psychosocial risks at work linked to post-Fordist work restructuring -- affect low-income workers the most.[59] As such, they result in a double injustice. Low-waged workers not only face difficulties paying their bills: they also are at a higher risk of mental health conditions.

2. Changing social protection

30. Improving income security is essential for the prevention of mental health conditions. Some studies suggest that, even more than poverty itself, such conditions can result for changed life circumstances, such as an illness or a family separation, against which the individual is not protected.[60] There is also strong evidence that the worries and uncertainty created by economic shocks, leading to increased income volatility, or even the mere anticipation of such shocks, are a major source of depression.[61] This highlights the importance of the right to social security and of rights-based social protection floors in preventing mental health challenges: a study covering 114 million beneficiaries of the Bolsa Familia cash transfer program in Brazil between 2004 and 2012 showed, for instance, the impact of Bolsa Familia in lowering suicide rates.[62]

31. Since the 1990s however, the pressures from globalization, the ageing of societies particularly in affluent countries, the destandardization of employment relations and the emergence of new social risks (primarily attributable to the acceleration of skills depletion in the face of rapid technological change) have led to significant transformations of welfare in even the most advanced economies.[63] We have witnessed a gradual merger between social assistance and unemployment assistance, as the former was made increasingly conditional upon the beneficiary actively seeking work or undergoing training for work, and as the levels and the duration of unemployment benefits were drastically lowered. There has been a "contractualization" of the relationship between job-seekers and public employment agencies, with a view to "responsibilizing" both, and the imposition of a duty to accept "suitable" employment, with a generally broadened definition of what is suitable employment, based on the idea that the job-seeker should be "flexible" and encouraged to adapt to the exigencies of the employment market. This has created insecurity in the provision

[58] D. Schneider and K. Harknett, "Consequences of Routine Work-Schedule Instability for Worker Health and Well-Being", *American Sociological Review*, 84(1)(2019), pp. 82-114. https://doi.org/10.1177/0003122418823184.

[59] Guy Standing, *The Politics of Time. Gaining Control in the Age of Uncertainty* (Pelican Books, 2023), p. 193.

[60] Jishnu Das, et al., "Mental health and poverty in developing countries: Revisiting the relationship", *Social Science & Medicine*, 65(3)(2007), pp. 467-480.

[61] M. Ridley, et al., "Poverty, depression, and anxiety: Causal evidence and mechanisms", *Science*, 370(6522)(2020), https://www.science.org/doi/10.1126/science.aay0214

[62] D.B. Machado, et al., "Relationship between the Bolsa Família national cash transfer programme and suicide incidence in Brazil: A quasi-experimental study", *PLoS Med.* 19(5)(2022): e1004000. https://doi.org/10.1371/journal.pmed.1004000

[63] Anton Hemerijck, *Changing Welfare States* (Oxford: Oxford University Press, 2013).

of social security itself: social protection is combined with monitoring the behaviour of the beneficiary and no longer operates as a fully reliable safety net against destitution.

32. In an earlier report, the Special Rapporteur noted that excessive targeting and the imposition of strict conditionalities could result in higher rates of non-take-up, thus reducing the effectiveness of social protection in poverty reduction.[64] In addition, these transformations create more insecurity, increasing the risk of mental health impacts on beneficiaries. This is illustrated, for example, by the phased introduction in the United Kingdom, between 2013 and 2018, of Universal Credit. The UC brought together six earlier schemes covering housing and living costs for people facing adversity, such as unemployment, disabilities, and low-paid employment, thus rationalizing social support. It also introduced strict conditions backed up by sanctions, ostensibly to provide greater incentives for claimants to enter employment and to ensure that the receipt of benefits "maximises claimants' responsibility and self-sufficiency".[65] Following his visit to the country in November 2018, the former Special Rapporteur expressed his fear that the UC would worsen mental health outcomes for the beneficiaries.[66] This fear appears to now be corroborated by research: a study showed that the introduction of UC, while having no measurable effect in pushing individuals into employment, led to an increase of 6.57 percentage points in psychological distress among unemployed individuals affected by the policy.[67]

C. Nature-deficit disorders

33. A further factor putting people in poverty at higher risk of mental ill-health are the barriers they may face to have frequent contacts with nature.[68]

34. In urban settings, children from low-income background have generally reduced access to green areas. This may be due to the fact that they live in impoverished urban environments, which lack green areas, or where existing parks lack amenities such as restrooms, are less aesthetically pleasing, are unsafe, or do not include wooded areas. It may also be due to financial obstacles: leisure activities conducted in the natural world may be unaffordable for children in low-income households.

