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To Work and to Love: How International Human Rights Law Can Be Used to Improve Mental Health in the United States

Rebecca A. Zarett*

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NOTE

TO WORK AND TO LOVE: HOW INTERNATIONAL HUMAN RIGHTS LAW CAN BE USED TO IMPROVE MENTAL HEALTH IN THE UNITED STATES

Rebecca A. Zarett[*]

INTRODUCTION 192
I.MENTAL HEALTH UNDER INTERNATIONAL HUMAN RIGHTS LAW AND STANDARDS 196
A. An Overview of International Human Rights Law.....197
B. The International Right to Mental Health 200
1. The Universal Declaration of Human Rights.....200
2. The International Covenant on Economic, Social and Cultural Rights 202
3. Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care 204
4. Convention on the Rights of Persons With Disabilities 206
5. The World Health Organization.....210
II.EXAMPLES OF MENTAL HEALTH REFORM IN AUSTRALIA, SOUTH AFRICA, AND THE UNITED KINGDOM.....210
A. The Integration of Mental Health Care with Primary Care 211
1. Integration in Australia 212
2. Integration in South Africa 215

* J.D. Candidate, 2017, Fordham University School of Law; B.A., 2011, University of Rochester. I would like to express my gratitude to Professor Michael W. Martin for his invaluable guidance and insight, Olivia Gonzalez for constant encouragement, and the staff on the Fordham International Law Journal. I would also like to thank my family and friends for their tremendous love and support.

B. The Promotion of Human Rights to Treat Mental Illness in Prisons in the United Kingdom.....218
C. Modified Involuntary Treatment in the United Kingdom.....220
III. FEDERAL MENTAL HEALTH POLICY IN THE UNITED STATES 222
A. The Creation of a Federal Mental Health Program (1950s-1960s).....222
B. The Demise of Community Mental Health Centers (1970s-1980s).....225
C. Current State of Federal Mental Health Programs (1990s-Present) 228
1. Mental Health Parity Acts of 1996 and 2008.....228
2. The Mentally Ill Treatment Offender and Crime Reduction Act of 2004 231
3. The Helping Families in Mental Health Crisis Act ("The Murphy Bill") 233
IV. PROPOSALS TO REFORM MENTAL HEALTH CARE IN THE UNITED STATES.....235
A. Integrating Mental Health Care with Primary Care 238
B. Reshaping the Relationship between the Mentally Ill and Law Enforcement 241
C. Supervised Community Treatment.....243
CONCLUSION.....244

INTRODUCTION

Madison Holleran was a smart, attractive, and popular student at the University of Pennsylvania ("Penn"), where she ran on the school's Varsity Track & Field team.[1] Madison was the face of happiness, but secretly she was not.[2] To Madison, Penn—only two

1. *See* Kate Fagan, *Split Image*, ESPN (May 7, 2015), http://espn.go.com/espn/feature/story/_/id/12833146/instagram-account-university-pennsylvania-runner-showed-only-part-story (reporting the story of Madison Holleran); Julie Scelfo, *Suicide on Campus and the Pressure of Perfection*, N.Y. TIMES (July 27, 2015), http://www.nytimes.com/2015/08/02/education/edlife/stress-social-media-and-suicide-on-campus.html (discussing Madison Holleran's suicide).

2. *See supra* note 1.

hours from home—felt like a foreign land.[3] She was a perfectionist, and cared deeply about the perception others had of her.[4] The reality Madison projected on her Instagram account was the "filtered" version of her life.[5] She depicted images that confirmed everyone's expectations: she was having fun and making friends.[6] But secretly, Madison was battling anxiety and depression.[7] In November, she began seeing a therapist.[8] Madison admitted to her therapist she was having suicidal thoughts.[9] Madison's father never considered suicide a real possibility for his daughter.[10] However, shortly after returning to Penn for her spring semester, Madison took a running leap off a nine-story parking garage to her death.[11]

Unlike Madison, Timothy Perry began displaying signs of mental illness at a young age after he was adopted by a Connecticut family because a court found his mother unfit as a parent.[12] At age eleven, Timothy was expelled from school and committed to a mental hospital.[13] Almost a decade later, Timothy was diagnosed with schizophrenia, impulse control disorder, borderline personality disorder, and major depressive disorder.[14] Timothy's illness contributed to his uncontrollable and violent behavior.[15] Arising from various incidents with the hospital staff, charges were pressed against him and he was transferred to a state prison.[16] Less than two weeks after his transfer, Timothy experienced a violent and manic episode,

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3. *Id.*
4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*
8. *Id.*
9. *Id.*
10. *Id.*
11. *Id.*
12. *See* Christina Canales, *Prisons: The New Mental Health System*, 44 CONN. L. REV. 1725, 1729-32 (2012) (summarizing the history and effects of Timothy Perry's mental illness). *See generally* James D. McGaughey, *The Death of Timothy Perry*, *An Investigative Report*, ST. CONN. OFF. PROTECTION & ADVOC. PERSONS WITH DISABILITIES (Aug. 2001), https://www.prisonlegalnews.org/media/publications/ct_office_of_protection_and_advocacy_for_ada_perry_in-custody_death_report_2001.pdf (providing a comprehensive summary of the Perry case).
13. *See supra* note 12.
14. *Id.*
15. *Id.*
16. *Id.*

requiring six prison guards to restrain and sedate him.[17] However, the sedative was misadministered and Timothy died at the age of twenty-one.[18]

Billy—a native of the United Kingdom—never displayed any signs of mental illness or had any trouble with law enforcement.[19] Like Madison, Billy was smart, social, and ambitious.[20] He looked forward to serving in the English military.[21] Almost overnight, Billy began suffering from severe schizophrenia symptoms.[22] One night, as Billy was walking down a crowded London street, he hallucinated that two men were planning to attack his mother, so he stabbed and seriously injured one of them.[23] Billy was refused bail and sent to a maximum-security prison in Belmarsh, England.[24] Initially, Billy did not receive the medical attention he desperately needed.[25] Instead he was left isolated in a filthy cell.[26] Luckily, after numerous calls to the English Ministry of Justice, Billy was appropriately transferred to a psychiatric unit and is now receiving care.[27]

The English Ministry of Justice does not comment on individual cases.[28] However, one reason Billy might have been transferred was because of the United Kingdom's implementation of the "equivalence principle." [29] The equivalence principle—influenced by the International Covenant on Economic, Social and Cultural Rights—is

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17. *Id.*

18. *Id.*

19. Billy's last name is undisclosed. *See* Alistair Sloan & Eric Allison, *We Are Recreating Bedlam*: *The Crisis in Prison Mental Health Services*, GUARDIAN (May 24, 2014), http://www.theguardian.com/society/2014/may/24/we-are-recreating-bedlam-mental-health-prisons-crisis (discussing Billy's experience with mental illness and the prison system in London); Nick Cohen, *Our Prisons Have Mental Health Problems*, GUARDIAN (May 31, 2014), http://www.theguardian.com/commentisfree/2014/may/31/nhs-cuts-mental-health-prisons (commenting on mental illness in prisons in England).

20. *See supra* note 19.

21. *Id.*

22. *Id.*

23. *Id.*

24. *Id. See* Adrian Brown, *Prison Wrong for Mentally Ill Inmates*, BBC NEWS (Feb. 4, 2009), http://news.bbc.co.uk/2/hi/uk_news/7868330.stm (noting problems with inmate mental health).

25. *See* Sloan & Allison*, supra* note 19; Brown, *supra* note 24.

26. *See supra* note 25.

27. *Id.*

28. *Id.*

29. *See infra* Part II (providing an example of mental health reform in the United Kingdom).

the notion that prisoners with mental illness should be provided the same quality of care as they would receive outside prison, and should be transferred to an appropriate psychiatric facility if the prison is not meeting that standard.[30]

Billy's case is an example of how States are working towards improving mental health care. Despite some improvement over time, the World Health Organization ("WHO") estimates that mental illness continues to represent the biggest economic burden of any health issue in the world, accounting for US$2.5 trillion in 2010.[31] Of the 450 million people worldwide who suffer from mental illness, approximately sixty percent do not receive any form of care.[32] Furthermore, mental health problems often translate into physical ones, and evidence shows that mental disorders are linked to chronic diseases, including diabetes, cancer, cardiovascular disease, respiratory disease, and obesity.[33] Untreated mental illness also impairs social, professional, and family relationships, and can result in suicide, mass violence, and increased homelessness and incarceration rates.[34]

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30. *Id.*

31. *See* Michael Friedman, *The Stigma of Mental Illness is Making Us Sicker*: *Why Mental Illness Should be a Public Priority*, PSYCHOL. TODAY (May 13, 2014), https://www.psychologytoday.com/blog/brick-brick/201405/the-stigma-mental-illness-is-making-us-sicker (citing evidence reflecting the global rate of mental illness); Thomas Insel, *Director's Blog*: *The Global Cost of Mental Illness*, NAT'L INST. MENTAL HEALTH (Sept. 28, 2011), http://www.nimh.nih.gov/about/director/2011/the-global-cost-of-mental-illness.shtml (revealing statistics about the global burden of mental illness).

32. *See supra* note 31.

33. *See* MICHELLE FUNK ET AL., WHO, *INTEGRATING MENTAL HEALTH INTO PRIMARY CARE*: *A GLOBAL PERSPECTIVE* 27 (2008), http://www.who.int/mental_health/policy/Integratingmhintoprimarycare2008_lastversion.pdf?ua=1 (explaining how mental health problems manifest into physical ones); *Mental Health Basics*, CDC, http://www.cdc.gov/mentalhealth/basics.htm (last updated Oct. 4, 2013) (linking mental health to chronic illnesses).

34. *See* Memorandum from the Subcommittee on Oversight & Investigations Majority Staff to the Energy & Com. Committee Members 1 (May 15, 2014), http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/letters/MentalHealth/051514MH-Staff-Memo.pdf [hereinafter *Committee's Investigation of Federal Programs Addressing Severe Mental Illness*] (regarding the Committee's investigation of federal programs addressing severe mental illness, referring to Adam Lanza in Newtown, Connecticut; James Holmes in Aurora, Colorado; Jared Loughner in Tucson, Arizona; Aaron Alexis at the Navy Yard in Washington, D.C.; and Ivan Lopez at Ford Hood in Texas); FUNK ET AL., *supra* note 33 (discussing the full impact of mental disorders); Jennifer Brown, *Breakdown*: *Mental Health in Colorado*, DENVER POST (Nov. 21, 2014),

Regardless of these alarmingly high costs, mental illness continues to be neglected by policymakers and legislatures worldwide, particularly in the United States.[35] However, within the past two decades, the global attitude toward mental illness and disabilities in general has shifted, and some countries are beginning to reform their mental health policies.[36] For this reason, this Note evaluates how mental health can be reformed based on international human rights law and norms that protect the rights of the mentally ill.

Specifically, this Note compares how various countries have structured mental health policies based on international human rights law.[37] Part I describes the progression of mental health rights under international human rights law, and the relevant conventions, declarations, resolutions, and principles that define the rights of people with mental illness.[38] Part II summarizes several examples of mental health reform in Australia, South Africa, and the United Kingdom, based on the law and norms identified in Part I.[39] Part III focuses on mental health in the United States and describes the rise and fall of federal mental health law between the 1950s and present day.[40] Lastly, Part IV proposes several solutions to improve mental health legislation in the United States.[41] The proposals in Part IV are a reflection of the underlying international law and principles that triggered reform in Australia, South Africa, and the United Kingdom.[42]

I. MENTAL HEALTH UNDER INTERNATIONAL HUMAN RIGHTS LAW AND STANDARDS

This Part explains the development of the right to mental health under international human rights law. First, this Part provides a

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http://extras.denverpost.com/mentalillness/ (explaining the social costs of untreated mental illness); Fagan, *supra* note 1 (recounting Madison Holleran's suicide); .

35. *See infra* Part III (providing an overview of mental health law in the United States).

36. *See infra* Parts I and II (discussing the progression of mental health law over time).

37. *See generally infra* Parts I-IV.

38. *See infra* Part I (discussing international human rights law regarding the rights of people with mental illnesses).

39. *See infra* Part II (providing examples of mental health reform).

40. *See infra* Part III (summarizing federal mental health law in the United States).

41. *See infra* Part IV (proposing reform in the United States).

42. *Id.*

general description of international human rights law.[43] Next, it examines the specific development of mental health rights within an international context.[44] This includes the consideration of the principal covenants, declarations, and guidelines that help define and clarify the right to mental health.[45] Lastly, this Part discusses the role WHO plays in clarifying what States' obligations towards the mentally ill are.[46]

A. An Overview of International Human Rights Law

International human rights law developed after World War II, with the publication of the United Nations ("UN") Charter.[47] The Universal Declaration of Human Rights ("UDHR") was the first application of international human rights law.[48] Following the inception of the UN Charter and UDHR, various UN organizations, regional human rights systems, and international norms were created.[49] Over time, an international regime of government

43. *See infra* Section I.A (providing an overview of international human rights law).

44. *See infra* Section I.B (describing the right to mental health under international human rights law).

45. *See infra* Sections I.B.1-4 (listing the various human rights treaties, conventions, and principles that protect the right to mental health).

46. *See infra* Section I.B.5 (explaining the role the World Health Organization plays in protecting the rights on the mentally ill).

47. *See* Harold Hongju Koh, *How Is International Human Rights Law Enforced? Addison C. Harris Lecture* (Jan. 21, 1998), *in* 74 IND. L.J. 1397, 1999, at 1408 (describing the foundation of international human rights law). *See generally* Tom J. Farer, *The United Nations and Human Rights: More than a Whimper Less than a Roar*, 9 HUM. RTS. Q. 550 (1987) (providing an overview in the foundation of the United Nations system).

48. *See supra* note 47.

49. The UN Charter was assigned as a binding treaty on June 26, 1945 and came into force on October 24, 1945. *See* Introductory Note to the U.N. Charter, http://www.un.org/en/sections/un-charter/introductory-note/index.html (last visited Jan. 4, 2015) (stating the dates the treaty was signed and ratified). Some examples of UN organizations are the UN Human Rights Commission, the Council of Europe, the Organization of Security and Cooperation, the Inter-American Commission, the Court of Human Rights, and the World Health Organization. *See About WHO*, WHO, http://www.who.int/about/en/ (last visited Jan. 3, 2015) ("Our primary role is to direct and coordinate international health within the United Nations system."); Koh, *supra* note 47 (summarizing leading human rights institutions).

developed.[50] This regime is responsible for promoting, encouraging, and maintaining respect for human rights and dignity.[51]

In 1946, the Commission on Human Rights—chaired by Eleanor Roosevelt—was charged with the task of drafting the "International Bill of Rights."[52] The International Bill of Rights is made up of three distinct sections.[53] First, the UDHR represents the first global expression of fundamental human rights to which everyone is entitled.[54] Second, the International Covenant on Civil and Political Rights ("ICCPR"), and the International Covenant on Economic, Social and Cultural Rights ("ICESCR" or "Covenant"), define specific civil and social rights.[55] For example, some of the rights

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50. *See* Koh, *supra* note 47 (describing the development of international law and the United Nations). *See generally* Farer, *supra* note 47.

51. *See* U.N. Charter art. 1, ¶ 3 (stating that the purposes of the UN are "[t]o achieve international cooperation in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language or religion"); Farer, *supra* note 47, at 553-54 (explaining that the UN Charter announces its fundamental purpose as promoting the full realization of human rights).

52. Eleanor Roosevelt was the First Lady of the United States between March 1933 and April 1945 during her husband President Franklin D. Roosevelt's four terms in office. She is regarded as an American politician, diplomat, and human rights activist. *See* Lawrence O. Gostin & Lance Gable, *The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health*, 63 MD. L. REV. 20, 30 (2004) (establishing that the International Bill of Human Rights forms the foundation for human rights law). *See generally* Farer, *supra* note 47 (stating the first priority of the UN Commission on Human rights was to draft an international bill of rights).

53. *See* Eric Rosenthal & Clarence J. Sundram, *The Role of International Human Rights in National Mental Health Legislation*, DEP'T MENTAL HEALTH & SUBSTANCE DEPENDENCE, WHO 4 (2004), http://www.who.int/mental_health/policy/international_hr_in_national_mhlegislation.pdf ("The two core UN human rights conventions are the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social, and Cultural Rights. Together with the Universal Declaration of Human Rights, they make up what is known as the "International Bill of Rights."); Frank C. Newman, *The United States Bill of Rights, International Bill of Human Rights, and Other "Bills"*, 40 EMORY L.J. 731, 735 (1991) (pointing out that the Bill of International Human Rights consists of five UN instruments: the UN Charter, the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and the Optional Protocol to the Civil and Political Covenant).

54. *See* G.A. Res. 217 (III) A, Universal Declaration of Human Rights, pmbl. (Dec. 10, 1948) [hereinafter UDHR] (stating the UDHR represents a common standard of achievement "for all peoples and all nations"); Newman, *supra* note 53 (reiterating that the UDHR is the first document in the International Bill of Rights); Farer, *supra* note 47, at 555-60 (describing the UDHR as the first step towards the creation of the International Bill of Human Rights).

