

Minding Your Noggin: A comparative analysis of mental health care law in the U.S., U.K., and China.

Wilson

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I. INTRODUCTION

The United States (“U.S.”), United Kingdom (“U.K.”), and People’s Republic of China (“China”) each passed legislation bringing mental health care (“care”) into parity with physical health care.¹ Each country continues to struggle to meet the demand for care, in part, because the existing legislation fails to adequately provide for community-based treatment facilities and thousands of people continue to undergo involuntary commitment without due process of law. These results are out of line with the United Nations’

¹ Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3765 (2008); Mental Health Act 1983, c. 20 (Eng.); HH Chen et. al., MENTAL HEALTH LAW OF THE PEOPLE’S REPUBLIC OF CHINA (ENGLISH TRANSLATION WITH ANNOTATIONS), Shanghai Archives of Psychiatry (Dec. 2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4198897/>.

Convention on the Rights of Persons with Disabilities (“CRPD”).² To rectify the problem, legislators should adopt legislation to 1) complement the rights and liberties expounded in the CRPD,³ and 2) refine and narrow existing civil commitment legislation allowing for involuntary detainment of persons struggling with mental health.

For centuries before modern, though not perfect, approaches to mental health treatment were conceived of, the U.K., and later the U.S., viewed mental illness as a personal weakness and a wholly negative disease to be excised from an otherwise strong and healthy society.⁴ While historical evidence exists to suggest the Chinese culture took a more caring approach to treating mental illness, the problem was dealt with privately, within the family, away from a societal stigma similar to the country’s western neighbors.⁵ The effect was to relegate mental illness to the darkness, outside the gaze of others. In what follows, Section II will briefly offer an overview of the history of care in the countries at issue. Section III will look at modern approaches to care and how international goals established by the United Nations (“U.N.”) may or may not have had an impact on progress in each of the target countries. Finally, Section IV will offer a solution to a fragmented and often slow march to progress in achieving a mentally healthy society.

II. BACKGROUND OF THE ISSUE: A BRIEF HISTORY OF MENTAL HEALTH CARE IN EACH TARGET COUNTRY

This section will briefly delve into the history of care in the three countries at issue before the heavy institutionalization period of the mid-twentieth century, during the institutionalization period, and finally the process of deinstitutionalization.

A. Pre-deinstitutionalization

² Convention on the Rights of Persons with Disabilities, May 3, 2008, 2515 U.N.T.S. 3 [hereinafter CRPD].

³ *Id.*

⁴ See Catherine Ryan Gawron, *Funding Mental Healthcare in the Wake of Deinstitutionalization: How the United States and the United Kingdom Diverged in Mental Health Policy After Deinstitutionalization, and What We Can Learn From Their Differing Approaches to Funding Mental Healthcare*, 9 NOTRE DAME J. INT’L & COMP. L. 85, 89 (2019).

⁵ See Howard Chiang, *Introduction: Historicizing Chinese Psychiatry*, in *PSYCHIATRY AND CHINESE HISTORY*, 5 (Howard Chiang ed., 2014).

For centuries, mental health problems were addressed clinically only if the illness was severe or misunderstood.⁶ Persons suffering from a mental illness in the U.S. or U.K. were most often committed to an asylum or imprisoned.⁷ Committed persons were institutionalized and underwent psychosurgery against their express wishes, even if they retained decision-making capacity.⁸ In China, mental health problems were not discussed socially and were mostly confined to the family unit.⁹

1. In the U.K.

Reaching back to as far as 1247, the U.K. (comprising England, Wales, Scotland, and Northern Ireland) removed mentally ill persons from the community, essentially incarcerating them in “lunatic asylums” without medical treatment.¹⁰ The general attitude toward mental illness was that, rather than a medical problem, mental illness was a “moral or attitudinal problem” within the individual.¹¹ The first piece of mental health legislation was passed by the U.K. Parliament in 1774.¹² The Madhouses Act-1774 was passed to regulate the private “madhouses” where the landlords raked in profits while severely mistreating mentally ill persons.¹³ The act aimed to provide dignity and humane treatment to the mentally ill, and lasted five years before it underwent various iterations and re-adoptions, which left it significantly altered until its repeal in 1850.¹⁴

⁶ See Gawron, *supra* note 4, at 89.

⁷ “The pervasive idea until the mid-nineteenth century was that the mentally ill were, quite simply, mad. Society responded to such madness by removing affected individuals from society, through incarceration or placement in asylums. Removal was designed to assuage fear that these individuals could not function as members of society and would cause harm to their communities.” *Id.* (footnotes omitted).

⁸ See *id.* at 90.

⁹ See Chiang, *supra* note 5.

¹⁰ *Id.* at 101.

¹¹ *Id.* at 101.

¹² James Antony, *Mental Health Legislation: A Journey Back to “Madhouses Era?”*, 58 INDIAN J. PSYCH. 114, 118 (2016).

¹³ Madhouses Act 1774, 14 Geo. 3 c. 49 (Eng.).

¹⁴ Matthew Paul Rae, “*They too easily believe what they hear*” *The Victorian Insane Asylum, Accountability and the Problem of Perception, 1845-1890* 31-32 (2014) (MRes thesis, University of Kent) (on file with Kent Academic Repository). See Madhouses Law Continuation Act 1779, 19 Geo. 3 c. 15 (Eng.) (extending the initial 1774 legislation for a further seven years). See also Madhouses Law Perpetuation Act 1786, 26 Geo. 3 c. 91 (Eng.) (extending the legislation indefinitely), Madhouses Act 1828, 9 Geo. 4 c. 41 (Eng.) (repealing the 1774 Act and further bringing mental health care into government control).