35. Yet, the proximity of gardens and public parks and more frequent contact with nature results in improved cognitive functioning of adolescents, including improved attention, memory, cognitive performance, and cognitive development, reducing stress, anxiety, and symptoms of depression.[69] as well as behavior and social problems such as attention deficit and hyperactivity disorder (ADHD).[70] Thus, improving access to green spaces -- one element of creating more equigenic environment -- may benefit children's prosocial behaviors, with particularly important impacts among lower income children.[71]

[64] A/HRC/50/38.

[65] National Audit Office, Rolling out Universal Credit (Department for Work and Pensions, 2018), see https://www.nao.org.uk/wp-content/uploads/2018/06/Rolling-out-Universal-Credit.pdf

[66] A/HRC/41/39/Add.1, para. 47.

[67] Sophie Wickham, et al., "Effects on mental health of a UK welfare reform, Universal Credit: a longitudinal controlled study", *The Lancet Public Health*, 5(3)(2020, e157 - e164.

[68] See A/HRC/41/34, para. 81.

[69] M.C. Kondo, et al., "A greening theory of change: How neighborhood greening impacts adolescent health disparities", *American Journal of Community Psychology 73(3-4)(2024), pp. 541-553,* https://doi.org/10.1002/ajcp.12735

[70] R. Louv, *Last Child in the Woods* (Algonquin, 2005); Katherine Arbuthnott, "Nature exposure and social health: Prosocial behavior, social cohesion, and effect pathways", *Journal of Environmental Psychology* 90(102109)(2023), https://doi.org/10.1016/j.jenvp.2023.102109

[71] P. McCrorie, et al., "Neighborhood natural space and the narrowing of socioeconomic inequality in children's social, emotional, and behavioural wellbeing", *Wellbeing, space and society, 2(2021),* https://doi.org/10.1016/j.wss.2021.100051

IV. How mental health conditions push people into poverty

36. Some of the ways in which mental health conditions may lead to and entrench poverty are obvious enough. Discriminatory attitudes in the workplace, and a failure to provide reasonable accommodation, put people with mental health conditions at a higher risk of unemployment. In the OECD, people with a severe mental health condition are 6-7 times more likely to be unemployed than people with no such condition, and those with a common mental health condition 2-3 times.[72] In Finland, a nationwide cohort study covering more than 2 million individuals for the period 1988-2015 showed that being diagnosed with a mental health condition between the ages of 15 and 25 was a strong predictor of not being employed and not having any secondary or higher education between the ages of 25 and 52, as well as of having lower earnings.[73] Depression among the unemployed is also associated with lower rates of reemployment, especially as such depressive states lead to a loss of social connections.[74]

37. People with mental health conditions are also routinely excluded from the mainstream educational system.[75] They are disproportionately at risk of being homeless or of being incarcerated. In sum, they face a range of human rights violations, despite the protection afforded to them by the Convention on the Rights of Persons with Disabilities.

38. There is also a self-reinforcing loop between mental ill-health, physical ill-health, and unemployability. Depression, for example, predisposes people to myocardial infarction and diabetes, both of which increase the likelihood of depression, making it more difficult for the people affected to find work,[76] while at the same time exposing them to financial distress due to the costs of treatment. And people in poverty are more likely to adopt risky behaviours, including addictions, as a way to cope and seek relief from stressful lives.[77] Such behaviours can, in turn, cause physical health problems which lower work productivity and diminish life expectancy.

39. The stigma associated with a mental health condition makes things worse. A Lancet Commission report involving 50 experts and co-produced with people with lived experience of public health conditions identified four different forms through which stigma operates: self-stigma occurs when people with mental health conditions become aware of the negative stereotypes of others and turn them against themselves; stigma by association directs stigma against family members or carers; public and interpersonal stigma refer to the negative stereotypes and adverse treatment by members of society towards people with mental health conditions; and institutional stigma refers to policies and practices that work to the disadvantage of people with mental health conditions.[78]

40. These various forms of stigma impact all aspects of life. They affect self-esteem and the ability to develop social relationships. They limit access to employment and housing. They discourage individuals from seeking help, because of the fear of being labelled as having a mental health condition.[79] Moreover, negative stereotypes against people with a

[72] Sick on the Job?, p. 39.