55. *See* Newman, *supra* note 53 (specifying the International Covenant on Civil and Political Rights and the International Covenant Economic, Social and Cultural Rights as the

guaranteed by the ICCPR include the right to life, freedom of religion, speech, and assembly, electoral rights, and due process rights.[56] Complementing the ICCPR, the ICESCR protects rights such as the right to health, the right to an education, the right to an adequate standard of living, the right to work, and the right to form trade unions.[57] The third section of the International Bill of Rights contains the Optional Protocol to the ICCPR, which establishes formal procedures for individuals to file complaints with the UN Human Rights Committee against States if their civil or political rights have been violated.[58] With this framework in mind, the United Nations works towards defining and clarifying human rights, producing case studies concerning specific rights in particular regions, and providing assistance to the victims of humanitarian devastation.[59]

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second part of the International Bill of Rights); G.A. Res. 2200A (XXI), International Covenant on Economic, Social and Cultural Rights (Dec. 16, 1966) [hereinafter ICESCR] (enumerating various economic, social and cultural rights); Farer, *supra* note 47, at 555-60 (stating that the UN agreed on two international covenants: one addressing civil and political rights, and the other addressing economic, social and cultural rights); G.A. Res. 2200A (XXI), International Covenant on Civil and Political Rights (Dec. 16, 1966) [hereinafter ICCPR] (enumerating various civil and political rights).

56. *See* ICCPR, *supra* note 55 (enumerating various civil and political rights).

57. *See* ICESCR, *supra* note 55 (enumerating various economic, social, and cultural rights).

58. *See generally* G.A. Res. 2200A (XXI) (Dec. 16, 1966) (establishing complaint procedures to enforce the rights in the ICCPR); G.A. Res. 44/128 (Dec. 15, 1989) (updating the procedures to file complaints against states); *Human Rights Bodies - Complaints Procedures*, U.N. OFF. HIGH COMMISSIONER HUM. RTS., http://www.ohchr.org/EN/HRBodies/TBPetitions/Pages/HRTBPetitions.aspx (last visited May 1, 2016) (listing the administrative procedures for individuals to file complaints); Newman, *supra* note 53 (characterizing the Optional Protocol to the ICCPR). The ICESCR has a corresponding Optional Protocol monitored by the UN Committee on Economic, Social and Cultural Rights, but it was not adopted until 2008. *See* G.A. Res. 8/2 (June 18, 2008) (establishing formal complaint procedures under the ICESCR); *Optional Protocol to ICESCR Enters into Force*, HUM. RTS. L. CTR. (May 10, 2013), http://hrlc.org.au/optional-protocol-to-icescr-enters-into-force/ (discussing the optional protocol to the ICESCR).

59. *See* Farer, *supra* note 47, at 562-67 (listing the on-going functions of the UN as standard setting, studying particular human rights in particular places, recommending practices for the full realization of those rights, and providing assistance to victims of human rights delinquencies).

B. The International Right to Mental Health

This Section discusses the progression of the right to mental health under international human rights law.[60] This Section begins with a description of the UDHR and the ICESCR.[61] Next, it describes the interpretive guidelines used to clarify the right to mental health.[62] Third, it explains how the evolution of international law and standards ultimately culminated in the Convention on the Rights of Persons with Disabilities—the preeminent global treaty on disability rights.[63] This Section concludes with a discussion of WHO's role in promoting global mental health.[64]

1. The Universal Declaration of Human Rights

While the International Bill of Rights is the foundation of human rights law, its provisions do not explicitly focus on the rights of persons with mental disabilities.[65] Even though the United Nations adopted the Declaration on the Rights of the Mentally Retarded Person in 1971, many human rights experts qualify it as antiquated.[66] Regardless of the absence of international law, the global treatment of individuals suffering from mental illness has evolved significantly over time.[67] These rights are codified in a series of conventions,

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60. *See infra* Sections I.B.1-5 (describing the progression of the right to mental health under international law).

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

65. *See* Gostin & Gable, *supra* note 52, at 30 (explaining that a patchwork of evolving sources creates the protections for persons with mental disabilities). *See generally* Steven D. Jamar, *The International Human Right to Health*, 22 S.U. L. REV. 1, 19–28 (1994) (setting forth the various international sources that contain a right to health).

66. *See* G.A. Res. 2856 (XXVI), Declaration on the Rights of Mentally Retarded Persons (Dec. 20, 1971); Arlene S. Kanter, *The Globalization of Disability Rights Law*, 30 SYRACUSE J. INT'L L. & COM. 241, 254 (2003) (explaining that the Declaration does not even acknowledge that people with disabilities are capable of living a "normal life"); Rosenthal & Sundram, *supra* note 53, at 19–20 (clarifying that the declaration is dated because most international advocacy organizations oppose the terminology "mentally retarded").

67. *See* Gostin & Gable, *supra* note 52, at 44 (documenting that until recently, international treaty-monitoring bodies have not made significant efforts to enforce mental health rights); Sheila Wildeman, *Protecting Rights and Building Capacities: Challenges to Global Mental Health Policy in Light of the Convention on the Rights of Persons with Disabilities*, 41 J.L. MED. & ETHICS 48, 49 (2013) ("The last decade has seen a remarkable

declarations, and principles, which all serve as a model for States to implement national policy to improve the treatment of the mentally ill.[68]

Described by Eleanor Roosevelt as "the Magna Carta of all humankind," the UDHR is the cornerstone of international human rights law, and the primary standard by which many human rights conditions are evaluated.[69] The UDHR establishes human rights as "a common standard of achievement for all people and all nations."[70] Article 25 of the UDHR recognizes a general right to health.[71] However, the UDHR does not explicitly distinguish between mental and physical health.[72] For these reasons, some scholars argue that the right to mental health is indirectly included within Article 25 of the UDHR.[73] Regardless, the UDHR espouses broad principles that set the stage for subsequent international law and principles which has helped shape contemporary mental health law, such as the ICESCR, the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care ("MI Principles"), and

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intensification of international policy discourse directed at global mental health, after a long period of relative silence.").

68. *See* Gostin & Gable, *supra* note 52, at 30 (explaining that a patchwork of evolving sources creates the protections for persons with mental disabilities). *See generally* Jamar, *supra* note 65, at 19–28 (setting forth the various international sources that contain a right to health).

69. *See* Farer, *supra* note 47, at 557 (quoting Eleanor Roosevelt); Hurst Hannum, *The Status of the Universal Declaration of Human Rights in National and International Law*, 25 GA. J. INT'L & COMP. L. 287, 289 (1996) (noting how UDHR has served directly, and indirectly, as a model for many domestic constitutions, laws, regulations, and policies that protect fundamental human rights).

70. *See* UDHR, *supra* note 54, at pmbl.

71. *See* UDHR, *supra* note 54, art. 25 ¶ 1 ("Everyone has the right to a standard of living adequate for the health and well-being of himself, and his family, including food, clothing, housing and medical care, and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.")

72. *See* UDHR, *supra* note 54.

73. *See* Daniel McLaughlin & Elisabeth Wickeri, *Mental Health and Human Rights in Cambodia*, 35 FORDHAM INT'L L.J. 895, 905 (2012) ("The right to health provides a framework to discuss mental health within the international human rights context, which serves an important normative function."); Gostin & Gable, *supra* note 52, at 33 (commenting that the UDHR does not expressly focus on the rights of persons with mental illness; instead, it adopts broad principles to safeguard and promote these rights).

the Convention on the Rights of Persons with Disabilities ("CRPD").[74]

2. The International Covenant on Economic, Social and Cultural Rights

The International Covenant on Economic, Social and Cultural Rights was adopted on December 16, 1966 and put into force on January 3, 1976.[75] The ICESCR was adopted as a binding treaty emphasizing the protection of specific human rights.[76] Unlike the UDHR, the ICESCR places an affirmative duty on States to enforce the rights enumerated in the Covenant.[77]

Article 12 of the ICESCR recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[78] This places an affirmative obligation on States to create conditions that ensure physical and mental health.[79] For example, under the ICESCR, States are responsible for advancing access to medical care, developing effective and humane treatments for mental illness, and increasing the availability of educational and vocational training programs for persons with mental disabilities.[80]

Pursuant to the ICESCR, the Committee on Economic, Social and Cultural Rights ("CESCR"), and the Special Rapporteur on the Right to Health, were both established to monitor States' compliance

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74. *See* Gostin & Gable, *supra* note 52, at 33 (observing that the adoption of the UDHR set the stage for International Covenants on Human Rights); Hannum, *supra* note 69, at 289 ("Virtually every international instrument concerned with human rights contains at least a preambular reference to the Universal Declaration . . . .").

75. *See* ICESCR, *supra* note 55.

76. *See* Gostin & Gable, *supra* note 52, at 33 (describing the ICESCR as a binding treaty-based regime to promote and protect human rights). *See generally* ICESCR, *supra* note 55.

77. *See* ICESCR, *supra* note 55, art. 2 ¶ 1 ("Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.").

78. *See* ICESCR, *supra* note 55, art. 12 ¶ 1.

79. *See* ICESCR, *supra* note 55, art. 12 ¶ 2(d) ("The creation of conditions which would assure to all medical service and medical attention in the event of sickness.").

80. *See* Gostin & Gable, *supra* note 52, at 35. *See generally* ICESCR, *supra* note 55, art. 12 (placing an affirmative obligation on States to protect the right to mental health).

with the Covenant's requirements.[81] The CESCR adopted core standards that identify the minimum level of rights each State must achieve.[82] Some examples of these requirements include: (1) access to health facilities, (2) access to goods and services on a non-discriminatory basis, (3) the availability of essential drugs, and (4) the adoption and implementation of a national public health strategy.[83]

Other than establishing that States should take steps towards the realization of mental health, the ICESCR is silent regarding specific implementation.[84] However, over time, the rights of people with disabilities have gained substantial attention in the international community.[85] This ultimately led to the adoption of the MI Principles and the ratification of the CRPD.[86] Not only do both instruments reaffirm global recognition of the protection of people with

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81. *See Committee on Economic, Social and Cultural Rights*: *Monitoring the Economic, Social and Cultural Rights*, U.N. OFF. HIGH COMMISSIONER HUM. RTS. (Nov. 13, 2015), http://www.ohchr.org/EN/HRBodies/CESCR/Pages/CESCRIntro.aspx (announcing the CESCR was established to carry out the monitoring functions in Part IV of the Covenant); McLaughlin & Wickeri, *supra* note 73, at n.54 (explaining that CESCR is a body of independent experts that monitor the implementation of the ICESCR by state parties).

82. *See* General Comment No. 3: The Nature of States Parties' Obligations, U.N. Committee on Econ., Soc. & Cultural Rts., ¶ 10, U.N. Doc. E/1991/23 (Dec. 14, 1990) ("[T]he Committee is of the view that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party."); McLaughlin & Wickeri, *supra* note 73, at 907–08.

83. *See* General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12), U.N. Committee on Econ., Soc. & Cultural Rts., ¶ 43(a–f), U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) (confirming that states have an obligation to ensure minimum essential levels of the rights enunciated in the ICESCR); McLaughlin & Wickeri, *supra* note 73, at 907-08 (offering several examples of how a State Party can satisfy the minimum core requirement standard even where resources are scarce).

84. *See generally* ICESCR, *supra* note 55 (briefly describing the right to mental health).

85. *See* Janet E. Lord, David Suozzi, & Allyn L. Taylor, *Lessons from the Experience of U.N. Convention on the Rights of Persons with Disabilities: Addressing the Democratic Deficit in Global Health Governance*, 38 J.L. MED. & ETHICS 564, 564 (2010) (stating the CRPD constitutes a critical landmark in the development of international law on the rights of persons with disabilities); Gerard Quinn, *The United Nations Convention on the Rights of Persons with Disabilities: Toward A New International Politics of Disability*, 15 TEX. J. C.L. & C.R. 33, 41–42 (2009) (describing the CRPD as a "moral compass for change" that reconfigure how people conceptualize disabilities).

86. *See* Thomas D. Grant, *The U.N. Convention on the Rights of Persons with Disabilities (CRPD): Some Observations on U.S. Participation*, 25 IND. INT'L & COMP. L. REV. 171, 172 (2015) (providing an overview of the development of the CRPD); Quinn, *supra* note 85, at 41–42 (discussing the history of the CRPD).

disabilities, but they also provide more specific standards for State to ensure the protection of those rights.[87]

3. Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care

In 1988, the Subcommission on Prevention of Discrimination and Protection of Minorities began developing specific principles to protect the rights of the mentally ill.[88] Governments, specialized agencies, and NGOs supplemented the draft principles with their own individual comments.[89] Shortly thereafter in 1991, the MI Principles were finalized and adopted by the UN General Assembly.[90] The MI Principles are not legally binding, but they do provide agreed-upon standards that mental health systems are expected to protect.[91]

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87. *See* G.A. Res. 61/106, Convention on the Rights of Persons with Disabilities, art. 34 (Jan. 24, 2007) [hereinafter CRPD] (establishing the Committee on the Rights of Persons with Disabilities); *id.* art. 35 (establishing State reporting requirements); *id.* art. 40, (establishing conferences procedures); Grant, *supra* note 86, at 172 ("[T]he CRPD creates substantive obligations for state parties to establish and maintain national legislation protecting the rights of persons with disabilities.").

88. *See* Angelika C. Moncada, *Involuntary Commitment and the Use of Seclusion and Restraint in Uruguay: A Comparison with the United Nations Principles for the Protection of Persons with Mental Illness*, 25 U. MIAMI INTER-AM. L. REV. 589, 592–94 (1994) (describing the twenty year process of drafting the MI Principles). *See generally* Gostin & Gable, *supra* note 52, at 36-37 (asserting that the drafting process began in 1970 and culminated in the adoption of the MI principles); Kanter, *supra* note 66 (summarizing the foundation of global disability law).

89. *See* Moncada, *supra* note 88 (describing the twenty year process of drafting the MI Principles). *See generally* Kanter, *supra* note 66 (summarizing the foundation of global disability law).

90. *See* G.A. Res. 46/119, The Protection of Persons with Mental Illness and the Improvement of Mental Health Care (Dec. 17, 1991) [hereinafter MI Principles]; WHO, NATIONS FOR MENTAL HEALTH FINAL REPORT 6 (2002), http://www.who.int/mental_health/media/en/400.pdf; Moncada, supra note 88, at 589, 592-94.

91. *See* MI Principles, *supra* note 90 (listing various principles regarding the treatment of persons with mental illness); G.A. Res. 48/96, The Standard Rules on the Equalization of Opportunities for Persons With Disabilities (Dec. 20, 1993) [hereinafter Standard Rules]; Rosenthal & Sundram, *supra* note 53, at 22; Gostin & Gable, *supra* note 52, at 40-41. *See generally* Moncada, *supra* note 88, at 592-94 (describing the MI Principles); Kanter, *supra* note 66 (summarizing the foundation of global disability law). Like the MI Principles, the Rules on Equalization of Opportunities for People With Disabilities ("Standard Rules") are an additional tool for policy-making. However, the Standard Rules apply broadly to all disabilities whereas the MI Principles are specific to mental illness.

The MI Principles carry significant practical importance for three reasons.[92] First, they help clarify the obligations regarding the enforcement of the right to mental health.[93] Second, they explain how the right can be applied in practice.[94] Third, they create a uniform standard of fair and decent treatment around the world, which makes monitoring by not-for-profits, NGOs and the international community more effective.[95]

The MI Principles comprise the most direct expression of human rights in the context of mental illness.[96] These principles establish both procedural and substantive standards for protecting people with mental illness, both living in the community and those being treated within psychiatric facilities.[97] For example, substantive principles include Principle 1(4)'s prohibition of discrimination, Principle 3 and Principle 7(1)'s emphasis on the importance of providing treatment

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92. *See* Gostin & Gable, *supra* note 52, at 43 (explaining that the MI principles are not legally binding under international law but have significant functional importance); Moncada, *supra* note 88, at 591-92 (stating that the MI Principles articulate universal guidelines governing the treatment of the mentally ill).

93. *See* Michael L. Perlin, *An Internet-Based Mental Disability Law Program: Implications for Social Change in Nations with Developing Economies*, 30 FORDHAM INT'L L.J. 435, 447 (2007) (explaining the MI Principles are a useful interpretive guide for human rights that apply to people with mental disabilities); *see also* Gostin & Gable, *supra* note 52, at 42-44 (restating that the guidelines provide states with standards to evaluate their own level of compliance with international norms).

94. *See* Moncada, *supra* note 88, at 593 (describing that the MI Principles provide a model for states to adopt domestic policy); Rosenthal & Sundram, *supra* note 53, at 20-22 (listing Mexico, Hungary, Costa Rica and Portugal as countries using the MI Principles to model domestic mental health legislation).