The passage of the County Lunatic Asylums Act in 1845 overhauled the system of the time by requiring counties to set up institutions to house mentally ill persons, effectively ending the remnants of the private houses common in the preceding decades.¹⁵ The U.K. continued to expand government-run institutions for the mentally ill largely until the end of the twentieth century.¹⁶

2. In the U.S.

While there is little in the way of information on mental health treatment in the United States during the Colonial Period through the early nineteenth century, it is likely that attitudes among Americans toward mental health were similar to their English counterparts of the same period.¹⁷ By the 1830s, and through World War II, mental health institutions were regarded as a medical and societal achievement: “In providing for the mentally ill, the state met its ethical and moral responsibilities and, at the same time, contributed to the general welfare by limiting, if not eliminating the spread of disease and dependency.”¹⁸ From the 1830s through 1880, long-term institutionalization or custodianship was not the norm in state-run care facilities.¹⁹ In his research on mental health policy during that period in American history, Professor for the History of Medicine Gerald Grob said, “[T]he prevailing belief was that a mental hospital with 200 beds could treat approximately 600 patients during a twelve-month period.”²⁰ Research conducted in the 1880s pointed to a net benefit in this short-term institutionalization: finding that 58 percent of people discharged from hospitals as “recovered” had “functioned in the community without relapse.”²¹

At the turn of the twentieth century and through World War II, long-term institutionalization in state-sponsored facilities for chronic mental illness rose dramatically.²² In 1904, 27.8 percent of the patient population nationwide had

¹⁵ County Asylums Act 1845, 8 & 9 Vict. c. 126 (Eng.).

¹⁶ See Gawron, *supra* note 4, at 102.

¹⁷ See Abigail Coy, *Mental Health in Colonial America*, THE HOSPITALIST (May 2006), <https://www.the-hospitalist.org/hospitalist/article/123117/mental-health-colonial-america#:~:text=Insanity%20in%20colonial%20America%20was,them%20were%20fueled%20by%20cruelty>.

¹⁸ Gerald N. Grob, *Mental Health Policy in America: Myths and Realities*, 11 HEALTH AFFAIRS 8 (1992).

¹⁹ *Id.* at 8-9.

²⁰ *Id.* at 9.

²¹ *Id.* (citing Worcester State Lunatic Hospital, *Annual Report* 61, 70 (1893)).

²² See *id.* at 10-11.

been institutionalized for twelve months or less, falling to 17.4 percent in 1923.²³ Patients institutionalized for five years or more was at 39.2 percent of the patient population nationwide in 1904 and rose to 54 percent by 1923.²⁴ Nationwide data for the same figures are unavailable after 1923, however, by the 1930s, 80 percent of mental health patients in Massachusetts were institutionalized in long-term care for chronicity.²⁵ The change is due in part to the alteration of the funding structure of care facilities during the period.²⁶

Prior to state-level legislation centralizing the care structure at the turn of the twentieth century, the cost of care in facilities was put on the local communities, specifically the individual patient or family of the patient.²⁷ As a result, a significant number of those struggling with mental illness either went untreated or were admitted to municipal almshouses.²⁸ State centralization starting in the 1880s absolved local communities of any role in care.²⁹ State institutions claiming new scientific and medical methods for treating mental illness began resorting to psychosurgery, electroconvulsive therapy, and other similarly cruel—and even violent—techniques.³⁰ Abuse of mental health patients continued in this way until the period of deinstitutionalization beginning in the 1950s.³¹

3. In China

Prior to the nineteenth century in China, mental health was monitored in communities, but discussion and treatment of mental health problems were

²³ *Id.* at 11 (citing *Insane and Feeble-Minded in Hospitals and Institutions*, 37 (1904); *Patients in Hospitals for Mental Disease*, 36 (1923)).

²⁴ *Id.*

²⁵ *See id.* (citing N. A. DAYTON, *New Facts on Mental Disorders: Study of 89,190 Cases*, 414-29 (Charles C. Thomas ed., 1940)).

²⁶ *See id.* at 10.

²⁷ *Id.* at 9.

²⁸ *Id.* at 9-10. Further, municipal almshouses became catch-all homes for the impoverished, mentally ill, and groups of people the society of the time deemed unfit to exist among the dominating social classes. DAVID WAGNER, *THE POORHOUSE: AMERICA'S FORGOTTEN INSTITUTION* (2005).

²⁹ *Id.* at 10.

³⁰ *See* Gawron, *supra* note 4, at 89-90.

³¹ *Id.* at 90-91. "In the early to mid-twentieth century, it became clear that individuals being 'treated' in psychiatric institutions were not being treated at all. They were either warehoused away from their communities in squalid conditions, or, more likely, involuntarily undergoing abusive medical procedures to 'treat' their mental illness."

confined to the family unit, not professionals.³² While indigenous doctors during that time were mindful of mental disorders, institutionalization of people struggling with mental illness was not considered until the late nineteenth century.³³ Confucian morals and values followed during the period advocated for familial responsibility for individuals struggling with mental illness.³⁴ The concentration on family and kinship attempted to create a culture of community-based tolerance and understanding of mental health problems rather than imposing a “physician-centered obligation.”³⁵ Little information is available about mental health treatment in China before the turn of the twentieth century, however, it is clear from the foregoing information that mental health was dealt with in close quarters amongst one’s family.

Medical missionaries appeared in China in the late nineteenth century and established the first psychiatric hospital in 1898 in Guangzhou.³⁶ This led to a chain reaction, with five major institutions subsequently developing in the country.³⁷ Institutions for mental health were, until 1898, non-existent, but even after the establishment of institutions in major geographic areas across the country, “mental health services in China were rare and confined to the influence of the western missionary” before the establishment of Communist China.³⁸ While formal medical training for psychiatrists did not begin in China until 1932, by 1926 an estimated 3 million Chinese persons had mental illnesses with about 1.3 million (43%) of that population institutionalized.³⁹ To further illustrate the scarcity of formal treatment during this period, Professors Doris Chang and Arthur Kleinman found that “[b]y 1948, China had only around 60 psychiatrists and five psychiatric hospitals with a total of 1,100 beds for a population of nearly 500 million people.”⁴⁰

³² See Chiang, *supra* note 5. For more detailed information on pre-twenty-first century mental health treatment practices in China see Brigid E. Vance, Hsiu-fen Chen, & Fabien Simonis, *Part I: Historical Precedents*, in *PSYCHIATRY AND CHINESE HISTORY*, 17 (Howard Chiang ed., 2014).