[73] C. Hakulinen, et al., "Mental disorders and long-term labour market outcomes: nationwide cohort study of 2 055 720 individuals", *Acta psychiatrica Scandinavica*, 140(4)(2019), pp. 371–381.

[74] N. Wege, P. Angerer and J. Li, "Effects of Lifetime Unemployment Experience and Job Insecurity on Two-Year Risk of Physician-Diagnosed Incident Depression in the German Working Population", *International Journal of Environmental Research and Public Health, 14(2017).*

[75] On the right to quality inclusive education, see article 24(1) of the Convention on the rights of persons with disabilities, and General Comment No. 4(2016) on the right to inclusive education adopted by the Committee on the Rights of Persons with Disabilities (CRPD/C/G/4).

[76] Comprehensive Mental Health Action Plan 2013–2030 (WHO, 2021), para. 12.

[77] V. Murali and F. Oyebode, "Poverty, social inequality and mental health", *Advances in Psychiatric Treatment* 10(3)(2004), pp. 216-224. doi:10.1192/apt.10.3.216

[78] Graham Thornicroft, et al., "The Lancet Commission on ending stigma and discrimination in mental health", *The Lancet*, 400(10361)(2022), pp. 1438-1480.

[79] M.C. Angermeyer and H. Matschinger, "The stigma of mental illness: effects of labelling on public attitudes towards people with mental disorder", *Acta Psychiatr Scandinavia* 108(4)(2003), pp. 304-9; P.W. Corrigan, "How clinical diagnosis might exacerbate the stigma of mental illness", *Soc Work* 52(1)(2007), pp. 31-39.

mental health condition can explain the unwillingness of public policymakers to invest in mental health.

41. People in poverty thus face a triple threat: they are economically disadvantaged; as a result of the financial stress they face, they are disproportionately affected by mental health conditions, with limited access to preventive and curative care; and they also suffer the stigma associated with the condition.

V. Breaking the vicious cycles

42. We have encouraged growth-obsessed societies, pressuring individuals to compete and to improve their performance, thus manufacturing status anxiety and pushing people into depression when they can't meet unrealistic expectations of what it means to live a productive life. We should instead move to designing care-obsessed societies, that provide economic security and help all individuals gain a sense of self-esteem and worthiness. The Special Rapporteur identifies four priority actions in this regard.

A. Investing in mental healthcare

43. Increasing investment in mental healthcare should be a first step. While not a substitute for poverty alleviation, such investment can have major impacts on mental, neurological, and substance misuse conditions, with significantly improved economic outcomes.[80] In other terms, mental healthcare is a major tool for human development. Investing in mental health may seem costly, but the costs of inaction are much higher in lost productivity at work and in anti-depressants.

44. The budget allocations going to mental healthcare remain grossly insufficient. On average, States dedicate only 2.1 per cent of their health expenditures to mental health, and the percentage is even lower in low- and middle-income countries. While globally the median number of mental health workers is 13 per 100,000 population, this figure varies enormously, from below two workers per 100,000 population in low-income countries to over 60 in high-income countries. And whereas there are only 0.11 community-based mental facilities per 100,000 population in low-income countries, there are 5.1 such facilities per 100,000 population in high-income countries.[81] According to the WHO, 76-85 per cent of people with severe mental heath conditions receive no treatment for their condition in low-income and middle-income countries, while this is the case for 35-50 per cent of people in high-income countries. Spending on mental health is not only too low (the global annual average is less than US$ 2 per person and it is less than US$ 0.25 per person in low-income countries), it is also allocated to the wrong things: 67 per cent of the resources go to stand-alone mental hospitals, despite this being widely recognized as an ineffective way to address the problem.[82]

45. While WHO's Comprehensive Mental Health Action Plan 2013–2030 sets a number of targets for countries, these targets will for the most part not be met[83], and the objective of universal health as set out under Target 3.8 of the Sustainable Development Goals (SGDs) remains a distant dream. When the SDGs were adopted, only one in five people in high-income countries and one in 27 in countries in low and lower middle-income countries received at least minimally adequate treatment for major depressive condition.[84] It is against this background that WHO launched a special initiative for mental health in 2019, in order to

[80] C. Lund, et al., "Poverty and mental disorders: breaking the cycle in low-income and middle-income countries", *The Lancet* 378(9801)(2011), pp. 1502–14, https://doi.org/10.1016/S0140-6736(11)60754-X

[81] *Mental Health Atlas 2020* (World Health Organisation, 2021).