95. *See* Rosenthal & Sundram, *supra* note 53, at 20-22 (acknowledging the MI Principles establish standards for treatment and living conditions in psychiatric institutions); Gostin & Gable, *supra* note 52, at 42-44 (emphasizing that the principles provide inter-governmental organizations with standards by which to judge domestic mental health policies); Moncada, *supra* note 88, at 595 ("[The MI Principles] provide specific guidelines which member nations can follow to create international uniformity in the protection of the mentally ill.").

96. *See* Rosenthal & Sundram, *supra* note 53, at 20 (commenting that MI Principles are recognized as "the most complete standards for protection of the rights of persons with mental disability at the international level"); Moncada, *supra* note 88, at 594 (claiming the MI Principles contain the most detailed and comprehensive statement of international standards for people with mental disabilities); Perlin, *An Internet-Based Mental Disability Law Program: Implications for Social Change in Nations with Developing Economies, supra* note 93, at 447 (classifying the MI Principles as a critical global step in recognizing mental disability rights in the context of mental health).

97. *See generally* MI Principles, *supra* note 90, princ. 24 (enumerating principles to adhere to); Gostin & Gable, *supra* note 52, at 38-39 (qualifying that a mental institution can involuntary admit a patient under particular circumstances).

within the community, Principle 9(2) and Principle 10(1)'s insistence on individualized treatment plans and access to medication, and Principle 13's description of rights within mental facilities.[98] Examples of procedural principles are Principle 11 and Principles 12's consent and notice of treatment, and Principle 16, 17 and 18's conditions for involuntary treatment.[99] These principles were influential in shaping Australia and South Africa's integration programs, discussed further in Part II.[100]

4. Convention on the Rights of Persons With Disabilities

The CRPD is the seminal treaty on disability rights.[101] Ratified in 2008, the CRPD is the most recent human rights treaty intended to protect the rights of persons with disabilities.[102] For people with disabilities, the CRPD recognizes the right to equality in all aspects of

98. *See* MI Principles, *supra* note 90, princ. 1(4) (barring discrimination against the mentally ill); *id.* princ. 3 (naming life in the community as a principle); *id.* princ. 7(1) (emphasizing the role of the community and culture); *id.* princ. 9(2) (discussing individualized treatment plant); *id.* princ. 10(1) (discussing access to medication); *id.* princ. 13 (Dec. 17, 1991) (protecting human rights in mental institutions); Kanter, *supra* note 66, at 257 (noting that the MI Principles provide the basis for reports about treatment of people with disabilities and the conditions to which they are subjected in institutions).

99. *See* MI Principles, *supra* note 90, princ. 11 (discussing consent); *id.* princ. 12 (discussing notice); *id.* princ. 16 (discussing involuntary admission); *id.* princ. 17 (discussing judicial review process); *id.* princ. 18 (discussing procedural safeguards).

100. *See infra* Section II.A (documenting the process of integrating mental health care with primary care).

101. *See* Michael L. Perlin*, "Abandoned Love": The Impact of Wyatt v. Stickney on the Intersection Between International Human Rights and Domestic Mental Disability Law*, 35 L. & PSYCHOL. REV. 121, 138 (2011) (explaining that there is no question the most important international development in this area of policy to date has been the ratification of the United Nations Convention on the Rights of Persons with Disabilities); Lord et. al., *supra* note 85, at 45 (articulating that the CRPD is the first legally-enforceable UN instrument specifically targeted at the rights of persons with disabilities); Jacqueline Laing, *Information Technology and Biometric Databases: Eugenics and Other Threats to Disability Rights*, 3 J. LEGAL TECH. RISK MGMT. 9, 22 (2008) (the CRPD "brings hope of the vulnerable").

102. *See* CRPD, *supra* note 87, art. 1 ("The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity."). *See generally* McLaughlin & Wickeri, *supra* note 73, at 910-12 (explaining the adoption of the CRPD created a specific tool to assess state compliance with the rights of persons with disabilities).

life.[103] Most importantly, the CRPD provides a framework that fully recognizes the rights of people with mental illness.[104]

The CRPD contains familiar civil, political, economic and social rights initially outlined in the ICESCR and MI Principles.[105] Some examples include the right to physical and mental integrity, freedom of expression, the right to an education, the right to vote, the right to work, and the right to inclusion in the community.[106] The CRPD also contains substantive enforcement mechanisms, such as the establishment of a committee to oversee the implementation of international obligations.[107]

Furthermore, the CRPD safeguards several rights specific to the mentally ill.[108] Two of the most prominent—but controversial—features include the use of involuntary hospitalization and the establishment of legal capacity.[109] Article 14(1)(b) protects against the

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103. *See* Perlin, *"Abandoned Love": The Impact of Wyatt v. Stickney on the Intersection Between International Human Rights and Domestic Mental Disability Law*, *supra* note 101, at 138 (commenting that the CRPD sketches the full range of human rights that apply to all human beings with a particular application to people with disabilities). *See generally* CRPD, *supra* note 87, art. 34.

104. *See* Perlin, *"Abandoned Love": The Impact of Wyatt v. Stickney on the Intersection Between International Human Rights and Domestic Mental Disability Law*, *supra* note 101, at 138 (establishing that the CRPD pre-conceptualizes mental health rights as disability rights); Quinn, *supra* note 85, 41-42 (celebrating the CRPD as being revolutionary in its treatment of people with intellectual disabilities).

105. *See* Wildeman, *supra* note 67, at 55 (listing the substantive rights proscribed in Article 10-30). *See generally* CRPD, *supra* note 87, art. 40.

106. *See* CRPD, *supra* note 87, art. 17 ("Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others."); *id.* art. 21; *id.* art. 24 ("States Parties recognize the right of persons with disabilities to education."); *id.* art. 29; *id.* art. 27 ("States Parties recognize the right of persons with disabilities to work . . . ."); *id.* art. 19 ("States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community . . . .").

107. *See* CRPD, *supra* note 87, arts. 34, 36 (establishing the CRPD committee and reporting mechanism); Wildeman, *supra* note 67, at 55 (documenting that the CRPD includes extensive implementation mechanisms); Lord et. al., *supra* note 85, at 570-71 (summarizing the enforcement mechanisms).

108. *See* CRPD, *supra* note 87, arts. 14, 17, 19 (addressing involuntary hospitalization standards); Wildeman, *supra* note 67 (discussing the contestation of Articles 12, 14, 17 and 19 of the CRPD).

109. *See generally* CRPD, *supra* note 87, arts. 14, 17; Wildeman, *supra* note 67 (discussing the contestation of Articles 12, 14, 17 and 19 of the CRPD).

arbitrary and unlawful deprivation of liberty.[110] International law scholars argue that this provision intends to protect against involuntary institutionalization.[111] However, States disagree whether hospitalization without consent is warranted under certain circumstances.[112] In response, some pundits argue that involuntary hospitalization is permissible when someone poses a serious risk of harm to himself or others.[113] Even though this objection was raised during the drafting process, the text of the CRPD is silent as to a solution.[114] Some academics argue that almost any form of involuntary commitment will ultimately conflict with the CRPD and human rights because Article 19 ensures the protection of

110. *See* CRPD, *supra* note 87, art. 14(1)(b) ("[Persons with disabilities a]re not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.").

111. *See generally* Wildeman, *supra* note 67, at 56-58 (explaining the conflict regarding what criteria should be considered when determining if involuntary hospitalization is permitted under the CRPD); Michael L. Perlin & Meredith R. Schriver, *"You Might Have Drugs at Your Command": Reconsidering the Forced Drugging of Incompetent Pre-Trial Detainees from the Perspectives of International Human Rights and Income Inequality*, 8 ALB. GOV'T L. REV. 381, 390 (2015) (discussing if involuntary medication is permitted under the CPRD); Vandana Peterson, *Understanding Disability Under the Convention on the Rights of Persons with Disabilities and Its Impact on International Refugee and Asylum Law*, 42 GA. J. INT'L & COMP. L. 687, 696-97 (2014) (arguing that Article 14 prohibits compulsory treatment).

112. *See* Comments from Representatives of Japan, Thailand, Uganda and Mexico from the Fifth Session of the Ad Hoc Committee (Dec. 17, 2015), http:// www.un.org/esa/socdev/enable/rights/ahc5sum26jan.htm [hereinafter Ad hoc Committee Comments] (explaining the possibility of self-harm, or harm to others, warranting involuntary hospitalization). *See generally* Wildeman, *supra* note 67, at 56-58 (explaining the conflict regarding what criteria should be considered when determining if involuntary hospitalization is permitted under the CRPD).

113. *See supra* notes 108-12 and accompanying text.

114. *See* Wildeman, *supra* note 67, at 54-61 (explaining debates were resolved by textual silence, leaving considerable room for interpretive controversy). *See generally* Tina Minkowitz, *Why Do So Few People Know That CRPD Prohibits Forced Psychiatry?*, MAD IN AM. (Oct. 14, 2012), http://www.madinamerica.com/2012/10/why-do-so-few-people-know-that-crpd-prohibits-forced-psychiatry/ (explaining various textual ambiguities in the CRPD).

independent living and community inclusion.[115] Thus, States can make these determinations at their own discretion.[116]

Additionally, Article 17's protection of physical and mental integrity does not include any specific legal protections or procedures necessary to guarantee that right.[117] Compared to other articles in the CRPD, Article 17 is particularly vague.[118] Furthermore, legal capacity is addressed in Article 12.[119] However, there is substantial disagreement as to the appropriate degree of authority conferred on guardians.[120] The CRPD does not proscribe uniform standards for which state parties can ascertain legal capacity and guardianship.[121] Like involuntary institutionalization, states have wide discretion in determining legal capacity.[122] Despite these criticisms, the CRPD still represents a global paradigm shift towards the treatment of people with disabilities, particularly those suffering from mental illness.[123]

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115. *See* CRPD, *supra* note 87, art. 19 ("States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community . . . ."); Wildeman, *supra* note 67, at 52-53 (explaining the conflict between human rights and involuntary hospitalization).

116. *See* Wildeman, *supra* note 67, at 57-58 (providing Australia as an example); Minkowitz, *supra* note 114; *supra* notes 108-15 and accompanying text.

117. *See* CRPD, *supra* note 87, art. 17 ("Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others."); Wildeman, *supra* note 67, at 57 (elucidating that some commentators believe Article 17 is a missed opportunity to mandate procedural and substantive protection concerning involuntary hospitalization).

118. *See* Wildeman, *supra* note 67, at 57 (stating that Article 17 is noteworthy for its lack of specification compared to other sections of the CRPD); Minkowitz, *supra* note 114.

119. *See* Wildeman, *supra* note 67, at 58-59 (introducing the controversy with Article 12 and legal capacity). *See generally* CRPD, *supra* note 87, art. 12 (discussing equal protection before the law).

120. *See* Wildeman, *supra* note 67, at 58-59 (recounting that some laws provide for plenary guardianship while others contemplate more limited authority); Minkowitz, *supra* note 114.

121. *See* Wildeman, *supra* note 67, at 58 (listing the standards to determine legal capacity as status, age, type of disability, specific decision-making abilities, and reasonableness of decision-making abilities); Ad hoc Committee Comments, *supra* note 112 (debating what the meaning of equal protection before the law).

122. *See* Wildeman, *supra* note 67, at 58 (arguing why the definition of legal capacity is ambiguous in the CRPD); Minkowitz, *supra* note 114.

123. *See generally* Wildeman, *supra* note 67 (discussing the evolution of human rights and persons with disabilities); Grant, *supra* note 86 (discussing global disability law).

5. The World Health Organization

The ICESCR, MI Principles, and CRPD establish the right to mental health and then identify basic legal obligations associated with protecting that right.[124] However, these instruments still lack clarity in the context of mental health.[125] Moreover, there is still no binding convention that specifically addresses the rights of the mentally ill.[126] As a result, WHO—an institution within the United Nations—has become one of the leading advocates of mental health awareness.[127] WHO plays a substantial role in defining the rights of the mentally ill, and guiding States how to incorporate the ICESCR, MI Principles, and CRPD into their domestic policy.[128]

II. EXAMPLES OF MENTAL HEALTH REFORM IN AUSTRALIA, SOUTH AFRICA, AND THE UNITED KINGDOM

There is no single best practice model that can be applied to reform the mental health services in any given country.[129] However,

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124. *See supra* Sections I.B.1-4.

125. *See supra* Part I.

126. *Id*.

127. *See infra* Section II.A.

128. *See Training Opportunities*, WHO, http://www.who.int/mental_health/policy/training/en/ (last visited Jan. 26, 2016) ("The objective of WHO's work related to mental health and distance learning is to develop capacity within countries to reform and/or develop mental health policy, legislation and services, in order to promote mental health, facilitate effective service delivery and better protect the rights of people with mental disorders."); FUNK ET AL., *supra* note 33 (illustrating how mental health can be incorporated into primary care). *See generally* WHO, WHO RESOURCE BOOK ON MENTAL HEALTH, HUMAN RIGHTS AND LEGISLATION 9-11, 13-14 (2005), http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf [hereinafter WHO RESOURCE BOOK 2005] (documenting the various international human rights instruments that influence domestic policy); WHO, HEALTH POLICY AND SERVICE GUIDANCE PACKAGE: MENTAL HEALTH LEGISLATION & HUMAN RIGHTS (2003), http://www.who.int/mental_health/policy/essentialpackage1/en/ [hereinafter WHO GUIDANCE PACKAGE 2003] (providing guidance for state to implement mental health policy); WHO, IMPROVING HEALTH SYSTEMS AND SERVICES FOR MENTAL HEALTH (2009), http://apps.who.int/iris/bitstream/10665/44219/1/9789241598774_eng.pdf [hereinafter WHO REPORT 2009] (discussion how state can improve their mental health policies); Wildeman, *supra* note 67, at 51-52 (describing substantive and procedural protections WHO adopted in the *WHO Resource Book On Mental Health, Human Rights and Legislation*); Rosenthal & Sundram, *supra* note 53, at 26 ("In 1996, WHO adopted 'Mental Health Care Law: Ten Basic Principles' as a further interpretation of the MI Principles.").

129. *See generally* WHO RESOURCE BOOK 2005, *supra* note 128 (discussing varieties of ways mental health can be reformed); WHO Integration Report 2008, *supra* note 33 (providing

States have reformed their mental health laws in an effort to improve access to quality treatment.[130] Part II of this Note addresses how the rights established under the ICESCR, MI Principles, and CRPD are codified in domestic legislation.[131] This Part evaluates reform in three different countries: Australia, South Africa, and the United Kingdom.[132] For example, Australia and South Africa both enacted policies that integrate primary care with mental health care.[133] Additionally, in the United Kingdom, human rights law and principles are used to guide the treatment of mental illness in prisons.[134] The United Kingdom also adopted a modified version of involuntary treatment pursuant to the Mental Health Act of 2007 ("MHA 2007").[135] Each example is discussed in turn.[136]

A. The Integration of Mental Health Care with Primary Care

One solution WHO recommends to States to reform their mental health policies is by integrating mental health care with primary care.[137] In 2008, WHO issued a manual that explains how—and why—integration protects mental health rights.[138] WHO emphasizes that under their model of integration, mental illness is detected earlier, treated more effectively, and ultimately general practitioners, mental health professionals, and the public become more educated about these issues.[139] According to WHO, education is imperative because it helps reduces the stigma associated with psychiatric disorders, thus, encouraging individuals to seek treatment if necessary.[140]

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different examples of successful mental health reform in countries with different demographics).

130. *See infra* Part II.

131. *Id* at Sections (A-C).

132. *Id*.

133. *Id*.

134. *Id*.

135. *Id*.

136. *Id*.

137. *See* WHO Integration Report 2008, *supra* note 33 (discussing the integration of primary care with mental health care); WHO REPORT 2009, *supra* note 128 (decrying that mental health services should be incorporated into primary care).

138. *See* WHO Integration Report 2008, *supra* note 33, at 1; WHO REPORT 2009, *supra* note 128, at 21-23.

139. *See* WHO Integration Report 2008, *supra* note 33, at 17; WHO REPORT 2009, *supra* note 128, at 21.

140. *See* WHO Integration Report 2008, *supra* note 33, at 39. *See generally* WHO REPORT 2009, *supra* note 128.

Integration of mental health care with primary care has the potential to expand access to mental health services, improve rehabilitative services, provide hospital diversion programs, mobile crisis teams, therapeutic supervised services, group homes, and other supportive services.[141] WHO emphasizes that self-care is ultimately one of the most effective ways to treat mental illness, but this requires an environment that fosters mental health promotion and provides effective programs.[142] Self-care improves mental health literacy, helps people to recognize problems or illnesses, and improves their overall knowledge of where, and how, to get treatment if needed.[143] Based on two case studies, WHO documented how successful integration helped increase access to mental health services in regions throughout Australia and South Africa.[144]

1. Integration in Australia

Australia ratified the ICESCR on December 10, 1975, and the CRPD on July 17, 2008.[145] However, it began reforming their mental health system as early as 1992.[146] This case study emphasizes how

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141. *See* WHO Integration Report 2008, *supra* note 33, at 18; WHO REPORT 2009, *supra* note 128, at 21-23.