³³ See Chiang, *supra* note 5.

³⁴ *Id.*

³⁵ *Id.*

³⁶ Kam-Shing Yip, *AN HISTORICAL REVIEW OF THE MENTAL HEALTH SERVICES IN THE PEOPLE’S REPUBLIC OF CHINA*, 51 *INT’L J. SOC. PSYCHIATRY* 107 (2005).

³⁷ See *id.* at 107-08.

³⁸ *Id.* at 107.

³⁹ *Id.* at 108 (citing J.L. MCCARTNEY, *NEUROPSYCHIATRY IN CHINA: A PRELIMINARY OBSERVATION*, 42 *J. OF CHINESE MED.* 616 (1920)).

⁴⁰ DORIS F. CHANG & ARTHUR KLEINMAN, *GROWING PAINS: MENTAL HEALTH CARE IN A DEVELOPING CHINA*, 1 *YALE-CHINA HEALTH J.* 85, 87 (2002).

Conduct toward mental health during the Maoist period shifted away from treatment, medical or otherwise, and toward re-education to correct what was seen as wrong political thought processes.⁴¹ During that period, the political indoctrination of people considered mentally ill functioned in three ways. First, by mutual collective help which separated patients into fighting groups where, in theory, they would learn to rely on each other and fight for the common Maoist goal.⁴² Second, patients needed to learn self-reliance, meaning patients needed to understand their illness and recognize it as capitalistic indoctrination that could be cured by Marxist and Leninist thoughts and attitudes.⁴³ Finally, patients attended study groups to study “Mao’s works, such as ‘On Practice’, ‘On Contradiction’, ‘Serve the people’, ‘The Foolish Old Man Who Moved the Mountain’, and ‘Where Do Correct Ideas Come From.’”⁴⁴ The thought was that studying Mao’s works would cure the patients through reflection and self and mutual criticism.⁴⁵

At the end of the Cultural Revolution,⁴⁶ by 1976, psychiatry and mental health care were revitalized by development and extension of state-run services, education for mental health professionals, and a more concentrated focus on care leading up to the period of deinstitutionalization.⁴⁷

B. Deinstitutionalization

In the 1950s, the U.S. began the movement away from institutionalization⁴⁸ and the mindset that those struggling with mental illness needed to be removed from society for their own good.⁴⁹

1. In the U.S.

By 1955, under the leadership of President John F. Kennedy, a movement away from segregating mentally ill people led to the closure of asylums and the

⁴¹ *Id.*

⁴² See Yip, *supra* note 36, at 109.

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ Paul Clark, *China’s Cultural Revolution was a sociopolitical movement spearheaded by Mao Zedong in a bid to reassert his control over the Communist Party*, in *THE CHINESE CULTURAL REVOLUTION: A HISTORY* (2008).

⁴⁷ See Yip, *supra* note 36, at 87-88.

⁴⁸ See Gawron, *supra* note 4, at 91. See also Chang & Kleiman, *supra* note 40, at 13-14.

⁴⁹ *Id.*; See Gawron, *supra* note 4, at 101.

integration of those struggling with mental illness back into the community.⁵⁰ The movement was significant: “[F]rom 1955 to 1994, there was an approximately ninety percent reduction of those living in public psychiatric hospitals and institutions.”⁵¹ The first major legislative shift came in 1963 when Congress passed the Mental Health Retardation Facilities Construction Act, re-named the Community Mental Health Act (“CMHA”).⁵² The legislation effectively ended support for state-run mental health institutions, and instead funded community-based mental health treatment and research facilities.⁵³ While the legislation was a good first step toward better care and more progressive thinking toward mental health, its implementation led to undesirable results.

Congress’s intent in passing the CMHA was to improve care conditions for mentally ill persons by releasing them from the institutional setting and transitioning care to community-based outpatient social and medical services.⁵⁴ The effect, however, was that formerly institutionalized patients had nowhere to go and no care to rely on because the infrastructure for community-based treatment had not developed sufficiently to support the significant migration.⁵⁵ The lack of resources available led to disproportionately high rates of homelessness among the population of people suffering from mental illness.⁵⁶ By the 1990s, “one-third of the homeless population had a mental illness.”⁵⁷ Today, the Department of Housing and Urban Development reported that about one in five homeless individuals suffer from a serious mental illness, specifically 111,122 out of 552,830 homeless individuals.⁵⁸ With nowhere to go, the prison system housed more and more people with mental illness. While hundreds of thousands found themselves outside the grasp of the poor conditions of mental institutions, by the 1980s, six to ten percent of the prison population suffered from a mental illness.⁵⁹ By

⁵⁰ See Gawron, *supra* note 4, at 91.

⁵¹ *Id.*

⁵² *Mental Retardation Facilities Construction Act*, Pub. L. 88-164, 77 Stat. 282 (1963).

⁵³ *Id.*

⁵⁴ See Gawron, *supra* note 4, at 92-3.

⁵⁵ *Id.* at 93.

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ U.S. DEP’T OF HOUSING AND URBAN DEV., CONTINUUM OF CARE HOMELESS ASSISTANCE PROGRAMS HOMELESS POPULATIONS AND SUBPOPULATIONS (2018).

