

The Treatment of Mental Illness Is a Human Right

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J Am Acad Psychiatry Law 46:2–4, 2018

The only people with a constitutional right to health care in the United States are those remanded to jail or incarcerated in prison. This constitutional right was affirmed only in the 1970s and is derivative of the rights of due process and against cruel and unusual punishment. Subsequent findings by the U.S. Supreme and appellate courts extended these rights to include treatment of mental illness for incarcerated individuals. The rest of the people in the United States have access to health care as a commodity. It is viewed as something in general that we should work to earn.¹ Exceptions to this, under the context of limited-entitlement programs such as Medicaid and Medicare, are legislated into existence, and, as we have seen, can be legislated out (or defunded). That everyone is not eligible for health care strikes me as fundamentally wrong.

As early as 1946, the World Health Organization described health as one of the fundamental rights of every human being. Their constitution asserts that “governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures” (Ref. 2, p 1). Health care in general and mental health treatment in particular have been affirmed repeatedly by the United Nations declarations of human rights and other international treaties.³ In virtually every developed nation in the world, health care, inclusive

of mental health treatment, is provided as a basic human right. What does it mean that the United States does not recognize mental health care as a human right? How do we psychiatrists view this? What does our nation demonstrate by excluding mental health treatment from our basic human rights?

Early attempts in this country floundered. Dorothea Dix’s proposal for treatment of the “curable and incurable insane” was proposed as federal legislation and indeed passed the House and Senate in 1854. It was vetoed by President Franklin Pierce on the grounds of federalism. A more recent effort was doomed from the start, when President George W. Bush, in 2002, included in his charge to the New Freedom Commission on Mental Health explicit language endorsing federalism and precluding a coherent national approach.⁴

The right to adequate treatment is another perspective to consider. Over the years of the 20th century different cases and legislative actions attempted to define the right to adequate treatment. Talbott⁵ attempted to classify many of these challenges into categories. Among these categories were: who decides the rights of the mentally ill (e.g., families, advocates, doctors, courts, or the individual); where patient rights are defined (locally, by state or federal regulation, or by the courts); and the scope of such rights (access, quality, and specificity of the right). All of these approaches, with the exception of such case law as *Estelle v. Gamble*⁶ and its derivatives (regarding jail and prison inmates) and *O’Connor v. Donaldson*⁷ (regarding involuntary psychiatric hospital patients), do not carry the weight of defining the basis of treatment as deriving from a basic human

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Disclosures of financial or other potential conflicts of interest: None.

right. One interesting argument focuses on a violation of the right to “life, liberty, and the pursuit of happiness.” The assertion is that those with severe mental illnesses experience numerous inequities, including diminished life expectancy, excessive involuntary commitment, and high rates of unemployment and homelessness.⁸ This argument has never been made successfully to the Supreme Court.

It clearly is not a question of money: we do not stint on expenditures. Health care spending in this country is about 18 percent of our entire gross domestic product. We spend just under \$10,000 per person each year in the United States on health care. Despite that, by virtually every test comparing the United States with others in the developed world (quality, access, efficiency, and equity), our population does not live as long nor function as well.⁹ Most notably, equity of access to, and provision of, care is sorely compromised. Equity has been defined as care provision “that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.”¹⁰ The southern United States, for example, experiences some of the highest uninsured rates and worst health outcomes in the United States.¹¹ The Medicaid nonexpansion states are dealing with dramatic challenges and face the potential of worsening coverage and care access in the years ahead. Socioeconomic status is a well-documented driver of poor health care outcomes in our nation.⁸ In the developed and undeveloped nations worldwide, life expectancy of people with severe mental illnesses is decreased 8 to 25 years in comparison with unaffected comparison groups; the same is true in the United States.¹²

Attempts to change meaningfully our health care and mental health care systems have repeatedly been frustrated. The multiple stakeholders in insurance and health care delivery have much to lose with any significant change to the current system. Such a complex and conundrum-filled transformation meets the criteria for being a “wicked problem.”¹³ Such problems are identified as difficult to describe clearly, until a solution has been proposed; as having no precise point at which the problem is apparently solved; and as having no obvious right or wrong solutions. Each attempt to resolve such a problem is unique and effects a seemingly unending set of cascading problems. Although wicked problems are by definition complicated and difficult to address, they can nevertheless be resolved when a clear focus is maintained.

In this case, I suggest that the first step is not a wicked problem. The first step is to accept that health care in general, inclusive of mental health care, is simply and fundamentally a human right. Once that critical starting point is acknowledged, we will find solutions to the implementation challenges.

There are many appropriate debates on the ethics-based limitations that should be applied to psychiatric treatment. The right to autonomy versus the right to treatment and the criteria for involuntary treatment are central concerns.¹⁴ The use and availability of evidence-based treatment also play a large role. The many stakeholders argue extensively about appropriate limitations and protections that should be included. I assert, however, that these arguments are moot when meaningful effective treatment is neither available nor accessible. A recent observation¹⁵ is that many in the field of bioethics distanced themselves from mental illness. The potential role of bioethicists in advocacy for mental health care as a human right may be best framed through “understanding of autonomy as not only free from abusive intrusions but also with rights to treatment and other fundamental necessities for restoring freedom of choice and self-determination” (Ref. 15, p 221). Actively engaging bioethicists in this debate may help both clarify and advance this effort.

In 2013, the World Health Organization’s comprehensive mental health action plan¹⁶ recognized mental health as a global health priority. Although we may vary in our perspectives on the appropriate structure for mental health treatment, those of us who see the consequences of untreated mental illness must continue to advocate for access to care, assure that the care provided is evidence-based, and ensure that it is effectively integrated into general medical care. The principle that people with mental disorders have a universal right to a life with dignity and inclusion must be recognized. In addition to the moral and humanitarian arguments there are the scientific and economic arguments. Appropriate delivery of evidence-based care has repeatedly been demonstrated to reduce disability and suffering, increase health and well-being, and increase productivity. Effective treatment of mental illness reduces the economic impairment of these problems, not only for those individuals affected but for their families and society as a whole. Sadly, the scientific literature on health and human rights with a focus on the United States is quite limited and should be a larger voice in

this debate.¹⁷ It is time for us to assert vigorously that health care, inclusive of mental health treatment, is indeed a human right.

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