142. *See* WHO Integration Report 2008, *supra* note 33, at 18-19; WHO REPORT 2009, *supra* note 128, at 21–23.

143. *See supra* note 142.

144. *See infra* Sections II.A.1-2 (discussing WHO case studies in Australia and South Africa). Belize has also made strides in improving access to mental health services. Previously, Belize primarily emphasized psychiatric and institutional care for the severely mentally disabled, with very few resources. However, Belize is improving accessibility of mental health services and shifting towards a communal approach. Starting in the 1990s, the Ministry of Health implemented the Psychiatric Nurse Practitioners. Through this program, outreach mental health services are provided to people in the community at the primary care level. Psychiatric nurses attend to patients at the outpatient clinic at district hospitals in which they are based. They also provide community mental health services through mobile clinics and home visits. As a result, outpatient care has increased while in-patient care has decreased. Furthermore, community-based mental health prevention and promotion programs are now in place. *See Belize: Prioritizing Mental Health Services in the Community,* WHO DEP'T MENTAL HEALTH & SUBSTANCE ABUSE 4 (2013), http://new.paho.org/hq/dmdocuments/2009/Belize-Country-Summary-March-2009.pdf (discussing the success of the Belize mental health program). *See generally* WHO Integration Report 2008, *supra* note 33; WHO REPORT 2009, *supra* note 128.

145. *See generally United Nations Treaty Collection*, U.N., https://treaties.un.org/Pages/Home.aspx?clang=_en (last visited Feb. 2, 2016) [hereinafter UN Treaty Collection] (listing when various countries signed and ratified each treaty).

146. *See* WHO Integration Report 2008, *supra* note 33, at 69-77 (discussing the integration process in Sydney, Australia). *See generally* Shalailah Medhora, *Sweeping*

integration improved access to care and reduced the stigma associated with mental illness for a population of adults over the age of sixty-five living in Sydney, Australia.[147] This policy was influenced and shaped by Article 12 of the ICESCR and the MI Principles.[148] The Australian integration policy embodies Principle 1(1) that all people have the right to the best possible health care, and Principles 3 and 7(1), that every person has a right to treatment within the community.[149]

The goal of the integration program in Sydney was to identify adults over the age of sixty-five with mental health problems as early as possible, and deliver rehabilitative treatment within a primary care setting.[150] The process of integration began with the formation of a strategic plan, drafted by a committee-appointed chief psychiatrist.[151] The committee included representatives from local hospitals and community service leaders.[152] The plan defined mental health services for people over the age of sixty-five, and secondary referral

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Changes to Mental Health Provision Aim to Foster Personalized Care, GUARDIAN (Nov. 25, 2015), http://www.theguardian.com/society/2015/nov/26/sweeping-changes-mental-health-provision-foster-personalised-care (discussing changes in the Australian mental health system).

147. *See infra* notes 148-63 and accompanying text.

148. *See* WHO Integration Report 2008, *supra* note 33, at 70-71 (reiterating the influence of the MI Principles in the formation of the Australian policy). *See generally* ICESCR *supra* note 55, art. 12 (protecting the right to physical and mental health).

149. *See* WHO Integration Report 2008, *supra* note 33, at 70-71(reiterating the influence of the MI Principles in the formation of the Australian policy). *See generally* MI Principles, *supra* note 90, princ. 1(1) ("All persons have the right to the best available mental health care, which shall be part of the health and social care system."); *id.* princ. 3 ("Every person with a mental illness shall have the right to live and work, to the extent possible, in the community."); *id.* princ. 7(1) ("Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.").

150. *See* WHO Integration Report 2008, *supra* note 33, at 69-77 (noting the goal of reform). *See generally* Namratha Rao, *Australia*: *Integrating Mental Health Services at the Primary Care Level*, GLOBAL HEALTH AGING (Apr. 25, 2015), http://globalhealthaging.org/2015/04/25/australia-integrating-mental-health-services-at-the-primary-care-level/ (summarizing the goal of mental health integration).

151. *See* WHO Integration Report 2008, *supra* note 33, at 69-77 (describing the process of integration). *See generally* Rao, *supra* note 150.

152. *See* WHO Integration Report 2008, *supra* note 33, at 69-77 (describing the process of integration). *See generally* NEW MINISTRY OF HEALTH, EFFECTIVE MODELS OF CARE FOR COMORBID MENTAL ILLNESS AND ILLICIT SUBSTANCE ABUSE: EVIDENCE CHECK REVIEW (Aug. 2015), http://www.health.nsw.gov.au/mhdao/publications/Publications/comorbid-mental-care-review.pdf (evaluating various plans to treat physical and mental illness).

services.[153] General practitioners were then contacted and informed they would receive additional training in areas where patients would likely need assistance.[154] This is important because general practitioners are often the first point of contact for people with mental illness, and need to be able to recognize signs and symptoms of psychiatric illness.[155] Payment was on the same basis as if the patient was being treated for any other typical primary condition.[156]

Under this plan, general physicians provided primary care for mental health, whereas community psychogeriatric nurses, psychologists, and geriatric psychiatrists provided additional support as needed.[157] Some specialist services included community-aged care, geriatric medicine, and old age psychiatry.[158] To ensure general practitioners are highly qualified to treat mental illness, they undertake mental health training at both the undergraduate and postgraduate levels.[159]

According to WHO, this model has proven successful in Australia.[160] General practitioners have developed the skills necessary to manage older adults with mental health problems.[161] Consequently, mental health specialists have noted a substantial reduction in "revolving door" patients.[162] WHO explains that this model is not only a good use of scarce resources, but is also best for patients

153. *See supra* notes 146-47 and accompanying text.

154. *Id.*

155. *Id.*

156. *Id.*

157. *Id.*

158. *See* Judith Healy, Evelyn Sharman & Buddhima Lokuge, *Australia*: *Health System Review*, EUR. OBSERVATORY ON HEALTH SYS. & POLICIES 109 (2006), http://www.euro.who.int/__data/assets/pdf_file/0007/96433/E89731.pdf ("The mental health sector has been radically restructured over the last few decades, so that people with mental health problems now mostly are treated in the community rather than in long-stay psychiatric hospitals."); FUNK ET AL., *supra* note 33, at 69-77 (listing services provided).

159. *See* FUNK ET AL., *supra* note 33, at 71 ("Currently, all general practitioners in Australia undertake mental health training at both undergraduate and postgraduate levels, and practitioners are expected to be able to deal with uncomplicated mental health problems in the same way as they deal with physical problems."). *See generally* NEW MINISTRY OF HEALTH, *supra* note 152.

160. *See* Healy et. al., *supra* note 158. *See generally* NEW MINISTRY OF HEALTH, *supra* note 152.

161. *See* FUNK ET AL., *supra* note 33, at 69-77 (emphasizing the success of the integration program). *See generally* NEW MINISTRY OF HEALTH, *supra* note 152.

162. *See supra* notes 151–52.

because they are treated holistically and do not need to spend additional money on specialists.[163]

2. Integration in South Africa

South Africa did not ratify the CRPD until November 30, 2007, and the ICESCR on January 12, 2015.[164] Regardless, the South African government began reforming its mental health services in 1994, when the Apartheid rule came to an end.[165] Within ten years, mental health care was integrated with primary care throughout the region.[166] By the end of 2002, fifty percent of primary care clinics were delivering mental health services, and by 2007, that number rose to eighty-three percent.[167]

The National Department of Health is responsible for developing health policies throughout South Africa.[168] Within this structure, a mental health policy based on primary care principles was adopted in 1997.[169] The integrated package of primary care included reproductive health, management of childhood disorders, immunization, management of communicable diseases, trauma and emergency, oral health, and mental health.[170]

Like the model developed in Sydney, Australia, integration in South Africa embodies several of the MI Principles.[171] For example, Principles 3 and 7(1), which encourage treatment within the community, are respected because under South Africa's system of

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163. *Id.*

164. *See* Daniel McLaren, *Ratification of Human Rights Treaty Reaffirms SA's Commitment to Socio-Economic Rights and Internationalism*, S. AFR. CIV. SOC'Y INFO. (Jan. 30, 2015), http://sacsis.org.za/site/article/2264.

165. *See* WHO REPORT 2009, *supra* note 128, at 23-24 (documenting the beginning of mental health integration in South Africa). *See generally* Inge Peterson et. al., *Integrating Mental Health into Chronic Care in South Africa*: *The Development of a District Mental Healthcare Program,* BRIT. J. PSYCHIATRY (Oct. 7, 2015), http://bjp.rcpsych.org/content/bjprcpsych/early/2015/10/01/bjp.bp.114.153726.full.pdf (evaluating mental health integration in South Africa).

166. *See* WHO REPORT 2009, *supra* note 128, at 24; FUNK ET AL., *supra* note 33, at 145-61 (providing a thorough description of the South Africa case study).

167. *See supra* note 146.

168. *See* FUNK ET AL., *supra* note 33, at 163.

169. *See supra* notes 159-68.

170. *Id.*

171. *See* WHO REPORT 2009, *supra* note 128, at 23-24 (listing the principles embodied in integration). *See generally* MI Principles, *supra* note 90 (advising how to protect people with mental illness).

integration, government officials and medical professionals are working to provide accessible care within five kilometers of the home.[172] Second, South Africa is working to eliminate discrimination against people with mental illness by shifting the traditional attitudes towards people with mental illness, in accordance with Principle 1(4).[173] Lastly, primary mental health care professionals are advised to develop individualized treatment plans that increase access to psychotropic medication, in accordance with Principles 9(2) and 10(1).[174]

Two different models of integration emerged in Mpumalanga, South Africa.[175] Under the first model, a specialized nurse sees all patients with mental health issues.[176] The nurse's primary function is to conduct routine assessments of people with mental disorders, prescribe psychotropic medication, provide basic counseling, and identify social issues for amelioration.[177] Under this model, primary care professionals are trained to identify mental illness, but treatment is predominantly in the hands of the specialized nurses.[178] Under the second model, mental health is treated the same as any other medical

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172. *See supra* notes 159-68 (explaining how care is to be provided within 5 kilometers of the home); MI Principles, *supra* note 90, princ. 3 ("Every person with a mental illness shall have the right to live and work, to the extent possible, in the community."); *id.* princ. 3, 7(1) ("Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.").

173. *See* FUNK ET AL., *supra* note 33, at 145-61 (explaining the importance of undermining the stigma associate with mental illness); MI Principles, *supra* note 90, princ. 1(4) ("There shall be no discrimination on the grounds of mental illness. 'Discrimination' means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights.").

174. *See* FUNK ET AL., *supra* note 33, at 145-61 (explaining the importance of individual treatment); MI Principles, *supra* note 90, princ. 9(2) ("The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff."); *id.* princ. 10(1) ("Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others. Subject to the provisions of paragraph 15 of principle 11 below, mental health practitioners shall only administer medication of known or demonstrated efficacy.").

175. *See* FUNK ET AL., *supra* note 33, at 145-61 (summarizing the two models of integration in Mpumalanga); WHO REPORT 2009, *supra* note 128, at 23-24; (advocating for integration in South Africa); Peterson et. al., *supra* note 165.

176. *See supra* notes 160-74.

177. *Id*.

178. *Id.*

condition.[179] Nurses and physicians are trained to treat mental and physical problems holistically.[180]

In both models, nurses are responsible for detecting mental illness, prescribing medication, counseling, intervention during crisis, and making referrals to additional services if necessary.[181] A district mental health officer (trained as a psychiatric nurse) and a medical officer provide support when needed.[182] Some of their functions include supervising the general health staff, accessing patients referred from primary care, stabilization when necessary, making medication changes, making home visits, tracking local mental health statistics, and writing sub-district reports.[183]

There are advantages and disadvantages to both models.[184] Under the second model, for example, patients are not stigmatized because they are treated in the same manner as all other patients.[185] They are also treated more holistically, instead of separating the treatment of their physical and mental needs.[186] On the other hand, treating mental health problems by primary care doctors can lead to treatment by slightly less experienced professionals, unlike the specialty nurses in model one.[187] Overall, these integrated models have proven to be effective and functional for the past ten years.[188] Both models demonstrate that integration should be understood flexibly, and different clinics can apply different models based on their local needs.[189]

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179. *Id.*
180. *Id.*
181. *Id.*
182. *See supra* note 166.
183. *See supra* notes 160-74.
184. *Id.*
185. *Id.*
186. *Id.*
187. *Id.*
188. *Id.*
189. *Id.*

B. The Promotion of Human Rights to Treat Mental Illness in Prisons in the United Kingdom

The United Kingdom ratified the ICESCR on May 20, 1976, and the CPRD on June 8, 2009.[190] In 2002, the United Kingdom enacted *A Human Rights Approach to Prison Management: Handbook for Prison Staff* ("Handbook").[191] In response to its enormous success, a second edition was published in 2009.[192] The Handbook is intended to assist anyone working within a prison environment.[193] The Handbook incorporates international human rights law, such as the ICCPR and the ICESCR.[194] Additionally, the Handbook also incorporates various aspects of the Standard Minimum Rules for the Treatment of Prisoners (1957), The Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment (1988), The Basic Principles for the Treatment of Prisoners (1990), The Standard Minimum Rules for the Administration of Juvenile Justice (1985), and the UN Conventions Against Torture (1987).[195]

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190. *See* UN Treaty Collection, *supra* note 145 (listing when various countries signed and ratified the ICECSCR).

191. *See* Kim P. Turner, Note, *Raising the Bars: A Comparative Look at Treatment Standards for Mentally Ill Prisoners in the United States, United Kingdom, and Australia*, 16 CARDOZO J. INT'L & COMP. L. 409, 426-31, 444-45 (2008) (addressing the various reforms the UK has passed to improve access to mental health services). *See generally* Andrew Coyle, *A Human Rights Approach To Prison Management: Handbook for Prison Staff*, INT'L CTR. FOR PRISON STUD. (2002), http://www.prisonstudies.org/sites/default/files/resources/downloads/handbook_2nd_ed_eng_8.pdf [hereinafter First Edition Handbook] (the first edition of the handbook); Andrew Coyle, *A Human Rights Approach To Prison Management: Handbook for Prison Staff (Second Edition)*, INT'L CTR. FOR PRISON STUD. (2009), http://www.prisonstudies.org/sites/default/files/resources/downloads/handbook_2nd_ed_eng_8.pdf [hereinafter Second Edition Handbook] (the second, revised edition of the handbook).

192. *See* Second Edition Handbook, *supra* note 191, at 3 ("The first edition of this handbook was published in English in 2002. Since then it has been translated into sixteen other languages. More than 70,000 copies have been printed and several of the versions are available for download from the internet."); Turner, *supra* note 191, at 444-45 (providing the history of the first edition of the manual).

193. *See* First Edition Handbook, *supra* note 191, at 4 ("This handbook is intended to assist everyone who has anything to do with prisons."). *See generally* Louis Appleby et. al., *Prison Mental Health*: *Vision and Reality*, ROYAL C. NURSING (Sept. 2010), http://www.rcpsych.ac.uk/pdf/prison_mental_health_vision_reality.pdf (discussing how the United Kingdom is working towards decreasing the number of mental ill prisoners).

194. *See* Second Edition Handbook, *supra* note 191, at 4 (mentioning the influence of the international law and standards in creating the handbook). *See generally supra* Part I (discussing the ICCPR and ICESCR).

195. *See supra* note 194.

In the context of Article 12's right to physical and mental health, the Handbook instructs that medical treatment provided by the prison must be comparable to what is available in the outside community.[196] More importantly, the Handbook advises that prisoners diagnosed as mentally ill should be transferred to a suitable psychiatric center, rather than being continually detained in prison.[197] Medical experts refer to this concept as the "equivalence principle," which means that prisoners should receive the same quality of care as they would receive outside prison.[198] This is one possible explanation for why the Ministry of Justice transferred Billy to an appropriate psychiatric center to treat his schizophrenia.[199]

Furthermore, in an effort to improve prison structure and management, the United Kingdom has created a partnership between the Bureau of Prison Services and the National Health Service to improve mental health care by integrating the two systems.[200] Therefore, the responsibility of funding health care in prisons is now under the jurisdiction of the Department of Health, rather than the Prison Service.[201] Supporters of this transition laud the program as a major step towards better accommodating the financial needs of the mentally ill in prisons.[202]

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196. *See* First Edition Handbook, *supra* note 191, at 51 ("Whenever possible prisoners should have full access to medical facilities which are available to the public at large."); Turner, *supra* note 191, at 444-45 (highlighting some of the provisions in the handbook).

197. *See* First Edition Handbook, *supra* note 191, at 55 ("Where prisoners are diagnosed as mentally ill they should not be held in prison but should be transferred to a suitably equipped psychiatric facility."); Turner, *supra* note 191, at 444-45.