⁵⁹ Seth J. Prins, *The Prevalence of Mental Health in U.S. State Prisons: A Systematic Review*, 65 PSYCHIATRIC SERVS. 862, 866 (2014); Doris J. James & Lauren E. Glaze, U.S. DEP’T OF JUSTICE,

2006, about half of prison inmates suffered from mental illness.⁶⁰ Prison conditions were no better, and perhaps worse, than the mental health institutions.⁶¹

Facing high demand for mental health services and few care resources, Congress passed legislation to bring mental health treatment into parity with physical health treatment.⁶² The Mental Health Parity Act (“MHPA”), passed in 1996, required that lifetime dollar limits under group health insurance plans for mental health care were no lower than the same limits for physical health care.⁶³ Prior to this legislation, insurers were not required by law to cover mental health care; thus access to care was severely limited. Amended in 2008, the Mental Health Parity and Addiction Equity Act preserved the requirements of the MHPA and added protections extending parity to substance use disorders.⁶⁴ Upon passage of the Affordable Care Act in 2010, Congress decided that in addition to the protections offered by the preceding legislation, insurers may not deny coverage to persons with pre-existing mental health problems, and may not limit mental health care in terms of finance, treatment, and care management more than limits applied to physical care.⁶⁵

Important to note is that in the employment context, the Americans with Disabilities Act of 1990 (“ADA”) protects individuals suffering from severe mental illness from unfair employment considerations by employers.⁶⁶

2. In the U.K.

While the history and treatment of mental illness in the U.K. was similar to the U.S., the countries diverged on their approaches to deinstitutionalization.⁶⁷ The onslaught of deinstitutionalization was slower in the U.K. than in the U.S., which resulted in less of an immediate shock to the

MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES: BUREAU OF JUSTICE STATISTICS SPECIAL REPORT 1 (2006).

⁶⁰ *Id.*

⁶¹ See Gawron, *supra* note 4, at 95.

⁶² Mental Health Parity Act, Pub. L. 104-204, 110 Stat. 2874 (1996); Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343, 122 Stat. 3765 (2008); Affordable Care Act, 42 U.S.C § 18001 (2010).

⁶³ Mental Health Parity Act, Pub. L. 104-204, 110 Stat. 2874 (1996).

⁶⁴ Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343, 122 Stat. 3765 (2008).

⁶⁵ Affordable Care Act, 42 U.S.C § 18001.

⁶⁶ Americans with Disabilities Act, 42 U.S.C. § 12101.

⁶⁷ See Gawron, *supra* note 4, at 100.

system when formerly institutionalized people moved back into the community. However, ultimately the U.K. too struggled with implementing community-based resources voluminous enough to care for so many people.⁶⁸

Medical treatment, both physical and mental, is administered through the National Health Service (“NHS”).⁶⁹ The NHS was established in 1948, and coupled with the social and political movements of the 1950s, closure of the Victorian age mental health institutions began.⁷⁰ While progress toward community-based treatment facilities was slower than the shift in the U.S., the first move toward outpatient care came in 1930 with the passage of the Mental Treatment Act.⁷¹ That legislation encouraged institution leaders to invest in outpatient departments to combat the increasing institutionalized patient population.⁷²

The passage of the 1959 Mental Health Act was the first time distinctions between involuntary and voluntary treatments for institutionalized mental health patients became clearer.⁷³ The goals of the act were largely based on a movement away from involuntary medical treatment towards voluntary treatment, with a central tenet being that when treatment was necessarily compelled, it should be based on a sound legal framework.⁷⁴ The 1959 Mental Health Act repealed the Mental Treatment Act of 1930 but retained the spirit of the legislation by promoting outpatient care.⁷⁵

Leading up to the 1980s, the U.K. began prioritizing mental health treatment; however, the progress was mired by scarce funding and, like its western neighbor, too few community-based care resources.⁷⁶ The Mental Health Act of 1983 is the basis of the modern statutory framework for mental

⁶⁸ *Id.*

⁶⁹ *Id.* at 100-01.

⁷⁰ Helen Killaspy, *From the Asylum to Community Care: Learning From Experience*, 79-80 BRITISH MED. BULL. 245, 248 (2007).

⁷¹ *Id.* at 248.

⁷² *Id.*

⁷³ Mental Health Act 1959, c. 20 (UK).

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ See Gawron, *supra* note 4, at 102; see also *id.* at 101-02 (citing remarks given by then-Minister of Health Enoch Powell in 1961 concerning the government’s advocacy for changes to the institutional model of mental health care)(“We have to strive to alter our whole mentality about hospitals and about mental hospitals especially [A] hospital is a shell, a framework, however complex, to contain certain processes, and when the processes change or are superseded, then the shell must most probably be scrapped.”).

health in the U.K.⁷⁷ Aimed at funding treatment centers and limiting circumstances under which a person could be involuntarily committed to an institution for mental illness, the 1983 iteration of the Mental Health Act established the scaffolding upon which the NHS began to build comprehensive mental healthcare nationwide.⁷⁸

3. In China

Following the Maoist period—when psychology was deemed “bourgeois pseudoscience” and was then abolished during the Cultural Revolution⁷⁹—demand for professional mental health treatment saw a boom.⁸⁰ After years of stunted research and education in psychology and care practices, many psychiatrists and other care professionals were not equipped to handle widespread demand for care.⁸¹

In 1958, following the founding of the People’s Republic of China in 1949, the first National Mental Health Meeting took place.⁸² After that meeting, officials put into action a community mental health plan that provided for professional training facilities and the development of “work plans for the prevention and treatment of psychoses, including early detection and treatment and relapse prevention.”⁸³

The committee met again in 1986 for the Second National Meeting on mental health services.⁸⁴ Here, the committee assessed the lingering inadequacies in the care system.⁸⁵ The State Council later adopted the findings from that meeting and created a formal document laying out the problems⁸⁶ as follows:

⁷⁷ Mental Health Act 1983, c. 20 (Eng.).

⁷⁸ *Id.*; see also Gawron, *supra* note 4, at 103.

⁷⁹ Hsuan-Ying Huang, *The Emergence of the Psycho-Boom in Contemporary Urban China*, *PSYCHIATRY AND CHINESE HIST.*, 183 (2014); see also Yip, *supra* note 36, at 109.

⁸⁰ *Id.* at 185.

⁸¹ *Id.* at 185-86.

⁸² Jin Liu et al., *Mental Health System in China: History, Recent Service Reform and Future Challenges*, 10 *WORLD PSYCHIATRY* 210 (2011).

⁸³ *Id.*

⁸⁴ See Yip, *supra* note 36, at 110.

⁸⁵ *Id.*

⁸⁶ See Yip, *supra* note 36, at 110; see also Veronica Pearson, *The Chinese Equation in Mental Health Policy and Practice: Order Plus Control Equal Stability*, 19 *INT’L J. L. AND PSYCHIATRY* 437 (1996).

