The right to mental health and parity

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INTRODUCTION

The prevalence of mental disorders is common, but although many policies and settings cover patients with psychoses, other psychiatric conditions are put to one side. Furthermore, the majority of people with common mental disorders (which include anxiety and depressive disorders), addictions, intellectual disabilities and co-morbidities receive no intervention even in the best-resourced countries. Although mental disorders are defined by diagnostic criteria, social and value-laden personal constructs usually override these so that stigma, discrimination and ignorance result in a lack of access to evidence-based interventions to treat mental disorder, prevent mental disorder and promote mental health. In this paper, we highlight the need for both the policy makers and those who provide services to consider issues related to parity between resources allocated to physical and mental health.

RIGHT TO HEALTH

Right to health incorporates civil, social and health dimensions. Regarding the right to health, the World Health Organization (WHO, 1946) constitution made it clear that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures.”[1] The Universal Declaration of Human Rights (1948) also reads: “Everyone has the right to a standard of living adequate for the health of himself and of their family, including food, clothing, housing and medical care and necessary social services.”[2] Subsequently, the Alma Alta declaration[3] of 1978 reiterated the fundamental right to the enjoyment of the highest attainable standard of health and is widely recognized in many human rights declarations (International Convention on the Elimination of All Forms of Racial Discrimination: ICEAFRD, 1965;[4] Convention on the Elimination of All Forms of Discrimination against Women: CEAFDAW, 1979;[5] Convention on the Rights of the Child: CORC, 1989;[6] European Social Charter, 1965;[7] African Charter, 1981;[8] American Convention, 1988[9]). These charters and amendments are often used as the basis of the legal framework, but regrettably not all the time.

The Universal Declaration of Human Rights has at its core three key aspects important to health care:

• Preserve, extend and improve the life of the people in need based on equality (for treatment and cure irrespective of gender, race, language, religion and opinions and socioeconomic conditions)
• Quality (high quality, up-to-date interventions)
• Social responsibility (health and well-being of citizens as a well-funded priority and effective in health promotion and prevention of ill health).

In looking at human rights based parity across all health – be it physical or mental or psychosomatic – policymakers must bear these three facets in mind.

Hogerzeil in 2006 has pointed out that human rights are legally guaranteed by international, regional and national human rights laws through which individuals are protected especially against actions, which may interfere with human dignity and fundamental freedoms.[10] The right to a disability-free life and to health is closely associated with the right to life, and these rights are indispensable for...
the exercise of most other human rights. Freedom from discrimination is at the core of all rights.

**EVOlUTION OF RIGHTS**

It is important to acknowledge that these frameworks and associated changes take a considerable period to be implemented. Higgins in 2012 has highlighted that the recognition of rights at an international level gathered pace after the Nazi atrocities and mass migration after the Second World War. Furthermore, although equality has often been referred to, there has been very little progress on this in some parts of the world. Hogerzeil emphasizes that the principle of “progressive realization” carries with it limits related to available resources. However, two immediate obligations include the guarantee that the right to health will be exercised without discrimination, and deliberate, targeted steps are taken toward their full realization.

Although human rights have evolved over the centuries, the legal and philosophical development of rights did not always occur in parallel. The idea of natural law emerged from religion and philosophy while attitudes to mental disorder were strongly influenced by prevalent knowledge, religion and understanding of causative factors. However, mainstream Anglo-American conception of rights have tended to confine themselves to individualistic, civil and political rights to the exclusion of rights relating to collectivist social, economic and the right to health. This tension between individual and collectivist or community rights lies at the core of the relationship between those providing treatment for illness including mental illness and indubitably also affects attitudes, which will vary between ego-centric and collectivist societies.

**RIGHTS IN THE CONTEXT OF THE MENTAL HEALTH INTERVENTION GAP**

Although mental disorders are common and affect up to 10% of the world’s population, 31.2% of the European population is affected each year. Furthermore, mental disorders are responsible for 22.8% of global burden of disease and 29.2% of burden of disease in Europe (when examining the 20 leading causes of years lost due to disability: YLD). The large burden of mental disorders is due to a combination of high prevalence, early onset in the life course and a broad range of impacts. These impacts result in annual global costs of US$2.5 trillion and €532.2 billion in the European Union.