198. *See* Appleby et. al., *supra* note 193, at 1 (noting that the "equivalence principle" does not mean that health care will be identical to outside services, but will aim to achieve the same quality of treatment). *See generally* First Edition Handbook, *supra* note 191, at 57 (defining equivalence of care).

199. Billy is the individual from the United Kingdom discussed in the introduction who suffered from mental illness and was subsequently transferred from prison to a more appropriate treatment facility. *See supra* notes 19–30 and accompanying text; *see also supra* notes 196-98.

200. *See Health and Justice*, NHS ENG., https://www.england.nhs.uk/commissioning/health-just/ (last visited Jan. 26, 2016) (explaining the commission of health care for prisoners through the NHS); Turner, *supra* note 191, at 427 (elaborating the transfer of funding from the UK Prison Service to the Department of Health).

201. *See supra* note 200.

202. *See Health and Justice*, *supra* note 200 (listing services that include secondary care [hospital care] substance abuse services); Turner, *supra* note 191, at 427 (elaborating on the transfer of funding from the UK Prison Service to the Department of Health).

C. Modified Involuntary Treatment in the United Kingdom

In addition to the treatment of mental illness in prisons, the United Kingdom has taken proactive measures to ensure the protection of people with mental illness in the context of involuntary treatment.[203] For example, the Mental Health Act 2007 ("MHA 2007"), which amended the Mental Health Act of 1983 ("MHA 1983"), establishes various protections for individuals who are subject to involuntary treatment.[204]

Some of the most significant amendments in MHA 2007 include revised criteria for involuntary detention, supervised community treatment ("SCT"), and advocacy.[205] The criteria for involuntary treatment was modified by MHA 2007 pursuant to the Appropriate Treatment Test.[206] The purpose of this test is to ensure that no one is subject to compulsory detention unless they are offered appropriate medical treatment for their mental disorder.[207] The test requires a consideration of the nature and degree of the mental disorder, and all circumstances of the patient's case.[208]

Unlike the MHA 1983, MHA 2007 includes SCT. SCT was enacted to avoid the "revolving door" phenomenon and reduce the

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203. *See generally* Nicola Glover-Thomas, *The Mental Health Act 2007 in England and Wales: The Impact on Perceived Patient Risk Profiles*, 29 MED. & L. 593, 593-94 (2010) (acknowledging the Mental Health Act of 2007); Turner, *supra* note 191, at 427-31 (acknowledging the United Kingdom's efforts to provide prisoners with greater access to mental health services); FUNK ET AL., *supra* note 33, at 173-85 (acknowledging the United Kingdom's plan to provide mental health services to disadvantaged communities).

204. *See* Mental Health Act 2007, Explanatory Notes, ¶ 4 (Eng.), [hereinafter *Mental Health Act 2007 Explanatory Notes*] (stating the overall purpose of the 2007 amendments relate to "deprivation of liberty safeguards"); Glover-Thomas, *supra* note 203 (comparing the MHA 2007 with its predecessor, the Mental Health of 1983).

205. *See Mental Health Act 2007 Explanatory Notes*, *supra* note 204, at 2-3.

206. See *Mental Health Act 2007 Explanatory Notes*, *supra* note 204, at 5-8 (comparing the criteria for detention under the MHA 1983 and MHA 2007); Glover-Thomas, *supra* note 203, at 604-05 (discussing the Appropriate Treatment Test).

207. *See* Glover-Thomas, *supra* note 203, at 604-05 (defining the Appropriate Treatment Test); *Mental Health Act 2007 Explanatory Notes*, *supra* note 204, at 2 ("[I]t will not be possible for patients to be compulsorily detained or their detention continued unless medical treatment which is appropriate to the patient's mental disorder and all other circumstances of the case is available to that patient . . . .").

208. *See* Glover-Thomas, *supra* note 203, at 604-05 (specifying this requires the consideration of the appropriateness of the clinical treatment, and the appropriateness of the circumstances more generally); *see generally Mental Health Act 2007 Explanatory Notes*, *supra* note 204 (reiterating the importance of the consideration of the nature and degree of the patients' illness, and all other relevant circumstances).

overall hospitalization rate in the United Kingdom.[209] Under SCT, patients previously detained in hospitals can live in the community so long as they continue their medical treatment, subject to their individual Community Treatment Order ("CTO").[210] A CTO specifies the conditions SCT patients live under.[211] Some conditions include requiring a patient to stay at a particular address, attending treatment, and taking medications.[212] Lastly, MHA 2007 enacted the Mental Health Advocates.[213] The program aims to ensure all patients are provided advocacy services, subject to certain qualifications.[214] Although MHA 2007 intended to update its outdated predecessor, some medical experts argue that its provisions violate international human rights law.[215] Because the CRPD is silent as to the

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209. The "revolving door" phenomenon is the belief that a psychiatric patient is readmitted to an institution or facility resulting from a previous discharge absent an adequate recovery. *See Reducing the Revolving Door Phenomena*, HEALTH RES. BOARD, http://www.hrb.ie/health-information-in-house-research/mental-health/research/ongoing-research/reducing-the-revolving-door-phenomena/ (last visited Jan. 27, 2016) (discussing the revolving door phenomenon); Marlene Busko, *Revolving Door Phenomenon Seen in Mentally Ill Inmates*, MEDSCAPE (Jan. 16, 2009), http://www.medscape.com/viewarticle/586926 (explaining the revolving door phenomenon in the prison setting); *Mental Health Act 2007 Explanatory Notes*, *supra* note 204, at 3 ("Currently some patients leave the hospital and do not continue with their treatment, their health deteriorates and they require detention again – the so-called 'revolving door'."); Glover-Thomas, *supra* note 203, at 606-07 ("[T]he CTO may offer a means by which individuals are no longer regarded as a social nuisance and along with this, there may be a reduction in the perceived threat or risk they represent.").

210. *See Mental Health Act 2007 Explanatory Notes*, *supra* note 204, at 20 (explaining the purpose of SCT is to allow individual to live in the community while continually seeking treatment subject to certain conditions); *Mental Health Act*, INST. PSYCHIATRY, PSYCHOL. AND NEUROSCIENCE: KINGS COLLEGE LONDON (last updated Feb. 26, 2015), http://www.mentalhealthcare.org.uk/mental_health_act (describing CTOs). *See generally* Glover-Thomas, *supra* note 203, at 606-07 (noting that CTOs are being used at a much higher rate than anticipated).

211. *See Mental Health Act 2007 Explanatory Notes*, *supra* note 204, at 21 (defining "CTO"); *Mental Health Act*, *supra* note 210 (describing CTOs).

212. *See Mental Health Act*, *supra* note 210 (pointing out some of the qualifications for CTOs); *Mental Health Act 2007 Explanatory Notes*, *supra* note 204, at 21 (defining "CTO").

213. *See* Glover-Thomas, *supra* note 203, at 598 (defining Mental Health Advocates); *Mental Health Act 2007 Explanatory Notes*, *supra* note 204, at 3 (introducing the structure of Mental Health Act).

214. *See Mental Health Act 2007 Explanatory Notes*, *supra* note 204, at 3 (describing the necessity of advocacy support)..

215. *See generally* George Szmukler, Rowena Daw & Felicity Collard, *Mental Health Law and the U.N. Convention on the Rights of Persons with Disabilities*, 37 INT. J. LAW PSYCHIATRY 245, 250 (2014) (describing the conflict between MHA 2007 and the CRPD); George Szmukler, *The UN Convention on the Rights of Persons with Disabilities and UK*

permissiveness of involuntary treatment, opponents of MHA 2007 argue that Articles 12 and 14—on legal capacity and involuntary treatment—are being undermined.[216]

III. FEDERAL MENTAL HEALTH POLICY IN THE UNITED STATES

The examples above demonstrate how Australia, South Africa, and the United Kingdom have made progress towards improving the quality of mental health care, based on provisions in the ICESCR, the MI Principles, and the CRPD.[217] Based on these examples, the remainder of this Note focuses on how these examples can be used to treat the mentally ill in the United States.[218] Part III provides a summary of the federal mental health legislation passed in the United States between the 1950s and the present day.

A. The Creation of a Federal Mental Health Program (1950s-1960s)

Congress did not formally address mental health care until the 1950s, when the process of deinstitutionalization began.[219] Prior to reform, most victims of mental illness were primarily treated in state institutions or private homes.[220] Beginning in the late nineteenth

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Mental Health Legislation, 205 BRIT. J. PSYCHIATRY 76 (2014) (arguing why MHA 2007 violates Article 14 of the CRPD).

216. *See* Szmukler et. al., *supra* note 215, at 248 (discussing the relationship between MHA 2007 and the CRPD).

217. *See supra* Part II.

218. *Id.*; *see also infra* Part III.

219. *See* Samantha M. Behbahani, et. al., *The Patient Protection and Affordable Care Act: Will Parity for Mental Health Care Truly Be Achieved in the 21st Century?*, 10 INTERCULTURAL HUM. RTS. L. REV. 153, 155-57 (2015) (explaining that in 1956 the United States began the process of deinstitutionalization by creating community mental health centers); E. FULLER TORREY, AMERICAN PSYCHOSIS: HOW THE FEDERAL GOVERNMENT DESTROYED THE MENTAL ILLNESS TREATMENT SYSTEM 20-32 (2014) [hereinafter TORREY, AMERICAN PSYCHOSIS] (explaining the role activists played in gaining national attention for mental health issues).

220. *See* Joanmarie Ilaria Davoli, *No Room at the Inn: How the Federal Medicaid Program Created Inequities in Psychiatric Hospital Access for the Indigent Mentally Ill*, 29 AM. J.L. & MED. 159, 165 (2003) ("Historically, care for mentally ill individuals was considered a family, locality, or state responsibility."); *see also* Behbahani et. al., *supra* note 219, at 155-57 (describing how prior to 1956, mental health care was exclusively the realm of institutions or private homes); Richard C. Boldt, *Perspectives on Outpatient Commitment*, 49 NEW ENG. L. REV. 39, 42 (2014) (discussing the highly subjective standards used by

century, and lasting for almost five decades, the population of state institutions flourished.[221] However, the Great Depression and World War II had a catastrophic effect on state hospitals, leaving them underfunded, understaffed, and overcrowded.[222] Concerned activists began uncovering the horrors that occurred in these institutions. For example, reporters documented that many naked patients were crowded into filth-infested wards.[223] Patients were often restrained by straightjackets or tied to bedposts for extended periods of time, subjected to electroshock therapy and invasive procedures, malnourished, and beaten.[224] Personal accounts from former patients—documented in Mary Jane Ward's *The Snake Pit*, Sylvia Plath's *The Bell Jar*, and Ken Kesey's *One Flew Over the Cuckoo's Nest*—confirmed many of the horrors that journalists reported.[225] It was in this context that deinstitutionalization began, and mental health was elevated to the federal political agenda.[226]

In December 1961, President John F. Kennedy appointed the Interagency Committee on Mental Health ("ICMH") to investigate the effects of mental illness in the United States, and recommend future

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physicians to make decisions whether persons should be civilly committed during the Civil War).

221. *See* Jonathan Fish, *Overcrowding on the Ship of Fools: Health Care Reform, Psychiatry, and the Uncertain Future of Normality*, 11 HOUS. J. HEALTH L. & POL'Y 181, 197 (2012) (observing the proliferation of state hospitals between the 1800s and 1940s); *see also* Davoli, *supra* note 220, at 165-69 (describing the evolution of the state institution in American history).

222. *See* Fish, *supra* note 221, at 197-98 (claiming institutions were in a state of physical decay); Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375, 376 (1982) (summarizing the appalling and inhumane conditions of a homeless shelter).

223 . *See* Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 68–71 (2011) (describing the role the media and journalism played in deinstitutionalization); *History of Mental Health Treatment*, DUALDIAGNOSIS.ORG, http://www.dualdiagnosis.org/mental-health-and-addiction/history/ (last visited Sept. 26, 2016) (documenting the living conditions in mental institutions).

224. *See* Harcourt, *supra* note 223, at 68 (pointing to inhumane conditions); *History of Mental Health Treatment*, *supra* note 223 (documenting the living conditions in mental institutions).

225. *See* Harcourt, *supra* note 223, at 69; *History of Mental Health Treatment*, *supra* note 223 (documenting the living conditions in mental institutions).

226. *See* Fish, *supra* note 221, at 197–98 (illustrating the political landscape when state hospitals began the process of releasing patients from institutions to the community with outpatient treatment); *see also* Davoli, *supra* note 220, at 167-69 (documenting the history of state institutions in the United States).

services.[227] The ICMH studied (1) whether mental health services should remain the jurisdiction of the state or the federal government, (2) where funding should come from, and (3) the potential establishment of community mental health centers.[228] Ultimately, the ICMH concluded that state hospitals were "bankrupt beyond repair," and advocated for the establishment of federal community mental health centers.[229]

President Kennedy and the ICMH envisioned the community mental health centers as designated places where a myriad of psychiatric services could be provided.[230] The overarching purpose of the community mental health centers was to provide psychiatric services to those in need, maintain family stability, and promote mental health education and prevention.[231] The ICMH was also hopeful that the centers could prevent mental illness through early detection and screening, and treat mental illness by studying the social, cultural and economic factors that contributed to mental illness.[232] On October 31, 1963, the Mental Retardation Facilities and

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227. *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 41-43 (describing the foundation of the Interagency Committee on Mental Health); *National Institute of Mental Health (NIMH): Important Events*, NIH, http://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh (last viewed Sept. 14, 2016) (listing 1961 as the year John F. Kennedy established a cabinet-level interagency committee to prepare recommendations in response to federal mental health issues).

228. *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 44-45 (identifying the role of the Interagency Committee on Mental Health). *See generally* John F. Kennedy, *Special Message to the Congress on Mental Illness and Mental Retardation*, AM. PRESIDENCY PROJECT (Feb. 5, 1963), http://www.presidency.ucsb.edu/ws/?pid=9546 (outlining his commitment to the treatment of mental health).

229. *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 45 (reaffirming the Commission rejected any significant role of state hospitals in the new mental health plan).

230. *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 45-49 (summarizing the intended role of community mental health centers); Mark Platt, Note, *The Due Process of Community Treatment of the Mentally Ill: A Case Study*, 59 TEX. L. REV. 1481, 1489-90 (1981) (emphasizing that federal policy favors community treatment of the mentally ill over institutionalization).

231. *See* Fish, *supra* note 221, at 201 (providing examples of care such as inpatient, outpatient and hospitalization services); Rhoden, *supra* note 222, at 383 (specifying services, such as emergency aid, transitional care and follow-up, and substance abuse treatment).

232. *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 45-49 (summarizing the intended role of community mental health centers); *Community Mental Health Act*, NAT'L COUNCIL BEHAV. HEALTH, http://www.thenationalcouncil.org/about/national-mental-health-association/overview/community-mental-health-act/ (last visited Jan. 1, 2016) (commenting that the development of new medication and approaches to psychiatry made community-based care a feasible solution to the mental health crisis).

Community Mental Health Centers Construction Act was passed ("Community Mental Health Center Act of 1963" or "CMHCA").[233]

Less than one month after President Kennedy signed the CMHCA, he was assassinated.[234] However, President Lyndon B. Johnson quickly assumed responsibility of the program and incorporated it into his legislative agenda.[235] The CMHCA was met with initial success; more than 789 centers were funded for a period of thirteen years.[236] The centers provided inpatient beds, partial hospitalization beds, emergency services, outpatient services, consultation and education services, and community outreach program.[237] Quickly, the community health centers became the future, and state hospitals faded into the past.[238]

B. The Demise of Community Mental Health Centers (1970s-1980s)

The creation of community mental health centers contributed to national deinstitutionalization and altered the delivery of mental health services, but a number of problems followed its creation.[239] As

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233. Mental Retardation Facilities Construction Act of 1963, Pub. L. No. 88-164, 77 Stat. 282; *see* Behbahani et. al., *supra* note 219, at 155 (documenting the alteration of the delivery of psychiatric services under the Community Mental Health Act).

234. *November 22, 1963: Death of the President*, JOHN F. KENNEDY PRESIDENTIAL LIBR. & MUSEUM, http://www.jfklibrary.org/JFK/JFK-in-History/November-22-1963-Death-of-the-President.aspx (last visited Sept. 28, 2016) (documenting the events of November 22, 1963, the date of John F. Kennedy's assassination).

235. *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 61 (noting that President Johnson stated, "We must step up the fight mental health and retardation."); Aubrey Chamberlin, Note, *Stop the Bleeding: A Call for Clarity to Achieve True Mental Health Parity*, 20 WIDENER L. REV. 253, 256-57 (2014) (articulating that under President Johnson's regime, financial resources were directed towards mental illness research).

236. *See* Harcourt, *supra* note 223, at 53-54 (positing that passage of the Community Mental Health Centers Act was followed by the largest deinstitutionalization in US history); *see also* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 61-63 (citing the inaugural success of the Act).