[82] *Comprehensive Mental* Health *Action Plan 2013–2030* (WHO, 2021), para. 14. See also A/HRC/41/34, para. 21.

[83] *World mental health report: transforming mental health for all* (Geneva: World Health Organization, 2022).

[84] G. Thornicroft, et al., "Undertreatment of people with major depressive disorder in 21 countries", *British Journal of Psychiatry* 210(2)(2016), pp. 119–24.

close the gap.[85] Yet, despite these pledges and initiatives such as the WHO Mental Health Gap Action Programme (mhGAP), in most low-income countries, more than three out of four people do not have access to the treatment they need.[86]

46. In part, low spending on mental healthcare is a collateral victim of underinvestment in healthcare in general. While the overall spending on healthcare increased in 2021 as a reaction to the Covid-19 pandemic, reaching 10.3 per cent of GDP or US$ 9.8 trillion on health that year, the budget constraints facing low-income countries actually forced them to reduce expenditures on public healthcare services, and the gaps between countries widened further: 11 per cent of the world's population live in countries which spend less than US$ 50 per year per person on healthcare (compared to an average of US$ 4,000 in high-income countries), and low-income countries, which host 8 per cent of the world's population, represent just 0.24 per cent of global health expenditure.[87] Moreover, although the public financing of healthcare through taxation or public healthcare schemes is more cost-effective and equitable[88], 40 per cent of healthcare funding is still based on private insurance schemes, which means that it is less affordable for the poor who are often left uninsured or face catastrophic healthcare expenditures.[89]

47. In addition, while healthcare is underfunded in general, preventive healthcare services fare even worse: in 2021, only 3 per cent of total health expenditure in high-income countries and 13 per cent in low-income countries related to prevention.[90]

48. Against this general pattern of underfunding of healthcare, mental healthcare services are even more neglected: because of the stigma attached to mental health conditions, because people facing mental distress are poorly organized to claim their rights, and because governments fail to recognize the importance of investing in mental health care services.

B. Reducing insecurity

49. Important as it is to invest more in mental health services, whether preventive or curative, this should not be seen as a substitute for addressing the background factors that cause depression and anxiety in the first place: poverty, social isolation, and inequalities leading to status anxiety.

50. The Special Rapporteur therefore reiterates his call for placing the fight against income and wealth inequalities at the heart of the search for a new eco-social contract, which he already identified as essential for a just transition, as well as for a shift to a post-growth development model that prioritizes well-being above GDP.[91] Combating inequalities, but also combating the tendency towards the precarisation of work and the contractualization of social protection (through the introduction of conditionalities and the monitoring of beneficiaries), should be central to combating the global pandemic of depression and anxiety. Eradicating poverty, guaranteeing income security and realizing the right to mental health are complementary and mutually supportive.

1. Preventing psychosocial risks at work

51. A 2012 OECD report acknowledges that, while "[w]orkers across the OECD have been exposed to changes in working conditions as a result of structural adjustments in the past decades…poor quality jobs or a psychologically unhealthy work climate can erode

[85] *The WHO special initiative for mental health (2019-2023): universal health coverage for mental health* (Geneva: World Health Organization, 2019). https://iris.who.int/handle/10665/310981.

[86] https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme (last consulted on 24 June 2024).

[87] Global spending on health. Coping with the pandemic (Geneva: WHO, 2023). https://iris.who.int/bitstream/handle/10665/375855/9789240086746-eng.pdf?sequence=1

[88] . K. Sundaram, "Finance Healthcare, Not Insurance Premia", *IPS News*, 26 June 2024.

[89] WHO, Tracking Universal Health Coverage: 2023 Global monitoring report (2023).

[90] Financing universal social protection and universal health coverage. Background paper in preparation of the FfD4 workstream on financing social protection and health services in developing countries (unpublished, 20 June 2024), p. 9.