- Inadequate knowledge and understanding about the importance of mental health to the mental civilization of the whole country;
- Drastic increase in the prevalence of mental illness from 0.7% in 1970s to 1.54% in the 1980s;
- Insufficiency and shortfalls in treatment facilities such as hospital beds and rehabilitation services. It was estimated that 80% of patients were not able to receive treatment and 95% of patients could not be admitted to hospitals[;]
- Many mental hospitals were poorly funded which needed urgent repairs and renovations [;]
- Poor community support leading to outbreak of crimes, violent and disturbing behaviors that threatened the safety of the community [;]
- Poor coordination among treatment and rehabilitation services [;]
- Very inadequate training and social recognition of mental health workers.

Between the 1980s and the turn of the millennium, China continued to rely on state run institutions to provide care, while recognizing the system was deficient and in need of significant improvements.⁸⁷ In 2004, China implemented the “686 Programme,” named for the program’s initial funding allocation of 6.86 million yuan (approximately \$840,000 USD), which aimed to “integrate hospital and community services for patients with serious mental illness.”⁸⁸ In the intervening 12 years, this community-based approach to care netted 3.146 million patients who participated in community follow-up visits, 1.4185 billion yuan (about \$219 million USD) in national government funding, and an additional 730.6 million yuan (about \$112 million USD) in local government funding.⁸⁹ The numbers suggest that this program is thriving, and while it appears to be successful, it has not captured the volume and demand for care.⁹⁰

⁸⁷ See Liu, *supra* note 82, at 211 (stating that during the 1990s, mental health professionals began “to doubt the rationale for large hospital-based and profit-making models for mental health service delivery, and the Ministry of Health began to reconsider principles and approaches for mental health care.”).

⁸⁸ Di Liang, Vickie M. Mays & Wei-Chin Hwang, *Integrated Mental Health Services in China: Challenges and Planning for the Future*, 33 HEALTH POL’Y. AND PLAN. 107 (Oct. 13, 2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5886187/>.

⁸⁹ *686 Programme*, The Mental Health Innovation Network, <https://www.mhinnovation.net/innovations/686-programme> (last visited Nov. 8, 2019).

⁹⁰ See Liang, Mays & Hwang, *supra* note 88.

Even after the passage of its Mental Health Law in 2012, China continues to struggle with access to care, stigma, and managing the implementation of accessible community-based care facilities.⁹¹ As of 2014, 173 million people suffering from “diagnosable psychiatric disorders” had access to only 757 mental health facilities.⁹² There was one psychiatrist for approximately every 8,448 people seeking mental health treatment.⁹³

The resurgence of deinstitutionalization led to a cultural awakening whereby poor mental health conditions were viewed as an under addressed reality that must be fixed by community resources and growing acceptance and tolerance for mental health problems. While each of the target countries has passed legislation attempting to remedy problems, critical issues relating to access to treatment and the resulting stigma of living with a mental health problem persist.

III. UNDERSTANDING THE CURRENT CLIMATE: THE CRPD AND IMPLEMENTATION OF MENTAL HEALTH TREATMENT POLICIES

A. *The CRPD and the Multilateral Treaty Process*

The United Nations’ Convention on the Rights of Persons with Disabilities (“CRPD”)⁹⁴ is a human rights treaty that expounds language detailing how persons with a disability must be treated.⁹⁵ It was adopted on December 13, 2006 by the United Nations General Assembly.⁹⁶ “The Convention was negotiated during eight sessions of an Ad Hoc Committee of the General Assembly from 2002 to 2006, making it the fastest negotiated human rights treaty.”⁹⁷ The CRPD was later ratified by 180 member states and signed by 162 member states, including the U.K. and China, which signed and ratified the CRPD, and the U.S., which only signed the CRPD.⁹⁸

⁹¹ *Id.*

⁹² Yang Shao, Jijun Wang & Bin Xie, *The First Mental Health Law of China*, 13 *ASIAN J. OF PSYCHIATRY* 72-74 (2015).

⁹³ *See id.*

⁹⁴ CRPD, *supra* note 2.

⁹⁵ CRPD, *supra* note 2.

⁹⁶ *Id.*

⁹⁷ CRPD, *supra* note 2.

⁹⁸ CRPD, Ratifications and Signatures of the CRPD and Optional Protocol, May 3, 2008, 2515 U.N.T.S. 3, [https://treaties.un.org/doc/Publication/MTDSDG/Volume%20I/Chapter%20IV/IV-15.en.pdf_\(last visited Oct. 11, 2019\)](https://treaties.un.org/doc/Publication/MTDSDG/Volume%20I/Chapter%20IV/IV-15.en.pdf_(last%20visited%20Oct.%2011,%202019)); The U.K. and China ratified the convention subject to exceptions relating to national sovereignty and free movement of persons while the U.S. did not acquiesce to be bound by the convention. *See id.*

It is important to note the difference between simply signing a treaty and signing and ratifying a treaty. When a member state signs and ratifies a treaty, it agrees to be bound by the treaty's terms and enact domestic legislation to effectuate those terms.⁹⁹ Signing a treaty subject to ratification, acceptance, or approval lacks the key binding commitment to the treaty.¹⁰⁰ Therefore, if a member state signs and ratifies a treaty, it must enact domestic legislation to effectuate the treaty's terms, while the act of signing a treaty alone signals approval of the treaty's terms but does not require any further action on the part of the member state to enact domestic legislation effectuating its terms.¹⁰¹ Further, the CRPD is a multilateral as opposed to a bilateral treaty, meaning it includes more than two nations. The practical difference lies mostly in the ratification process. Where bilateral treaties are normally ratified by exchanging the requisite instruments, multilateral treaties include an open time frame for member states to obtain the required domestic approval and give notices of ratification to the U.N.¹⁰²

Here, the U.K. signed the CRPD on March 30, 2007 and ratified it on June 8, 2009.¹⁰³ China signed the CRPD on March 30, 2007 and ratified it on August 1, 2008.¹⁰⁴ The U.S. signed the CRPD on July 30, 2009 (over two years after it was open for signature), and has yet to ratify it.¹⁰⁵

A note on the relationship between the U.K. and the European Union ("EU") as it relates to the CRPD: as noted above, the U.K. signed and ratified the treaty in its individual sovereign capacity; additionally, the EU signed the CRPD on March 30, 2007 and formally confirmed the CRPD on December 23, 2010.¹⁰⁶ According to a declaration by the EU, included in the notes following the official status log of the CRPD, the European community is only bound to the extent individual EU member states signed and ratified the CRPD.¹⁰⁷ In

⁹⁹ Vienna Convention on the Law of Treaties, May 23, 1969, 1155 U.N.T.S 331 [hereinafter Vienna Convention].