237. *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 61–63 (citing the inaugural success of the Act). *See generally* Kennedy, *supra* note 228 (announcing that the use of new drugs, treatment and public awareness has the potential to redefine the mental health landscape).

238. *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 63 (citing the inaugural success of the Act). *See generally* Kennedy, *supra* note 228 (restating his ambitions regarding the treatment of the mentally ill).

239. *See* Behbahani et. al., *supra* note 219, at 155-58 (explaining the 1963 Act did not ensure that effective mental health services were provided); TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 75–91 (outlining the demise of the community mental health centers).

patients were released from state hospitals, their treatment was transferred into the hands of family members who lacked the resources and training to provide adequate care.[240] While the CMHCA increased mental health awareness, funding was still insufficient.[241] Furthermore, treatment was not advancing at the rate and intensity needed to properly treat mental illness.[242] Consequently, the lack of uniform treatment resulted in an increased number of patients being treated at nursing homes, increased incarceration rates, and increased homelessness.[243]

Unfortunately, the Nixon administration intended to phase-out the federal mental health program because evidence suggested that the program was not successful.[244] Because of forced deinstitutionalization, states began implementing—and experimenting—with their own treatment centers that conflicted with federal ones.[245] One possible explanation for this struggle is that the National Institute of Mental Health ("NIMH") never established an effective relationship with the states, leading to contradictory and superfluous regulation.[246]

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240. *See* Behbahani et. al., *supra* note 219, at 156 (restating that family members inherited the care of psychiatric patients after they were release from institutions); Davoli, *supra* note 220, at 175 (setting-forth that it became increasingly common for state hospitals to discharge patients to nursing homes or similar institutions with inferior care).

241. *See* Behbahani et. al., *supra* note 219, at 156 (affirming that the Act raised awareness, but funding was limited and patients suffered as a result); Fish, *supra* note 221, at 201 (documenting that inadequate funding of community mental health centers).

242. *See* Behbahani et. al., *supra* note 219, at 156; Fish, *supra* note 221, at 201-02 (noting that the national mental health program failed to provide even the minimal level of care of which state hospitals were capable).

243. *See* Behbahani et. al., *supra* note 219, at 156 (confirming a high rate of incarceration occurred among those suffering from psychiatric problems); Davoli, *supra* note 220, at 174-75 (analyzing the current statics which demonstrate that severely mentally ill have high rates of incarceration, homelessness, and shortened life expectancies).

244. *See* Rhoden, *supra* note 222, at 387 ("It is abundantly clear that deinstitutionalization has failed to live up to its initial promise."). *See generally* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 75-77 (asserting that the patients being discharged were not being treated properly by community health centers).

245. *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 50-54 (illustrating various examples of state policies that conflicted with federal ones). *See generally* Rhoden, *supra* note 222, at 392-95 (outlining the failure of community health centers).

246. *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 75-91 (elaborating on the failure of the National Institute of Mental Health to work productively with the states). *See generally* Fish, *supra* note 221, at 203-04 (reiterating the ineffectiveness of community mental health centers).

In extreme cases, some community health centers received federal funding that never materialized into treatment centers.[247] Some states used the federal money to construct private psychiatric centers with swimming pools and gymnasiums.[248] This misappropriation of funds became a widespread and well-known abuse, leading to the divisiveness of the centers.[249]

In 1977, President Jimmy Carter—in an effort to revive the federal mental health program—created the President's Commission on Mental Health ("PCMH"), and charged it with making recommendations on how to best solve the mental health crisis.[250] Developed by President Carter's PCMH, the Mental Health System's Act ("MHSA") was signed and purported to continue Kennedy's legacy by re-establishing community mental health centers with renewed federal financing and additional state involvement.[251] The MHSA encouraged the prevention of mental illness, the continued promotion of mental health, community-level treatment, and advocacy projects that promoted the rights of the mentally ill.[252]

The MHSA also gave new flexibility to community mental health services because it authorized funds for one or more mental health services without requiring a comprehensive package be developed as a prerequisite to financial assistance.[253] This flexibility

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247. *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 79 ("[T]here is a long list of federally funded CMHC's that delivered almost no public psychiatric services and were grossly out of compliance with federal regulation . . . ."). *See generally* E. Fuller Torrey, *Community Mental Health Policy – Tennis Anyone*?, WALL ST. J., March 29, 1990, at A12 [hereinafter Torrey, *Tennis Anyone?*] (explaining the corruption of federal mental health facilities).

248. *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 79-80 (providing several example of states that did not implement federal funds in compliance with the Act). *See generally* Torrey, *Tennis Anyone?, supra* note 247 (explaining the corruption of federal mental health facilities).

249. *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 79-80 (describing the demise of the CMHC's). *See generally* Torrey, *Tennis Anyone?, supra* note 247 (explaining the corruption of federal mental health facilities); Rhoden, *supra* note 222, at 376-77 (discussing the bureaucratic pressure that contributed to the failure of deinstitutionalization).

250. *See* Jimmy Carter, *Mental Health Systems Legislation Message to Congress Transmitting the Proposed Legislation*, AM. PRESIDENCY PROJECT (May 15, 1979), http://www.presidency.ucsb.edu/ws/?pid=32339 (documenting President Carter's message to Congress about the Mental Health Systems Act); Chamberlin, *supra* note 235, at 257 (explaining President Carter's role in the mental health crisis).

251. *See supra* note 250.

252. *Id.*

253. *Id.*

allows communities to structure programs that are unique to the locality.[254] Despite this progress—one year after the legislation was passed—President Ronald Reagan signed the Omnibus Budget Reconciliation Act of 1981, repealing the Mental Health Systems Act and marking the death of the federal mental health program.[255]

C. Current State of Federal Mental Health Programs (1990s-Present)

Since MHSA was repealed, several presidential administrations have attempted to resuscitate federal mental health programs.[256] Various Presidents have attempted to reform mental health care by (1) implementing changes to employer's insurance policies in the Mental Health Parity Acts of 1996 and 2008, (2) reconsidering the treatment of mental illness in the prison system in the Mentally Ill Offender Treatment Act, and (3) revisiting the concept of involuntary treatment in the Murphy Bill.[257] The remainder of this Part discusses each piece of legislation in turn.[258]

1. Mental Health Parity Acts of 1996 and 2008

The Mental Health Parity Act of 1996 ("MPHA") attempted to create an equal opportunity for people with mental illness to acquire greater access to insurance coverage through their employers.[259]

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254. *Id.*

255. *See* Omnibus Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357; Chamberlin, *supra* note 235, at 257 (noting that the Reagan and George H.W. Bush administration's blocked federal grants to states); TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 87-91 (concluding that the federal mental health program ended under the Reagan administration);.

256. *See infra* Sections III.C.1- 3.

257. The Patient Protection and Affordable Care Act also includes the treatment of mental illness. However, this section addresses the federal legislation that explicitly addresses mental illness. *See infra* Sections III.C.1-3. *See generally* Behbahani et. al., *supra* note 219 (describing the mental health services provided in Patient Protection and Affordable Care Act); Chamberlin, *supra* note 235 (summarizing the Affordable Care Act)..

258. *See infra* Sections III.C.1-3.

259. The federal government regulates employer-provided insurance plans under the Employment Retirement Income Security Act ("ERISA"). Although ERISA contains a non-discrimination principle, advocates called for parity legislation, which eliminated the gap between mental health care benefits and physical ones. *See* 29 U.S.C. § 1140 ("It shall be unlawful for any person to . . . discriminate against a participant or beneficiary . . . for the purpose of interfering with the attainment of any right to which such participant may become entitled under [an employee benefit] plan."); Christopher Aaron Jones, *Legislative*

MHPA required that annual or lifetime dollar limits on mental health benefits be no lower than the dollar limits for medical or surgical benefits offered by a group health plan. Prior to MHPA, insurers were not required to cover treatment for mental health care.[260] For this reason, the legislation was rooted in the concept that access to mental care should be equal to access to physical care.[261]

However, many of these goals were not realized.[262] First, insurers could limit the scope of mental health care benefits under MHPA by imposing maximum number of provider visits, and caps on the number of days an insurer would cover inpatient hospitalization.[263] Second, employers retained discretion regarding the scope of mental health services an insurance plan provided, such as cost-sharing, limits on the number of days of coverage, and requirements related to medical necessity.[264] Third, small employers—any business with two to fifty employees—were exempted under the MHPA. Fourth, in response to MHPA, many insurers imposed high co-pays, deductibles, and out-of-pocket maximums.[265] Lastly, substance abuse treatment was omitted from the legislation entirely, leaving many patients without services.[266]

Some of the deficits in the Mental Health Parity Act of 1996 were re-addressed in the Mental Health Parity and Addiction Equity

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"Subterfuge"?: Failing to Insure Persons with Mental Illness Under the Mental Health Parity Act and the Americans with Disabilities Act, 50 VAND. L. REV. 753, 765-67 (1997) (introducing the legal context of the Mental Health Parity Act of 1996).

260. *See* Michael J. Carroll, *The Mental Health Parity Act of 1996*: *Let It Sunset If Real Changes Are Not Made*, 52 DRAKE L. REV. 553, 553-54 (2004) (providing a detailed summary of MHPA); Jones, *supra* note 259, at 765–67 (introducing the legal context of the Mental Health Parity Act of 1996).

261. *See* Behbahani et. al., *supra* note 219, at 156-60 (analyzing the overall purpose of the 2008 Act). *See generally* Sara Nadim, Note, *The 2008 Mental Health Parity and Addiction Equity Act: An Overview of the New Legislation and Why an Amendment Should Be Passed to Specifically Define Mental Illness and Substance Use Disorders*, 16 CONN. INS. L.J. 297 (2009) (reviewing the foundation of the MHPA of 2008).

262. *See* Nadim, *supra* note 261, at 300-04 (documenting the ineffectiveness of the initial MHPA). *See generally* Carroll, *supra* note 260.

263. *See generally* Carroll, *supra* note 260 (listing various defects in MHPA); Nadim, *supra* note 261.

264. *See supra* note 263.

265. *Id.*

266. *See* Nadim, *supra* note 261, at 300-04 (reinforcing why it was illogical that substance abuse was omitted). *See generally* Mental Health Parity Act of 1996, Pub. L. 104-204, § 712(a), 110 Stat. 2874 (omitting substance abuse treatment).

Act of 2008 ("MHPAEA").[267] The MHPAEA resulted in a number of changes.[268] The companies that offered mental health treatment were now required to offer this option in an equal rate to physical care.[269] In other words, health insurers had to guarantee that financial requirements on benefits, such as co-pays, deductibles, out-of-pocket maximums, and treatment caps on mental health or substance abuse services are not more restrictive than the requirements for medical and surgical benefits.[270]

However, like its predecessor, MHPEAE only applies to employers with fifty or more employees.[271] Furthermore, MHPEAE does not require that insurance companies or employers provide mental health and substance abuse services.[272] Instead, it offers equality of services between mental and physical benefits if an employer chooses to offer mental health services.[273] MHPEAE also mandates that insurers provide specific medical criteria defining mental health and substance abuse services.[274] If reimbursement for treatment is withheld, MHPAEA requires that insurers provide specific information regarding their decision to deny benefits.[275]

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267. *See* Chamberlin, *supra* note 235, at 259 (articulating that the 2008 Act eliminated some of the problems in the initial 1996 Act because it minimized disparities between co-pays and deductibles for physical and mental illnesses). *See generally* Nadim, *supra* note 261 (comparing the 1996 Act with the 2008 Act).

268. *See supra* note 267.

269. *See* Behbahani et. al., *supra* note 219, at 160 (noting the accomplishment of the new legislation). *See generally* Nadim, *supra* note 261 (describing the various improvements in the 2008 Act).

270. *See Fact Sheet: The Mental Health Parity Act and Addiction Equity Act of 2008*, US DEP'T LAB. (Jan. 29, 2010), https://www.dol.gov/ebsa/newsroom/fsmhpaea.html [hereinafter MHPAEA Fact Sheet] (summarizing MHPAEA); Behbahani et. al., *supra* note 219, at 156-60 (weighing the advantages and disadvantages of MHPAEA).

271. *See supra* note 270.

272. *Id*.

273. *Id.*

274. *Id.*

275. *See* Chamberlin, *supra* note 235, at 259 (asserting that the 2008 Act still left the door open for the disparate treatment of physical and mental illnesses); Behbahani et. al., *supra* note 219, at 156-60 (contrasting the accomplishments of the 2008 Act with the downfalls).

2. The Mentally Ill Treatment Offender and Crime Reduction Act of 2004

Currently, the US institution that is holding the most people with a mental illness is not a specialized treatment center, but rather the Los Angeles County Jail.[276] Known as "Twin Towers," the prison houses approximately 1,400 mentally ill patients.[277] Despite the high number of prisoners with mental illness, few inmates report they receive treatment while detained.[278] For this reason, Congress passed mental health legislation in the context of prisons.[279] In 2004, The Mentally Ill Treatment Offender and Crime Reduction Act ("MITOCRA") was enacted.[280] MITOCRA is an unprecedented step by the federal government to begin to re-evaluate the treatment of mentally ill prisoners.[281] The goal of MITOCRA is to reduce the

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276. *See* Liesel J. Danjczek, *The Mentally Ill Offender Treatment and Crime Reduction Act and Its Inappropriate Non-Violent Offender Limitation,* 24 J. CONTEMP. HEALTH L. & POL'Y 69, 76 (2007) (analogizing the Los Angeles county jail with a mental institution); Renee Montagne, *Inside the Nation's Largest Mental Institution*, NAT'L PUB. RADIO (Aug. 13, 2008), http://www.npr.org/templates/story/story.php?storyId=93581736 (describing the mental facilities in the Los Angeles county jail).

277. *See id.*; Nicholas Kristof, *Inside A Mental Hospital Called Jail*, N.Y. TIMES (Feb. 8, 2014), http://www.nytimes.com/2014/02/09/opinion/sunday/inside-a-mental-hospital-called-jail.html?_r=0 (analogizing jails as mental hospitals); TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 117 (documenting a national survey in 2010 that found there are more than three times the number of seriously mentally ill patients in prisons than in hospitals).

278. *See* Ralph M. Rivera, *The Mentally Ill Offender: A Brighter Tomorrow Through the Eyes of the Mentally Ill Offender Treatment and Crime Reduction Act of 2004,* 19 J.L. & HEALTH 107, 133 (2005) (citing that only one-third of men and one-quarter of women report receiving treatment for mental illness while in prison); *Mentally Ill Offender Treatment And Crime Reduction Act Fact Sheet*, COUNCIL ST. GOV'TS JUST. CTR. (Feb. 2016), https://csgjusticecenter.org/wp-content/uploads/2014/08/MIOTCRA_Fact_Sheet.pdf [hereinafter MIOTCRA Fact Sheet] ("A 2006 U.S. Department of Justice study showed that approximately 45 percent of people in federal prison, 56 percent of people in state prison, and 64 percent of people in jail displayed symptoms or had a history of a mental disorder; among female inmates in state prisons, the rate was nearly three out of four."); Danjczek, *supra* note 276, at 76 (citing numbers that reflect an increase in the incarceration of the mentally ill).

279. *See* Turner, *supra* note 191, at 424-25 (introducing the potential effects and scope of the legislation). *See generally* Mentally Ill Offender Treatment and Crime Reduction Act of 2004, 42 U.S.C. § 3711 (2004) (promoting mental health awareness in prisons and correction facilities).

280. *See* 42 U.S.C. § 3711 (promoting collaboration to ensure resources are used effectively within the criminal and juvenile justice systems).

281. *See* Rivera, *supra* note 278, at 134 (reinforcing that Congress enacted this legislation in response to evidence brought to light during Congressional hearings that documented the rate of mental illness in prisons); Danjczek, *supra* note 276, at 73 (affirming

number of people incarcerated while simultaneously maintaining public safety.[282]

MITOCRA proscribes that funding be provided to state and local agencies to strategize how to appropriately treat criminals with mental illness and substance abuse problems in correction facilities.[283] Funding is also intended to help establish mental health courts, provide in-prison treatment and transitional services, and provide training for mental health personnel, such as police, judges, prosecutors and corrections officers.[284] A mental health court is generally described as a court specializing in the treatment of defendants with mental illnesses who have chosen court-supervised treatment over the traditional criminal justice system[285] Over time, the number of mental health courts has expanded in the United States.[286] Surveys indicate that there are approximately 150 mental health courts across the country.[287] Ultimately, the success of MITOCRA is unclear.[288] A recent study by the US Department of Justice revealed

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the purpose of MIOTCRA is to create useful new ways to raise mental health awareness in the criminal justice system).

282. *See* Rivera, *supra* note 278, at 110 (hypothesizing that government agencies and health care provides will be able to act more proactively to reduce the amount of crime committed by mentally ill individuals); Turner, *supra* note 191, at 424-25 (stating that the Act aimed to reduce the number of prisons while increasing public safety).