[91] A/75/181 (paras. 44-48); A/HRC/56/61 (paras. 32-37).

mental health, and in turn influence the position of individuals in the labour market".[92] Surprisingly, the Recommendation on Integrated Mental Health, Skills and Work Policy, which the OECD Council adopted on 14 December 2015, barely alludes to this structural dimension, simply insisting that Member States "promote and enforce psychosocial risk assessment and risk prevention in the workplace".[93]

52. We should go beyond this attitude of denial. Higher demands on the job, low job control (i.e. limited ability to make decisions about work) and unclear roles can all exacerbate work-related stress and heighten the risk of exhaustion, burnout, anxiety and depression.[94] In previous reports, the Special Rapporteur addressed some of the implications of the post-Fordist reorganisation of work, including how wages are set and working conditions determined.[95] These changes also increase psychosocial risks at work. Under the ILO's Occupational Safety and Health Convention, 1981 (No. 155) and the Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187) – both declared fundamental conventions in 2022 (implying that they should be complied with even by States having not ratified them) – States are expected to address such risks. Yet, by 2019, only 35 per cent of States had a national programme in place to address work-related mental health issues.[96]

53. While the 2022 WHO Guidelines on Mental Health at Work list a number of psychosocial risks to mental health at work, it is perhaps in the area of work schedules that the regulatory gap is clearest. Work scheduling regulations should help to mitigate the mental health impacts of unpredictable working schedules. Such regulations could require advanced notice of work schedules, and in cases where shift timing is changed with less notice, employees could be provided compensation, just as they are compensated for overtime work. On-call shifts should be discouraged, for instance by guaranteeing at least partial pay for workers who are on-call. Minimum rest periods between two shifts could be imposed. "Access to hours" rules could be introduced, ensuring that part-time workers working on call are guaranteed a minimum number of hours of work per week or per month, thus improving their economic security.[97]

2. Providing an unconditional basic income

54. Economic shocks are a major cause of depression and economic insecurity is a major cause of anxiety. In order to reduce both, social protection could be strengthened in order to make it more universal and to remove the conditionalities that exercise a permanent pressure on beneficiaries. The provision to low-income individuals in Oregon in 2008 of a largely free health insurance (worth US$ 550-750 per year) was shown to reduce rates of depression by about a quarter within a few months. This randomized control trial shows that the main contribution of social protection schemes to preventing mental health challenges is in the sense of security they provide, rather than in the increased levels of income they provide.[98] The provision of rights-based and unconditional schemes can thus create a sense of security and entitlement, with significant positive mental health impacts.

55. This is why the Special Rapporteur recommends implementing social protection schemes to the fullest extent possible, without excessive targeting, and without introducing conditionalities that can discourage take-up and create the very insecurity such schemes are meant to protect from. Unconditional basic incomes schemes provide the kind of security that can prevent mental health conditions linked to economic uncertainty. In an unconditional cash transfer experiment conducted in Malawi in 2008-2009, schoolgirls were around 38 percent less likely to suffer psychological distress than the control group, while the same

[92] Sick on the Job?, p. 40.

[93] OECD/LEGAL/0420, https://legalinstruments.oecd.org/en/instruments/334.

[94] WHO and ILO, *Mental health at work: Policy Brief* (2022), p. 4; *The effects of non-standard forms of employment on worker health and safety* (Geneva: ILO, 2016).

[95] A/78/175; and A/HRC/53/33.

[96] *Mental health atlas 2020* (Geneva: World Health Organization, 2021).

[97] D. Schneider and K. Harknett, "Consequences of Routine Work-Schedule Instability for Worker Health and Well-Being", *American Sociological Review*, 84(1)(2019), pp. 82-114. https://doi.org/10.1177/0003122418823184.

[98] Amy Finkelstein, et al., and Oregon Health Study Group, “The Oregon health insurance experiment: Evidence from the first year,” *Q. J. Econ.*, 127(3)(2012), pp. 1057–1106.

figure was 17 percent if the cash transfers offers were made conditional on regular school attendance. Researchers analysing the survey results commented that "when the transfers become an important source of income for the entire family and depend on [the beneficiary schoolgirl's actions], they might turn into too heavy a burden for her to shoulder and become detrimental to her mental health".[99] The MINCOME experiment, a Canadian guaranteed annual income field experiment carried out in the Manitoba province between 1974-1979,showed a reduction of 8.5 percent in the hospitalisation rate of the treatment group receiving a basic income relative to the control group for accidents and injuries and mental health, as well as reduced reliance of the treatment group's members on physicians, especially for mental health. Even a modest guaranteed income, researchers concluded, can lead to significant savings for the healthcare system.[100] In Finland, 2,000 unemployed individuals received an unconditional basic income of 560 Euros per month for two years (2017-2018). The beneficiaries reported higher life satisfaction, better health, less mental distress and depression, and stronger cognitive capabilities regarding memory, ability to learn new things, and ability to concentrate than the control group not receiving a basic income.[101]