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ Ratifications and Signatures of the CRPD, *supra* note 98, at 3.

¹⁰⁴ *Id.* at 1.

¹⁰⁵ *Id.* at 3.

¹⁰⁶ *Id.* at 2.

¹⁰⁷ See Ratifications and Signatures of the CRPD, *supra* note 98, at 4, Declarations and Reservations, European Union (stating "[p]ursuant to Article 299, this Declaration is not applicable to the territories of the Member States in which the said Treaty does not apply and is without prejudice to such act or positions as may be adopted under the Convention by Member States concerned on behalf and in the interests of those territories").

other words, the EU does not bind its member states to the CRPD by its own act of signing and formally confirming the treaty.

By way of illustration, the Paris Agreement is a good example of the effect of signatures, ratifications, accessions, acceptances and withdrawals from multilateral U.N. treaties. The Paris Agreement is a multilateral U.N. environmental treaty designed to decrease global greenhouse gas emissions.¹⁰⁸ It builds on the United Nations Framework Convention on Climate Change which recognizes a global climate change crisis and aims to prevent “dangerous [human] interference with the climate system.”¹⁰⁹

First, the U.S., U.K. and China each signed and ratified or accepted the Paris Agreement in 2016.¹¹⁰ By these actions, each country bound itself in some way to the Agreement. Between ratification and the present, each country undertook measures to decrease its overall greenhouse gas emissions.¹¹¹ The U.S., under President Barack Obama, accepted the Paris Agreement by executive agreement, without formal U.S. Senate approval.¹¹² Scholars debated the constitutionality of President Obama’s acceptance, but ultimately the U.S. followed the terms of the Paris Agreement through the rest of Obama’s tenure in office.¹¹³ The takeaway here is that President Obama committed the U.S. to the Paris Agreement.

The most common actions that, taken alone, bind a country to a U.N. treaty are ratification, accession, and acceptance or approval.¹¹⁴ Equally important is

¹⁰⁸ Paris Agreement, Dec. 12, 2015, C.N.63.2016.TREATIES-XXVII.7.d [hereinafter Paris Agreement].

¹⁰⁹ United Nations Framework Convention on Climate Change, art. 2, May 9, 1992, 1771 U.N.T.S. 107 [hereinafter UNCCC].

¹¹⁰ See Paris Agreement, *supra* note 108.

¹¹¹ See *China Meets 2020 Carbon Target Three Years Ahead of Schedule*, UN CLIMATE CHANGE NEWS (Mar. 28, 2018), <https://unfccc.int/news/china-meets-2020-carbon-target-three-years-ahead-of-schedule>; “How the UK is progressing,” COMMITTEE ON CLIMATE CHANGE (last visited Nov. 8, 2019); Nic Robertson et al., *Obama Defends Paris Climate Accord as Trump Mulls Ditching It*, CNN (May 9, 2017, 10:28 AM), <https://www.cnn.com/2017/05/09/politics/obama-climate-change-paris-agreement-italy/index.html>.

¹¹² See Tanya Somanader, *President Obama: The United States Formally Enters the Paris Agreement*, OBAMA WHITE HOUSE ARCHIVES (Sept. 3, 2016, 10:41 AM), <https://obamawhitehouse.archives.gov/blog/2016/09/03/president-obama-united-states-formally-enters-paris-agreement>. It is unclear whether President Obama’s executive agreement was constitutional.

¹¹³ See Rebecca Harrington, *Here’s What the US Actually Agreed to in the Paris Climate Deal*, BUSINESS INSIDER (June 1, 2017, 2:58 PM), <https://www.businessinsider.com/what-did-us-agree-to-paris-climate-deal-2017-5>.

¹¹⁴ See Vienna Convention, *supra* note 99.

the act of withdrawal. The Paris Agreement included a provision for how countries may withdraw.¹¹⁵ President Donald Trump announced the U.S.'s withdrawal from the Agreement in 2017, just over a year since President Obama's act of acceptance.¹¹⁶ The terms of withdrawal from the Paris Agreement required a three year cooling off period from the time a country bound itself to the Agreement.¹¹⁷ Thus, President Trump could not formally withdraw the U.S. as a party to the Agreement until November 2019.¹¹⁸ Trump announced his administration's formal intent to leave the Paris Agreement on Nov. 4, 2019.¹¹⁹ This triggered the withdrawal process.

Important to illustrate here is that the U.S. bound itself to the Paris Agreement through acceptance.¹²⁰ Since the U.S. bound itself through executive action rather than through Senate action, the executive may presumably withdraw from the same agreement.

While President Trump made clear when he took office that the U.S. would withdraw from the Paris Agreement, as a party to the Agreement, the U.S. was obligated to participate.¹²¹ Delegates from the U.S. attended international meetings and were influential in policy meetings regarding the implementation and progress of the Paris Agreement until the U.S.'s formal withdrawal.¹²² The U.S.'s continued participation, even after the announcement of withdrawal, illustrates the impact binding a country to a treaty has on its actions.

While not on track to meet the goal it set when it joined the Paris Agreement, the U.S. is on track to cut half as much carbon emissions as it promised.¹²³ Thus, even though a new presidential administration was forceful

¹¹⁵ See Paris Agreement, *supra* note 108.