The majority of people with a mental disorder can be effectively managed in primary care using a mixture of psychological and pharmacological therapies while a very small proportion require secondary mental health services mostly as outpatients. However, despite the fact that mental disorders result in such large impact and effective treatments exist, only 10% of people with mental disorder in Europe receive notionally adequate treatment, mostly from primary care while coverage is far less in low and middle-income countries.

Even fewer with a mental disorder receive intervention for either health risk behavior or physical health while coverage of interventions to address risk factors to prevent mental disorder is extremely low even in high-income countries. This is in contrast to areas such as cancer and cardiovascular disease, which invest in action to address associated risk factors.

A number of reasons account for such a large intervention gap, which includes the proportion of health budget spent on the treatment of mental disorders, which does not match the size of the burden. In the UK (United Kingdom), 11.2% of the health budget is spent on the treatment of mental disorders despite it being responsible for 22.8% of the burden of disease; however still UK has one of the highest proportions, spent on treatment of mental disorders in Europe. Other reasons include lack of intelligence about the size, impact and cost of the intervention gap, poor recognition of mental disorders by health professionals and the population, as well as stigma and discriminatory attitudes toward treatment of mental disorders. Debate about definitions of mental disorders despite internationally agreed diagnostic criteria further contributes to inaction.

World Health Organization reported in 2011, that there is a lack of mental health policy in 40% of countries despite the prevalence. However, even in countries with a mental health policy, this often focuses on detention of people with mental disorder despite this being required for only a very small proportion of people with mental disorder.

**THE RIGHTS APPROACH TO ADDRESS THE MENTAL HEALTH GAP**

Right to health includes universal access to effective treatment for an illness which should include mental disorder. Since the majority of lifetime mental disorders arise before adulthood, the rights of children and adolescents to treatment and prevention of mental disorders is particularly important.

As noted above, the relationship between mental disorder and human rights has various components which must be borne in mind: The first at an individual level involves the right of people to live, which will support their mental health and well-being and prevent a mental disorder; the second involves the right to early access of treatment for mental disorder and associated consequences such as
health risk behavior and physical illness; and the third, to access education, employment and other aspects of social and economic life without discrimination.\cite{22} In defining a human rights approach to mental health, it is absolutely critical that people with mental disorder are not seen as a product of their disorder but instead as having a condition which requires early recognition and treatment as is the case for physical illness.

The legal framework should go beyond the quality of care to include a rights approach, which enables early access to effective treatment and prevention according to the need. Implications of this right in itself means that not only are their needs assessed but they are met at all levels including individual, familial and social levels. In particular, such a rights approach recognizes that particular groups are at several fold higher risk of mental disorder and, therefore, need a proportionately targeted approach to both treatment and prevention which need to be part of the overall planning of health care.\cite{23} Such groups include women, children with learning disability and in the care of the state, those with a learning disability, certain black and minority ethnic groups, lesbian, gay, bigender and transexuals, migrants, etc. Such an approach improves coverage and also reduces discrimination at all levels.

Yamin and Rosenthal, in 2005, have argued that a human rights framework is critical and quality of care must form a part of this framework with a focus on ending discrimination against those with a mental disorder.\cite{24} Once treatment and prevention of mental disorder are seen as a central and integral part of health, health care delivery becomes more acceptable. In order to do this, it is helpful to have normative framework within international law (United Nations Committee on Economic, Social and Cultural Rights; UN-ESCR 2000) which can provide an oversight of human rights particularly for the more vulnerable groups.\cite{25}

Since the coverage and standards of care are extremely variable even within the same country, a rights-based international acknowledgement and agreement on minimum basic standards is required.