283. *See* Rivera, *supra* note 278, at 134 (reporting some of the protections proscribed in the legislation); MIOTCRA Fact Sheet, *supra* note 278 (indicating that MIOTCRA was enacted to help state and local government respond to people with mental disorders in the criminal justice system).

284. In 2008, Congress reauthorized MIOTCRA for an additional five years. This reauthorization extended training services to law enforcement officers. *See* Turner, *supra* note 191, at 424-25 (commenting on how funding is intended to help treat mental illness); MIOTCRA Fact Sheet, *supra* note 278 (establishing reauthorization in 2008).

285. *See* E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U.L. REV. 519, 520-21 (2012) (defining a "mental health court"). *See generally* Allison D. Redlich et. al., *The Second Generation of Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 527 (2005) (considering the development of mental health courts).

286. *See* Michael Thompson, Fred Osher, & Denise Tomasini-Joshi, *Improving Responses to People With Mental Illness: The Essential Elements of a Mental Health Court*, COUNCIL ST. GOV'TS JUST. CTR. (2008), https://csgjusticecenter.org/wp-content/uploads/2012/12/mhc-essential-elements.pdf (describing mental health courts in the United States). *See generally Mental Health Courts*, NYCOURTS.GOV, https://www.nycourts.gov/courts/problem_solving/mh/home.shtml (last visited Jan. 26, 2016) (summarizing mental health courts in New York).

287. *See* Thompson et. al., *supra* note 286.

288. *See* Press Release, Nat'l All. on Mental Illness, Department of Justice Study: Mental Illness of Prison Inmates Worse Than Past Estimates (Sept. 6, 2006), https://www.nami.org/Press-Media/Press-Releases/2006/Department-of-Justice-Study-Mental-

that sixty-four percent of local inmates, fifty-six percent of state prisoners, and forty-five of federal prisoners exhibit symptoms of serious mental illness.[289]

3. The Helping Families in Mental Health Crisis Act ("The Murphy Bill")

In 2013—primarily in response to a horrific shooting where twenty school-children were shot by a mentally ill assailant—Congressman and psychologist, Tim Murphy, introduced legislation intended to reform the delivery of mental health care services.[290] Academics and politicians describe this legislation as the most progressive since Kennedy's 1963 Community Health Center Act.[291] Murphy envisions a reformed system that includes modified Medicaid reimbursement practices, funding for community behavioral services, and revised patient-information sharing procedures.[292] Patient-information sharing is important because it facilitates communication

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Illness-of-Pris [hereinafter NAMI] (referring to Department of Justice study on prisons); *Inmate Mental Health*, NAT'L INST. MENTAL HEALTH (Jan. 5, 2016), http://www.nimh.nih.gov/health/statistics/prevalence/inmate-mental-health.shtml (referencing the same Department of Justice study).

289. *See* NAMI, *supra* note 288.

290. *See Committee's Investigation of Federal Programs Addressing Severe Mental Illness*, *supra* note 34, at 1-2 (introducing Tim Murphy's seminal mental health care legislation). *See generally* Helping Families in Mental Health Crisis Act of 2013, H.R. 3717, 113th Cong. (2013) (mandating the reform of the federal government's role in providing mental health services).

291. *See* Lloyd Sederer, *America Wakes Up to Mental Health*, U.S. NEWS & WORLD REP. (Aug. 11, 2015, 12:01 A.M.), http://www.usnews.com/opinion/blogs/policy-dose/2015/08/11/house-and-senate-mental-health-bills-show-americas-progress ("It's as if Congress went to sleep for 50 years on mental health issues."); Benedict Carey, *Mental Health Groups Split on Bill to Overhaul Care*, N. Y. TIMES (Apr. 2, 2014), http://www.nytimes.com/2014/04/03/health/mental-health-groups-split-on-bill-to-revamp-care.html (describing the Murphy Bill as "the most ambitious overhaul plan in decades"); Wayne Drash, *Tim Murphy's Journey to Reform Mental Health Laws*, CNN (Dec. 13, 2014), http://www.cnn.com/2014/12/11/us/tim-murphy-mental-health-profile/ (calling Murphy's legislation one of the most sweeping changes in the past two decades); *Committee's Investigation of Federal Programs Addressing Severe Mental Illness*, *supra* note 34, at 1 ("Despite that, for too long, mental health has been a topic kept in the shadows, often going unmentioned even as one in five Americans struggle with mental illness).

292. *See* H.R. 3717 §§ 201-301 (proscribing various federal reforms); Boldt, *supra* note 220, at 39-42 (listing some of the services the Murphy Bill is intended to reform); *Committee's Investigation of Federal Programs Addressing Severe Mental Illness*, *supra* note 34, at 1-2 (elaborating on the unwillingness of some patients to recognize the mental illness they suffer from and the need for familial intervention).

between family members, health care professionals, and caregivers, so a comprehensive treatment plan can be enacted.[293] The Murphy Bill also proposes to link primary care with mental health care in an effort to expand psychological services and early intervention.[294] However, the most controversial provision in the legislation encourages states to make greater use of outpatient services and involuntary treatment.[295] This provision is controversial because critics of the Murphy Bill suggest involuntary treatment reflects a punitive and institutional approach to mental health care, rather than community-based treatment.[296]

Like most legislation, the Murphy Bill attracted allies and opponents.[297] Advocates argue that the new bill fills the gaps in current mental health coverage.[298] For example, the Murphy Bill is expected to streamline payment for services under Medicaid, and provide funding for clinics for rigorous care and suicide prevention programs.[299] The Murphy Bill also calls for the training of police

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293. *See* NAMI, *supra* note 288.

294. *See* H.R. 3717 § 201(c)(2) (expanding services to rural communities and difficult-to-reach patients); Sederer, *supra* note 291 (noting that the bill integrates primary care with mental health). *See generally* Boldt, *supra* note 220, at 39-42 (recognizing Murphy's intent to expand mental health services).

295. *See* Sophie Tatum, *Mental Health Bill Part of Bipartisan Push at Hill Hearing on Tuesday*, CNN (June 16, 2015), http://www.cnn.com/2015/06/16/politics/mental-health-bill-congress/ (discussing the controversial nature of involuntary treatment); Boldt, *supra* note 220, at 39-42 (elaborating on court-ordered treatment).

296. *See* Leah Harris, *Washington's Horrible Mental Health Legislation*, HUFFINGTON POST (Nov. 23, 2015), http://www.huffingtonpost.com/leah-harris/washingtons-horrible-mental-health-legislation_b_8623226.html (criticizing the Murphy Bill); Scott Wong, *Ryan Pushes Mental Health Bill After Colo*. *Shooting*, HILL (Dec. 1, 2015), http://thehill.com/homenews/house/261625-ryan-pushes-mental-health-bill-after-colo-shooting (summarizing some Democrats' objections to the Murphy Bill).

297. *See generally Mental Health Legislation*: *Helping Families in Mental Health Crisis Act*, DUKE PSYCHIATY & BEH. SCI., http://psychiatry.duke.edu/news/news-archive/mental-health-legislation-helping-families-mental-health-crisis-act-0 (last visited Jan. 2, 2016) [hereinafter Mental Health Legislation] (listing privacy and civil rights as two controversies associated with the Murphy Bill); Carey, *supra* note 291 (claiming the Murphy Bill has "already stirred longstanding divisions in mental health circles").

298. *See* Mental Health Legislation, *supra* note 297 ("One piece of the bill proposes the creation of a National mental health Policy Laboratory with a five percent blog grant dedicated to study and implement innovative mental health delivery systems."); Drash, *supra* note 291 (stressing the importance treatment for mental illness in the wake of the Newtown shooting).

299. Carey, *supra* note 291 (explaining the widely supported provisions in the Murphy Bill); Tatum, *supra* note 295 (explaining that the Murphy Bill redistributes resources and funding to treat the mentally ill).

officials and emergency medical workers to identify and treat people with mental illness.[300]

On the other hand, opponents contest that the Murphy Bill is incorrectly premised on the assumption that mental health is the primary cause of violent crimes.[301] Some argue that court-ordered treatment is a violation of civil rights because it imposes coerced treatment against an individual's own will.[302] Critics also point out that the Murphy Bill also purports to amend federal privacy laws, and reduce funding for the Substance Abuse and Mental Health Services Administration.[303]

The Mental Health Parity Acts, the Mentally Ill Offender Treatment Act, and the Murphy Bill all represent Congress' attempt to reform mental health care and improve coverage in the United States.[304] This legislation has resulted in some positive changes, but mental health coverage remains incomplete.[305] Turning to Part IV, the following section proposes how these gaps can be filled based on the policies created in Australia, South Africa, and the United Kingdom.

IV. PROPOSALS TO REFORM MENTAL HEALTH CARE IN THE UNITED STATES

The United States signed the ICESCR and CRPD, but has not ratified either.[306] Thus, even though Article 12 of the ICESCR

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300. Carey, *supra* note 291 (justifying additional support for the bill). *See generally* Tim Murphy, *The Helping Families in Mental Health Crisis Act*, CONGRESSMAN TIM MURPHY, http://murphy.house.gov/uploads/MHOnePager2.18.15.pdf (summarizing the key provisions).

301. Tatum, *supra* note 295 (criticizing the Murphy Bill); *see* Carey, *supra* note 291 (arguing why the Murphy Bill should not be passed).

302. *See generally* Carey, *supra* note 291 (arguing why the Murphy Bill should not be passed); Wong, *supra* note 296 ("Some Democrats, however, have warned that the Murphy Bill could lower privacy protections by allowing more treatment information to be shared with caregivers.").

303. *See* Carey, *supra* note 291 (illustrating the negative effects of the Bill on other agencies); Drash, *supra* note 291 (naming budgetary concerns as an objection to the legislation).

304. *See supra* Sections III.C.1- 3.

305. *Id*.

306. *See* Yuval Shany, *How Supreme is the Supreme Law of the Land? Comparative Analysis of the Influence of International Human Rights Treaties Upon the Interpretation of Constitutional Texts by Domestic Courts,* 31 BROOK. J. INT'L L. 341, 343 (2006) (stating that in the United States, there is a deeply imbedded resistance to the idea that legislation should be

establishes a right to mental health, absent ratification, the United States is not legally obligated to enforce that right.[307] Nonetheless, with the passage of MITOCRA, and the introduction of the Murphy Bill, mental health care is resurfacing on the federal political agenda.[308] But, regardless of Congress' efforts, mental illness is still widespread, treatment is still inadequate, and Americans are still suffering.[309]

For example, in the United States, NIMH estimates that 43.8 million adults, and 13.7 million children, suffer from a mental illness.[310] Depression and anxiety disorders are the most common, affecting roughly twenty percent of the adult population.[311] Some common disorders include posttraumatic stress disorder, obsessive-

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construed in light of international human rights law); Turner, *supra* note 191, at 442 (reiterating the same principle).

307. *See supra* Sections I.B.2-4 (describing the ICESCR and CRPD in detail); ANDREW BYRNES ET. AL., U.N., FROM EXCLUSION TO EQUALITY: HANDBOOK FOR PARLIAMENTARIANS ON THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES AND ITS OPTIONAL PROTOCOL 39 (2007), http://www.un.org/disabilities/default.asp?id=231 (defining what it means to be a signatory to a treaty and optional protocol); UN Treaty Collection, *supra* note 145 (listing when various countries signed and ratified the ICECSCR). *See generally* ICESCR, *supra* note 55, art. 12 ¶ 1 (establishing a right to physical and mental health).

308. *See supra* Sections III.C.2-3 (discussing the substance of MITOCRA and the Murphy Bill).

309. *See* Lesley Russell, *Mental Health Care Services in Primary Care*: *Tackling the Issues in the Context of Health Care Reform*, CTR. AM. PROGRESS, at 3 (Oct. 2010), https://www.americanprogress.org/wp-content/uploads/issues/2010/10/pdf/mentalhealth.pdf (citing that fewer than one-half of adults, and one-third of children, who have an identifiable mental disorder are receiving mental health treatment).

310. *See Any Mental Illness (AMI) Among Adults,* NAT'L INST. MENTAL HEALTH, https:/www.nimh.nih.go/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml (last visited Nov. 14, 2015) (calculating the incidence of mental illness in the United States); Alan Johnson & Catherine Candisky, *Access to Mental-Health Care is Woeful*, COLUMBUS DISPATCH (May 27, 2003), http://www.dispatch.com/content/stories/local/2013/05/27/access-to-mental-health-care-is-woeful.html (recording the number of people who suffer from mental illness in the United States as high as 57.7 million); *Mental Health Basics*, *supra* note 33 (estimating only 17% of the population in the United States is considered to be in an optimal state of mental health); Russell, *supra* note 309 (citing mental illness rates in the United States).

311. *See Facts and Statistics*, ANXIETY & DEPRESSION ASS'N AM., http://www.adaa.org/about-adaa/press-room/facts-statistics (last updated Aug. 2016) (explaining anxiety disorders affect approximately 18% of the adult population); *Mental Health Basics*, *supra* note 33 (documenting depression as the most common mental illness in the United States); FUNK ET AL., *supra* note 33, at 24 (reporting that depression is the single largest contributor to the overall disease burden in high-income countries).

compulsive disorder, and specific phobias.[312] Fifty percent of chronic mental illness begins at age fourteen, seventy-five percent by age twenty-four.[313] However, despite the appearance of symptoms, there are typically significant delays prior to getting treatment.[314] In fact, mood disorders, such as depression and bipolar disorder are the third most common cause of hospitalization for youth and adults aged between eighteen and forty-four.[315] Sadly, suicide is the second leading cause of death for youths aged between fifteen and twenty-two.[316] Lastly, the Kaiser Family Foundation reports that the fifty states spent a total of thirty-eight billion dollars on mental health services in the fiscal year 2010.[317]

In response to these unsettling statistics, there are three ways that treatment for mental illness can be improved in the United States.[318] First, access to mental health care can be improved by re-designing integration programs throughout the country, similar to the ones WHO praised in Australia and South Africa.[319] Second, the relationship between the mentally ill and law enforcement can be improved by adopting more uniform standards regarding their treatment.[320] Third, the possibility of incorporating supervised

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312. *See Mental Health by the Numbers*, NAT'L ALLIANCE ON MENTAL ILLNESS, https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers (discussing incidence of mental illness in the United States). *See generally Any Anxiety Disorder Among Adults*, NAT'L INST. MENTAL HEALTH, http://www.nimh.nih.gov/health/statistics/prevalence/any-anxiety-disorder-among-adults.shtml (last visited Jan. 26, 2016) [hereinafter *Statistics*] (reporting rates of anxiety disorders in the United States).

313. *See Mental Health by the Numbers, supra* note 312. *See generally Statistics*, *supra* note 312 (reporting various statistics about mental health in the United States).

314. *See supra* note 313.

315. *Id.*

316. *Id.*

317. *See generally State Mental Health Agency (SMHA) Mental Health Services Expenditures*, KAISER FAM. FOUND. (Nov. 22, 2015), http://kff.org/other/state-indicator/smha-expenditures/#table (calculating mental health expenditures per state); Boldt, *supra* note 220, at 63 (citing the Kaiser Family Foundation study).

318. *See supra* Parts I-III (discussing the challenges of mental health reform); Russell, *supra* note 309 (categorizing the biggest issues within mental health reform).

319. *See infra* Section IV.A (discussing the integration of mental health care with primary care); Section III.A (discussing integration in Australia and South Africa).

320. *See infra* Section IV.B (discussing mental health reform within the context of prisons and law enforcement).

community treatment ("SCT") into the Murphy Bill can be reconsidered, like the procedures in the United Kingdom.[321]

A. Integrating Mental Health Care with Primary Care

The insurance system in the United States is unique compared to the models in other countries.[322] Rather than operating a national health service, the United States employs a hybrid system.[323] In the United States, private insurance can be purchased on a group basis—usually by a firm to cover employees—or individually.[324] However, there are also several public health and social insurance programs the federal and state government endorses, such as Medicare and Medicaid.[325] Regardless of these differences, the underlying principles of the integration of mental health care and primary health care can still be applied to structure reform in the United States.

The case studies conducted by WHO in Australia and South Africa—both ratifying parties to the ICESCR and CRPD—demonstrate how effective integration can be.[326] Some of the benefits of integration include increasing access to mental health care, reducing the stigma associated with mental illness, providing more holistic and affordable treatment, and educating the general public about mental health awareness.[327] Therefore, the underlying MI Principles used to shape the policies in Australia and South Africa, such as Principle 1(4)'s prohibition of discrimination, Principle 3's emphasis on providing accessible treatment in the community, and

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321. *See infra* Section IV.C (discussing the advantages and disadvantages of supervised community treatment).

322. *See The U.S. Health Care System: An International Perspective*, DEP'T PROF. EMP. (2014), http://dpeaflcio.org/programs-publications/issue-fact-sheets/the-u-s-health-care-system-an-international-perspective/ (summarizing the health insurance system in the United States); *Going Public and Private*, ECONOMIST (Dec. 21, 2013), http://www.economist.com/news/business/21591858-fuss-over-obamacares-teething-troubles-obscuring-bigger-story-investors-american (explaining the hybrid insurance system in the United States); Turner, *supra* note 191, at 426-27 (explaining that state-sponsored health care models makes certain reorganization of resources more feasible).