56. These conclusions were confirmed by a meta-study covering 27 studies of nine basic income-like interventions providing unconditional payments to individuals or families, many evaluated using randomised controlled trials or robust quasi-experimental methods. The findings showed strong positive effects on mental health outcomes.[102] Thus, unconditional cash transfer schemes can significantly help to deal with the high burden of disease due to common mental health challenges such as depression. These schemes (such as the Child Support Grant in South Africa[103]) therefore fulfil an important preventive function, reducing the costs of healthcare and the need for trained health staff and mental health treatment facilities.

57. Unconditional basic income-like schemes also can help address the cognitive bandwidth restrictions associated with scarcity. Conditionalities associated with cash transfer schemes and excessive targeting based on means-testing result in complex eligibility rules through which benefit recipients must maneuver under the threat of sanctions. Indeed, this is one explanation for high rates of non-take-up in certain social protection schemes, including minimum income schemes essential for people in poverty.[104] In contrast, an unconditional basic income ensures foreseeable income security and a regularity of payment which may minimize the interference with daily concerns of recipients, thus improving their cognitive abilities.[105]

C. Combating stigma and discrimination

58. The stigma associated with mental health conditions worsens the negative impacts of mental health problems on the ability for individuals to escape poverty.[106] In 2012, WHO launched the QualityRights Initiative to improve the quality of care, address stigma and

[99] Sarah Baird, Jacobus de Hoop and Berk Özler, "Income shocks and adolescent mental health", Policy Research Working Paper 5644 (World Bank, 2011), p. 19.

[100] E.L. Forget, "The town with no poverty: the health effects of a Canadian guaranteed annual income field experiment", *Canadian Public Policy*, 37(3)(2011), pp. 283–305.

[101] Miska Simanainen and Annamari Tuulio-Henriksson, "Subjective health, well-being, and cognitive capabilities", in Olli Kangas, Signe Jauhiainen, Miska Simanainen and Minna Ylikanno (eds), *Experimenting with Unconditional Basic Income Lessons from the Finnish BI Experiment 2017-2018* (Edward Elgar, 2021), pp. 71-88.

[102] M. Gibson, et al., 'The public health effects of interventions similar to basic income: a scoping review', *Lancet Public Health*, 5(3)(2020), pp. 165–176.

[103] Julius Ohrnberger, Laura Anselmi, Eleonora Fichera, Matt Sutton, "The effect of cash transfers on mental health: Opening the black box – A study from South Africa", *Social Science & Medicine* 260(2020), https://doi.org/10.1016/j.socscimed.2020.113181

[104] A/HRC/50/38, paras. 17 and 55.

[105] Simanainen et al. (2021), cited above.

[106] N. Ruesch, *The stigma of mental illness : strategies against social exclusion and discrimination* (Elsevier, 2022).

discrimination and promote the human rights of people with mental health conditions.[107] In order to reduce stigma, specific schemes could be designed to help individuals reintegrate into employment. People with a mental health condition could be empowered to be able to choose services that best meet their needs. Anti-discrimination legislation could be better enforced, in particular by improving the information of people about their rights.[108] This is in line with the Convention on the Rights of Persons with Disabilities, and with objective 3 of the WHO Comprehensive Mental Health Action Plan 2013-2030.[109]

59. In order to ensure that measures against stigma and discrimination are well informed and effective, people with lived experience of mental health conditions and people with lived experience of poverty should be involved in designing national action plans on mental health.