**PARITY AND RIGHTS**

A rights-based approach supports the achievement of parity between treatment for physical illness and mental disorder. Additional issues related to achieving rights based parity include research, policy, delivery and outcome indicators. Embedded within policy development and delivery are transparency and accountability: Civil and political rights are indivisible, and these play a powerful normative role in the health care development and delivery.\cite{26}

Hogerzeil in 2006 has suggested that the WHO Essential Medicines Program has much to offer with its consistent focus on sustainable universal access to essential medicine which includes those for mental disorder.\cite{10} This can be achieved through the development of national medicines policies in line with human rights principles of nondiscrimination and care for those at higher risk of physical illness and mental disorder including the poor and the disadvantaged. Careful evidence-based selection of essential medicines and making these available cheaply and reliably particularly for those at higher risk of illness is part of the good governance by the state. In the case of early intervention for mental disorder, this can also result in substantial net savings even in the short term as well as reduced risk of subsequent physical illness.\cite{27}

A rights approach also supports parity between prevention of physical illness and prevention of mental disorder. Since the majority of lifetime mental disorder has arisen by the mid-twenties, addressing risk factors and particular social determinants during childhood and adolescence is particularly important to prevent mental disorders although early intervention for mental disorder arising during adolescence can also prevent a proportion of adult mental disorders.\cite{28,29} The local levels of risk factors for mental disorder including inequalities can be locally assessed to inform required interventions to address such factors so as to prevent mental disorders.\cite{20} Public health and social care have important roles in addressing risk factors to prevent mental disorders such as through early detection and intervention of child abuse.\cite{20}

A rights-based approach is crucial in research: Amon et al. in 2012 suggested that the balance between protecting the state or protecting individuals is crucial in research.\cite{30} Risks in human rights investigations are related to potential conflict. Carrying research out and setting policy development in place when security is at risk can raise specific ethical issues. Consequences of reporting human rights abuses need to be remembered, especially from vulnerable individuals.

**HOW TO ACHIEVE PARITY?**

Achievement of parity for mental health will be supported by a human rights based approach, which affirms the right to effective interventions to treat and prevent mental disorders, and promote mental health.

The Royal College of Psychiatrists (2013) has recently made several recommendations to achieve parity between physical and mental health including leadership, policy change, addressing stigma and discrimination, improving physical health and reducing premature mortality in those with mental disorder, commissioning of appropriate levels of services according to need, addressing comorbidity, public health, funding and research.\cite{31}
Parity for mental health can be supported by appropriate monitoring of the parity gap; public mental health intelligence includes the local size, impact and costs of the intervention gap for treatment of mental disorders, prevention of mental disorder and promotion of mental health including for higher risk groups. It includes estimation of the net economic savings from implementation of cost-effective public mental health interventions including where such savings accrue and also enables monitoring of associated outcomes. Local members of the community are able to access such intelligence, challenge low coverage of treatment and advocate for parity. In this context, the role that social media is likely to play also becomes significant in highlighting the impact and cost of this gap. Regular feedback and transparency highlights the level of unmet need and facilitates and improved outcomes through appropriate commissioning.

Although much public mental health intelligence is available, it is often missing for higher risk groups which highlight the lack of parity of measurement for some and the need for collection of such information to address their needs. Such data collection can accordingly make stakeholders aware of the need and accuracy of the data.

Achieving parity requires transparency and accountability for the framework for rights. Clear targets, indicators and outcomes must be identifiable and used to monitor the progressive realization of the changes. This includes regular assessment of the proportion of those with the different mental disorder including from higher risk groups who receive appropriate intervention. Safeguards in the structures and also the possibilities of redressal are required if and when human rights are violated including from lack of access to effective interventions to both treatment and prevention of mental disorders. The legal and policy framework must take into account and emphasize the obligations incumbent upon the government.

Policy and legal frameworks which enable action towards the goal of parity must also focus on a nation-state’s relationships outside its external boundaries. Such frameworks can also help develop and regulate relationships across international agencies. These frameworks can offer protection both to the state and to the individual. In addition, these frameworks offer a mechanism for ensuring the success of multi-sector action and activities in any given sector, especially in the treatment and prevention of mental disorder.

CONCLUSION

Despite the large impact of mental disorders and the existence of effective treatments, the majority of people with the mental disorder receive no intervention, which represents a violation of their right to health. This intervention gap can be addressed in a number of ways, which are underpinned by rights approach. Avoiding discrimination in mental health service planning and delivery is at the heart of human rights based parity in psychiatry. Transparency and accountability within the legal framework and clear indicators and outcomes are essential if parity is to be achieved.

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