323. *See supra* note 322.

324. *Id.*

325. *Id.*

326. *See supra* Part II (discussing integration).

327. *Id.*

Principle 9(2)'s insistence on individual treatment plans can influence reform.[328]

At a minimum, integration can be adopted through private insurance. For example, physical checkups can include mental health screenings.[329] If a patient's height, weight, and blood pressure are measured, a patient should also be screened for depression, anxiety, or other common mental illnesses.[330] Integration also improves access to treatment because currently there is a reduction of mental health care professionals in the United States.[331] Extending mental health to primary care would widen the number of professionals suited to help treat mental illness.[332] Ensuring that primary care doctors are qualified to treat mental illness would perhaps include specific training and credentialing when appropriate.[333] Training can begin at the undergraduate level, like it does in Australia.[334]

The stigma commonly associated with mental illness is often one of the largest obstacles that prevent people from seeking treatment.[335] Integration helps reduce this stigma because physical and mental illness are treated together. Over time, the treatment of mental illness

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328. *See* MI Principles, *supra* note 90, princ. 1(4) (barring discrimination against the mentally ill); *id.* princ. 3 (naming life in the community as a principle); *id.* princ. 9(2) (discussing individualized treatment plant); Section I(B)(3) (explaining the MI Principles in detail). *See generally supra* Part II (discussing Australia and South Africa).

329. *See* Brown, *supra* note 34 (advocating for the integration of mental health care with primary care); *supra* Part II and accompanying text.

330. *See supra* note 329.

331. *See* Russell, *supra* note 309 (referring to statistics regarding the number of mental health care professionals in the United States); *see also* Brown, *supra* note 34, at 7, 11 (reporting on the low number of mental health workers in Colorado).

332. *See* Russell, *supra* note 309 (arguing why integration is advantageous); *see also* Brown, *supra* note 34 (discussing integration).

333. *See supra* note 332.

334. *See* FUNK ET AL., *supra* note 33, at 71 ("Currently, all general practitioners in Australia undertake mental health training at both undergraduate and postgraduate levels, and practitioners are expected to be able to deal with uncomplicated mental health problems in the same way as they deal with physical problems."). *See generally* New Ministry of Health, *supra* note 152.

335. *See Mental Health*: *Overcoming the Stigma of Mental Illness*, MAYO CLINIC (Feb. 2016), http://www.mayoclinic.org/diseases-conditions/mental-illness/in-depth/mental-health/art-20046477 (describing the stigma associate with mental illness); Friedman, *supra* note 31 (reporting on the stigma of mental illness).

becomes as ordinary as the treatment of high cholesterol diabetes, or chronic migraines.[336]

Take Tom Pelletier, for example.[337] Tom had been hiding his anxiety until he woke up one morning and was so overwhelmed he could not even dress himself.[338] Despite the advice of a doctor, he did not seek treatment because he was embarrassed by the stigma associated with mental illness.[339] Tom managed for a year until his second episode, which resulted in a nine-day hospital stay.[340] His family drained their retirement savings on his treatment.[341] Now, their home is up for sale, they have US$12,000 in credit card debt, and Tom still suffers from severe anxiety and depression.[342] If Tom and his family were not ashamed of the stigma of mental illness, he might have been more eager to get the help he needed.

In addition to reducing the stigma, integration is advantageous because it promotes more mental health awareness throughout the general public.[343] Sometimes families, teachers, or colleagues, might be aware of a person experiencing psychiatric symptoms, but do not know how to help.[344] On the other hand, sometimes these same people fail to take notice of warning signs entirely.[345] For this reason, increased awareness and education about mental illness and its symptoms will ultimately lead to more effective diagnosis and intervention.[346]

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336. *See* Brown, *supra* note 34 (advocating for the integration of mental health care with primary care); *supra* Part II and accompanying text.

337. *See* Brown, *supra* note 34, at 18-22 (recounting Tom Pelletier's experience with mental illness).

338. *Id.*; Phillip Lewis, *The Fact About Depression We Need to Start Talking About*, SCIENCE.MIC (Mar. 24, 2016), https://mic.com/articles/138671/the-facts-about-depression-we-need-to-start-talking-about#.vLab4nWIH (discussing mental illness in Colorado).

339. *See supra* note 338.

340. *Id.*

341. *Id.*

342. *Id.*

343. *See* Carolyn Reinach Wolf & Jamie A. Rosen, *Missing the Mark: Gun Control Is Not the Cure for What Ails the U.S. Mental Health System*, 104 J. CRIM. L. & CRIM. 851, 872-76 (2014) (promoting the benefits of increased mental health awareness); *supra* Part II and accompanying text (emphasizing the importance of education and mental health awareness).

344. *See supra* note 343.

345. *Id*.

346. *Id*.

B. Reshaping the Relationship between the Mentally Ill and Law Enforcement

Poor mental health conditions in prisons are a global reality.[347] In the United States, forty-five percent of inmates in federal jails are suffering from mental illness.[348] Meanwhile, in the United Kingdom, the rate of mental illness in prison facilities is approximately twenty percent. [349] Some academics attribute this difference to the comparatively higher standards the United Kingdom maintains regarding the treatment of the mentally ill. [350] For example, the Handbook initially published in the United Kingdom in 2002, has proven to be so successful that it has been translated into sixteen different languages.[351] The Handbook incorporates the ICESCR, and various international law instruments, to educate governments and inter-governmental organizations on how to maintain prisons successfully and comprehensively.[352] The Handbook incorporated the exact language of Article 12 of the ICESCR and states that all prisoners are entitled to the highest attainable standard of physical and mental health.[353]

One reason the Handbook was successful is because it provided the entire prison system with uniform standards and expectations of prison management.[354] For example, the Handbook proscribes that, at a minimum, the prison administration is expected to provide initial medical screening, regular out-patient consultation, emergency treatment, and an adequate supply of medicine dispensed by qualified

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347. *See supra* Introduction and Part III.

348. *See supra note 288*.

349. *See Mental Health Care in Prisons*, PRISON REFORM TR. (Jan. 22, 2016), http://www.prisonreformtrust.org.uk/projectsresearch/mentalhealth (recording a recent study that found 25% of women and 15% of men in prison reported symptoms indicative of psychosis); Turner, *supra* note 191, at 426 (documenting the number of mentally ill prisoners in penal establishments in the United Kingdom and Wales).

350. *See supra* note 349. The rate among the general public is about four percent. *Id.*

351. *See* Second Edition Handbook, *supra* note 191 (noting success of the initial Handbook); *supra* Section II.C (discussing the Handbook in detail).

352. *See* Second Edition Handbook, *supra* note 191, at 7-10 (presenting the overall purposes of the Handbook); *supra* Section I.B.2 (discussing the ICESCR).

353. *See* Second Edition Handbook, *supra* note 191, at 47-57 (presenting the overall purposes of the Handbook); *supra* Section I.B.2 (discussing the ICESCR).

354. *See* Second Edition Handbook, *supra* note 191 (presenting the overall purposes of the Handbook); *supra* Part II (discussing the use of the Handbook).

pharmacists, among other things.[355] The creation of uniform standards and expectations of prison management in the United States can help counteract the overcrowding of prisons with people suffering from mental illness. Some topics worth addressing are: creating more specific diagnostic procedures for the screening of mental illness, using mental health courts as an alternative to incarceration, and establish independent evaluations of prisons to ensure they are complying with federal, state and local regulations.[356] Most importantly, establishing uniform standards and specialized training for correction and police officers is invaluable to improving prison management.[357] For example, had correction officers been properly trained, Timothy Perry might not have lost his life due to the mis-administration of a sedative for a manic episode.[358]

Law enforcement officers also spend a significant amount of time interacting with individuals suspected of mental illness.[359] For example, in California, the San Diego County police force reported that their interactions with people that they suspect suffered from mental illness doubled between 2009 and 2011.[360] In response, some police precincts began consulting social and mental health services to train police officers.[361] For example, in Ventura County, California, local police work jointly with mental health services to identify and treat people with mental illness.[362] Perhaps federal, state and local officials should begin working together to establish uniform standards

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355. *See* Second Edition Handbook, *supra* note 191, at 49; *supra* Part II (discussing the use of the Handbook).

356. *See* SASHA ABRAMSKY & JAMIE FELLNER, HUMAN RIGHTS WATCH ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 9-15 (2003) (outlining suggestions for reforming the US prison mental health services). *See generally* Canales, *supra* note 12, at 1729-32 (summarizing the history and effects of Timothy Perry's mental illness); State of Connecticut Office of and Advocacy for Persons with Disabilities, *supra* note 12 (providing a comprehensive summary of the Timothy Perry case).

357. *See supra* note 356.

358. *See supra* Introduction and accompanying text.

359. *See* TORREY, AMERICAN PSYCHOSIS, *supra* note 219, at 120-23 (describing the relationship between law enforcement and individuals with mental illness). *See generally* Abramsky & Fellner, *supra* note 356 (discussing the role of law enforcement in the mental health crisis).

360. *See supra* note 359.

361. *Id.*

362. *Id.*

across the country to treat mental illness in prisons and throughout the community at-large, like the United Kingdom's Handbook does.[363]

C. Supervised Community Treatment

In light of the introduction of the Murphy Bill, the usage of outpatient treatment is worth considering. Despite the controversial nature of outpatient treatment, the essence of the bill is to increase access to services for people with mental health problems.[364] Similar to supervised community treatment in the MHA 2007 in the United Kingdom, under the Murphy Bill, assisted outpatient treatment ("AOT") laws enable a judge to require a mentally ill person to follow a treatment plan involuntarily.[365] Under this provision, states that utilize AOTs qualify for a two percent funding bonus.[366]

SCT and AOT allow high-risk patients to continue living in their communities, while ensuring that they continue to be treated for their mental illnesses.[367] On the other hand, opponents argue that AOTs—and SCT—undermine an individual's right to choose their own treatment.[368] Although unclear, some activists argue that this provision not only violates civil rights, it also violates international law under the CRPD prohibition of arbitrary detention.[369]

The Aaron Alexis tragedy illustrates some of the complications of AOTs and the Murphy Bill. Alexis exhibited several examples of high-risk behavior. He reported to law enforcement that people were

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363. *See supra* Part II (discussing the Handbook).

364. *See* Jon Reid, *Mental Health Bill's Language on Involuntary Treatment Will be Revised*, MORNING CONSULT (Oct. 29, 2015), http://morningconsult.com/2015/10/mental-health-bills-language-on-involuntary-treatment-will-be-revised/ (discussing AOTs in the Murphy Bill); *supra* Section III.C (discussing the Murphy Bill).

365. *See* Reid, *supra* note 364 (discussing AOTs in the Murphy Bill); *supra* Part II (discussing MHA 2007); *supra* Section III.C (discussing the Murphy Bill).

366. *See* Reid, *supra* note 364 (discussing AOTs in the Murphy Bill).

367. *See* Reid, *supra* note 364 (discussing AOTs in the Murphy Bill); *supra* Part II (discussing MHA 2007); Section III.C (discussing the Murphy Bill).

368. *See* Tracie Mauriello, *Rep. Tim Murphy's Mental Health Overhaul Bill Clears Subcommittee*, PITT. POST-GAZETTE (Nov. 8, 2015), http://www.post-gazette.com/local/2015/11/08/Rep-Tim-Murphy-s-controversial-mental-health-overhaul-bill-clears-subcommittee/stories/201511050189 (explaining objections to the Murphy Bill).

369. *See supra* Part II (discussing why the MHA 2007 violates the CRPD); CRPD, *supra* note 87, art. 14(1)(b) ("[Persons with disabilities a]re not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.").

talking to him through the walls of his hotel room, and that microwave vibrations were distracting him from his sleep.[370] Even though he complained, Aaron never received any treatment because he allegedly did not appear to be a serious threat to himself, or to others.[371] On September 16, 2013, Alexis walked into the Navy Yard in Washington, D.C. and shot twelve people.[372] Had AOT existed, Alexis could have received the help he needed.[373] AOTs are intended to balance individual civil rights with the protection of public safety and security. Furthermore, AOTs emphasize community treatment, much like the system President Kennedy designed when he envisioned a mental health system that included federal community mental health centers.[374]

CONCLUSION

Globally, persons suffering from mental illness are exposed to a range of human rights violations, such as a lack of adequate care, discrimination, and civil liberty infringements.[375] Many of these violations are often motivated by stigmas, myths, and misconceptions

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370. S*ee* Eric Tucker, *Aaron Alexis, Navy Yard Shooting Suspect, Thought People Followed Him with Microwave Machine*, HUFFINGTON POST (Sept. 18, 2013), http://www.huffingtonpost.com/2013/09/18/aaron-alexis-microwave-machine_n_3946916.html (discussing that police officers did not provide Alexis with treatment). *See generally* Wolf & Rosen, *supra* note 343, at 870–72 (noting Alexis was denied mental health treatment).

371. *See* Tucker, *supra* note 370 (claiming that Alexis displayed symptoms of serious mental illness and describing the delusions Alexis experienced); Jeremy W. Peters & Michael Luo, *Mental Health Again an Issue In Gun Debate*, N.Y. TIMES (Sept. 18, 2013) (asserting that Alexis demonstrated signs of psychosis). *See generally* Wolf & Rosen, *supra* note 343, at 870-72 (noting Alexis was denied mental health treatment).

372. *See* Tucker, *supra* note 370 (discussing that police officers did not provide Alexis with treatment). *See generally* Wolf & Rosen, *supra* note 343, at 870-72 (noting Alexis was denied mental health treatment).

373. *See* Wolf & Rosen, *supra* note 343, at 870-72 (advocating for the use of community mental health services); *Committee's Investigation of Federal Programs Addressing Severe Mental Illness*, *supra* note 34, at 1 (hypothesizing that violent acts can be avoided with proper treatment).

374. *See supra* Section III.A (describing President Kennedy's community treatment centers).

375. *See generally* Carla A. Arena Ventura, *International Law, Mental Health and Human Rights*, U. NOTRE DAME CTR. CIV. & HUM. RTS. (June 2014), https://humanrights.nd.edu/assets/134859/venturamentalhealth.pdf (providing an overview of international human rights law); *supra* Parts I-III and accompanying text.

associated with mental illness.[376] Nonetheless, attitudes towards people with mental illness have changed radically over time.[377] Beginning in the 1970s, with the ratification of the ICESCR, there emerged an international framework of law and principles dedicated to the protection of people with disabilities.[378] With the publication of the MI Principles in 1991, and the ratification of the CRPD in 2008, mental health is slowly becoming a global priority.[379]

WHO synthesizes the laws and principles embodied in these instruments and produces guidelines that States can utilize to modify and update their mental health legislation.[380] For example, WHO case studies in Australia, South Africa, and the United Kingdom illustrate examples where integration, prison reform, and supervised community treatment can be used to increase access to mental health care.[381] Even though the United States is not legally obligated to enforce the right to mental health in the ICESCR, underlying principles in the Convention, along with the MI Principles and CPRD can still influence reform.[382]

Despite some progress, human rights violations still occur repeatedly.[383] However, legislatures, mental health professionals, law enforcement, and individuals can begin working to evaluate how integration, education, uniform standards across prisons, and modified outpatient treatment can start to tackle the mental health crisis.[384] Although there are legitimate barriers to reform—such as funding, resources, and political divisiveness—it has the potential to save money in the long-term, and more importantly, can make lives remarkably better.[385] For example, Billy—an individual suffering from schizophrenia—was transferred from a prison to a treatment facility because the United Kingdom's infrastructure, attitude towards

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376. *See supra* note 376.

377. *Id*.

378. *Id.*

379. *Id.*

380. *See supra* Section I.B.5 (discussing the role of WHO).

381. *See supra* Sections II.A.1−2 (discussing the WHO case studies on integration in Australia and South Africa).

382. *See supra* Part IV (discussing proposed mental health reform in the US).

383. *See supra* Introduction (discussing individual examples of mental illness).

384. *See supra* Part IV (proposing various solutions to mental health reform in the United States).

385. *See supra* Introduction (describing Billy's experience with mental illness in the United Kingdom); *supra* Sections II.B−C.

mental health, and interpretation of international law establishes a solid foundation to protect the rights of the mentally ill.[386]

However, many stories unfold differently in the United States.[387] Tom Pelletier might still be living in the home where he raised his family had he and his wife not been intimidated by the stigma of mental illness.[388] Madison Holleran could have graduated with a degree from an Ivy League university.[389] Timothy Perry might still be alive.[390]

386. *See supra* Introduction (discussing Billy).

387. *See supra* Introduction (discussing Madison Holleran and Timothy Perry); *supra* Section IV.A (discussing Tom Pelletier).

388. *See supra* note 388.

389. *Id.*

390. *Id.*