D. Designing equigenic urban environments

60. The former Special Rapporteur on the right to health recommended that States take measures to "restore and protect existing green spaces to support community connections with nature, explore the creative use of the environment as a way to build relationships, including with the natural world, and facilitate individual and community healing".[110] The urban landscape can be transformed to improve access to green spaces and parks, with benefits not only to mental health but also to social health, defined as "the ability to form and maintain relationships as well as experiencing a sense of connection, acceptance, and belonging". Prosocial behavior and social connection are encouraged by facilitating contacts with nature.[111]

61. Healthcare initiatives can be taken in order to encourage people, especially children, to spend more time in nature.[112] While health care professionals now recommend more frequent interactions with nature to patients, an even more promising approach is to organize group activities to involve people in activities with nature, in a way that allows them to become active agents rather than mere passive recipients, thus also providing an opportunity for building social relations.[113]

VI. Conclusions and recommendations

62. **WHO's Comprehensive Mental Health Action Plan 2013–2030 outlines a vision for "a world in which mental health is valued, promoted and protected, mental health conditions are prevented and persons affected by these conditions are able to exercise the full range of human rights and to access high quality, culturally-appropriate health care and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination."[114]**

63. **For this vision to be realized, we must move from a biomedical approach to a biopsychosocial approach to mental health challenges: from the psychiatrization of poverty to addressing the structural causes of depression and anxiety. This requires**

[107] https://www.who.int/activities/transforming-services-and-promoting-human-rights-in-mental-health-and-related-areas.

[108] For guidance, WHO and OHCHR, *Mental Health, Human Rights, and Legislation: Guidance and Practice* (2023); and the tools developed under WHO's QualityRights Initiative.

[109] WHO Comprehensive Mental Health Action Plan 2013-2030, p. 27.

[110] A/HRC/44/48, para. 75.

[111] K. Arbuthnott (2023), cited above.

[112] Jules Pretty and Jo Barton, "Nature-Based Interventions and Mind-Body Interventions: Saving Public Health Costs Whilst Increasing Life Satisfaction and Happiness", *International journal of environmental research and public health*, 17(21)(2020), 7769. https://doi.org/10.3390/ijerph17217769

[113] W. Tate, et al., "Nature prescribing or nature programming? Complementary practices to increase time in nature to support mental health". *Ecopsychology* (2024), https://doi.org/10.1089/eco.2023.0064

[114] Comprehensive Mental Health Action Plan 2013–2030, para. 20.

questioning the way the economy treats women and men (as resources to be exploited, and to be made productive as possible), and the priority given to the productive economy to the reproductive economy: instead of GDP increase, the focus should be on improving well-being.

64. **In order to address the social determinants of depression and anxiety, States should put the fight against poverty and inequality at the heart of national strategies to improve mental health, and they should combat the rise of income and wealth inequalities, the informalization and destandardization of work, the contractualization of welfare, and housing segregation in urban areas which leads to depriving children in low-income neighbourhoods from accessing green spaces.**

65. **Breaking the vicious cycles linking poverty to mental ill-health also requires destigmatizing mental health conditions and investing more in preventing and treating such conditions, as noted under various General Assembly and Human Rights Council resolutions.**[115]

66. **The participation of people in poverty, including children**[116]**, is essential in the design, implementation and evaluation of measures that seek to address the social determinants of mental ill-health affecting them. Meaningful participation will ensure that policies are better informed and thus more effective – as building on the experiential knowledge of people in poverty allows to better identify the obstacles beneficiaries face and how to overcome them –. It is also an end in itself. Consistent with the right to participation as a human right as reflected in particular in Article 25 of the International Covenant on Civil and Political Rights and in Article 38 of the Guiding Principles on Extreme Poverty and Human Rights, it is empowering. It allows people in poverty to co-construct policies, thus contributing to rights awareness and to building the confidence, social capital and knowledge of people in poverty.**[117] **It is only through such participation that pathways towards building the human rights economy will be found.**

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[115] See A/RES/77/300, and HRC Res. 32/18, 36/13, and 43/13.

[116] For a promising example, see the project "What Do You Think?" led by Unicef in 2020-2022 to seek the views of 150 children from 6 to 17 years of age on their relationship to mental health interventions.

[117] See A/HRC/23/36; and the Guidelines on the right to participate in public affairs (A/HRC/39/28). In cooperation with the International Movement ATD Fourth World, the Special Rapporteur has developed a methodology to ensure effective participation of people in poverty through the setting up of deliberative processes for the design and evaluation of policies. The IDEEP (Inclusive and Deliberative Elaboration and Evaluation of Policies) tool was presented in Washington, D.C., on 15 February 2024, at a conference hosted by the World Bank and the International Monetary Fund. It could guide, for instance, the development of national action plans on mental health, in order to ensure that the concerns and proposals of people in poverty are fully integrated.