¹¹⁶ See Brady Dennis, *Trump Makes it Official: U.S. Will Withdraw from the Paris Climate Accord*, WASH. POST (Nov. 4, 2019), <https://www.washingtonpost.com/climate-environment/2019/11/04/trump-makes-it-official-us-will-withdraw-paris-climate-accord/>.

¹¹⁷ See Paris Agreement, *supra* note 108.

¹¹⁸ *Id.*

¹¹⁹ See Dennis, *supra* note 116.

¹²⁰ See Paris Agreement, *supra* note 108.

¹²¹ *Id.*

¹²² See Carolyn Beeler, *Nov. 4 is the First Day Trump Can Legally Leave the Paris Accord*, PUB. RADIO INT'L (Nov. 1, 2019, 4:30 PM), <https://www.pri.org/stories/2019-11-01/nov-4-first-day-trump-can-legally-leave-paris-accord>.

¹²³ *Id.*

in its intent to the leave the agreement, the U.S. is still making progress under the Paris Agreement because it was bound through accession.

Note again that the U.S. did not ratify, accept, or accede to the CRPD while both the U.K. and China did.¹²⁴ The U.S. merely signed the CRPD, signaling its approval of the overall framework of the treaty, but refused to commit itself to action.¹²⁵ The U.S. was bound to, or committed to act upon, the terms of the Paris Agreement.¹²⁶ That relationship does not exist under the CRPD.

B. The CRPD and Current Legislation of Member States

Implicit in the language of the CRPD is equal access to treatment and the requirement that laws relating to personal autonomy and mental capacity must show deference to, and yield to, the express wishes of each person with decision-making capacity, regardless of disability.¹²⁷ While problems with mental health, like physical health, fall on a spectrum, more severe cases may be a disability. Article 17 of the CRPD in particular acknowledges that every person “has a right to respect for his or her physical and mental integrity on an equal basis with others.”¹²⁸ The questions addressed here are 1) what framework each country has relating to when a person is deemed to have decision-making capacity, and at what point the government can place a person in institutional care without the person’s express consent, and 2) how accessible the care system is in each target country.

1. In the U.S.

Mental health laws in the U.S. are more developed and consistent with the goals of the CRPD, even though the U.S. is not bound by the CRPD.¹²⁹ Statutes specifically addressing mental capacity apply to criminal proceedings, ensuring that the court is satisfied that the accused understands what is happening during the proceeding and providing affirmative defenses.¹³⁰ As early as 1980, Congress adopted a “Bill of Rights” for “Mental Health Rights and Advocacy.”¹³¹ This legislation codifies principles for care that were lacking

¹²⁴ See CRPD, *supra* note 2.

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ See CRPD, *supra* note 2, arts. 3, 4, 12, 14, 17, 25.

¹²⁸ CRPD, *supra* note 2, art. 17.

¹²⁹ CRPD, *supra* note 2.

¹³⁰ 18 U.S.C. § 4241 (2012).

¹³¹ 42 U.S.C. § 9501 (2012).

during the period of institutionalization. Specifically, it allows for an institutionalized patient to receive all pertinent information regarding their course of treatment, it codifies the presumption that adults maintain decision-making capacity unless adjudicated otherwise by a court of law, and it requires consultation with the patient and consent from the patient before advancing a course of treatment.¹³² While the statute here expounds necessary rights for the patient population, it is important to note that following the U.S. Supreme Court case *O'Connor v. Donaldson*, each state maintained civil commitment criteria for involuntary treatment of persons struggling with mental illness.¹³³

O'Connor involved a man, Donaldson, diagnosed with paranoid schizophrenia who was involuntarily held in a psychiatric hospital for 15 years.¹³⁴ His requests for release were continuously denied, all while he showed no evidence of suicidal intent or intent to harm others.¹³⁵ On review concerning Donaldson's liberty interests, the U.S. Supreme Court held that patients may be held involuntarily when they either present a known risk to themselves or others or are in such a state that they would be "hopeless to avoid the hazards of freedom," or are in need of psychiatric treatment.¹³⁶ Persons struggling with mental problems may not be held involuntarily "without more."¹³⁷ The "more" referred to by the court is generally found to mean treatment.¹³⁸ The rule here appears clear; however, the U.S. continues to struggle with its application as it applies to the standards in each state.¹³⁹ Some states still allow direct involuntary admittance to hospitals, subject to time limitations.¹⁴⁰

While the presumption of competency for adults to make decisions for themselves related to their mental wellbeing is a principle of American

¹³² *Id.*

¹³³ Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 PSYCHIATRY (EDGMONT) 30 (2010).

¹³⁴ *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ Testa & West, *supra* note 133.

¹³⁹ See *supra* text accompanying note 133 (stating that state hospitals continued to admit patients directly to said hospitals against their wishes while questions of the person's procedural due process rights remained uncertain).

¹⁴⁰ See *supra* text accompanying note 133.

law,¹⁴¹ the treatment of mentally struggling members of the prison population,¹⁴² the remaining stigma attached to seeking treatment, and the lack of access to care¹⁴³ significantly hampers the ability of the U.S. to put into practice the goals of the CRPD.

2. In the U.K.

In 2005, the U.K. enacted the Mental Capacity Act, which codified some longstanding common law rules concerning mental capacity and established key principles for understanding mental capacity.¹⁴⁴ The statutory test by which professionals measure an individual's capacity to make decisions is based on a presumption that adults retain decision-making capacity unless the clinician had a "reasonable belief" that the patient lacked capacity and the clinician's actions were in the best interests of the patient.¹⁴⁵ "[A] person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain."¹⁴⁶

English case law is illustrative of the statutory principles. In *Re T*, a Jehovah's Witness was given a blood transfusion when he was unable to give or refuse consent.¹⁴⁷ The court there decided that the gravity of the circumstances were relevant to whether the patient's capacity was sufficient for the refusal of treatment to be respected.¹⁴⁸ There the physician made the correct determination.

¹⁴¹ For an example of codification of this principal in U.S. law see, D.C. Code § 21-2203 (2019); see also 18 U.S.C § 9501 (2012).

¹⁴² Lorna Collier, *Incarceration Nation: The United States Leads the World in Incarceration. A New Report Explores Why—and Offers Recommendations for Fixing the System*, 45 AM. PSYCHOL. ASS'N 56 (2014).

¹⁴³ National Alliance on Mental Illness, *Mental Health By the Numbers*, (last updated Sept. 2019), <https://www.nami.org/mhstats> [hereinafter NAMI].

¹⁴⁴ Mental Capacity Act 2005, c. 9 (UK), <https://www.legislation.gov.uk/ukpga/2005/9/contents>.

¹⁴⁵ *Id.*

¹⁴⁶ Mental Capacity Act, *supra* note 144, at § 2(1); see also Timothy R. J. Nicholson, William Cutter & Matthew Hotopf, *Assessing Mental Capacity: The Mental Capacity Act*, 336 BMJ 322 (2008) ("For a person to lack capacity, he or she must have an impairment of or disturbance in the functioning of the brain or mind, and this defect must result in the inability to understand, retain, use, or weigh information relevant to a decision or to communicate a choice.").

¹⁴⁷ Re "T." [1992] EWCA Civ 18 (Eng.).

¹⁴⁸ *Id.* ("[W]hat matters is that the doctors should consider whether at that time he had a capacity which was commensurate with the gravity of the decision. The more serious the decision, the greater the capacity required.").

In another mental capacity case, *Re B*, the court held that, after detailed review, the actions of two treating psychiatrists to allow B's decision to turn off her ventilator was acceptable because "her mental competence is commensurate with the gravity of the decision she may wish to take."¹⁴⁹ The court further noted that "[i]f refusal [of medical treatment] might have grave consequences for the patient, it is most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences."¹⁵⁰

The presumption of decision-making capacity is clear, although like the U.S., the U.K. allows for involuntary commitment (informally referred to as "detaining" or "sectioning") under sections 2 and 3 of the Mental Health Act for periods of assessment and treatment. Involuntary commitment is supposed to last no longer than six months, though the period may be renewed.¹⁵¹ Since 2005, the U.K. saw a 34 percent increase in the number of people detained under the Mental Health Act.¹⁵² In 2016, nearly 64,000 people were detained under that law.¹⁵³

While the U.K. chose to be bound by the CRPD, care in the country continues to struggle due to lack of access, funding, and the accompanying stigma.¹⁵⁴ Indeed, access to care provided through the NHS is the most significant problem standing between the U.K. and meeting the aims of the CRPD.¹⁵⁵

3. In China

China, too, chose to bind itself to the goals of the CRPD in 2008; however, despite passing its Mental Health Law in 2012, the country continues to struggle with access to care.¹⁵⁶

¹⁴⁹ *Ms B v. An NHS Hospital Trust* [2002] EWHC 429 (Fam) (Eng.).

¹⁵⁰ *Id.*

¹⁵¹ See Mental Health Act, *supra* note 73, §§ 2-3.

¹⁵² David Brown & Nick Triggles, *Mental Health: 10 Charts on the Scale of the Problem*, BBC NEWS (Dec. 4, 2018), <https://www.bbc.com/news/health-41125009>.

¹⁵³ *Id.*

¹⁵⁴ See Gawron, *supra* note 4, at 104-05.

¹⁵⁵ See *supra* text accompanying note 4, at 105 ("In other words, there is a severe inability for individuals to access care. This issue has plagued the NHS since at least the 1990s, and continues to be problematic today.").

¹⁵⁶ Shao et al., *supra* note 92.

Unlike the U.S. and the U.K., China has not established a presumption of capacity relating to mental health decision making. While the legislation more closely aligned care practices in China with the practices adopted by the U.S. and U.K. in the 1990s and forward, China has not yet adopted legislation enshrining patient autonomy as liberally as the U.S. and U.K. “Mental disorders” under the Mental Health Law encompass more severe cases rather than common widespread problems.¹⁵⁷ Harkening back to its long history of family-centered care in the country, the Mental Health Law impacts how decisions of mentally disabled patients may be made under the direction of a guardian.¹⁵⁸

Involuntary commitment in China is an easier and apparently all too common phenomenon even after the passage of the Mental Health Law.¹⁵⁹ In a 2018 study, only 45.3 percent of involuntarily committed patients met the criteria for such commitment under the Mental Health Law.¹⁶⁰ The criteria allow for involuntary commitment of individuals who pose a high risk of harm to self or others, though application of the standard appears lax.¹⁶¹

While adopting the Mental Health Law was a significant step toward complementing the goals of the CRPD, China has room to improve.

IV. A PATH FORWARD: ADOPTING LEGISLATION

Each target country can improve its care services by 1) clearly defining current and future rules for civil commitment under statute, and 2) investing in and incentivizing the establishment of community-based care programs. Specifically, the U.S. and U.K. must codify more detailed civil commitment rules to stamp out the unintended mistreatment of patients under the current statutes.¹⁶² The U.S. should make use of funding from redundant government

¹⁵⁷ HH Chen et al., *Mental Health Law of the People's Republic of China* (English translation with annotations), 24 SHANGHAI ARCHIVES PSYCHIATRY 305 (2012) (“Conditions considered mental disorders in this law can be the result of a variety of causes; they are disturbances or abnormalities of perception, emotion, thinking or other mental processes that lead to significant psychological distress or to significant impairments in social adaptation or in other types of functioning.”).

¹⁵⁸ *Id.* (“In this law, guardians of persons with mental disorders are persons who may assume the role of guardian as specified in the relevant regulations of the General Principles of the Civil Law.”).

¹⁵⁹ Feng Jiang et al., *The Implementation of China's Mental Health Law-Defined Risk Criteria for Involuntary Admission: A National Cross-Sectional Study of Involuntarily Hospitalized Patients*, 9 FRONTIERS PSYCHIATRY 560, 560 (2018).

¹⁶⁰ *Id.*

¹⁶¹ See Chen, *supra* note 157; see also Feng, *supra* note 159.

¹⁶² See Gawron, *supra* note 4, at 94-95, 106.

programs to invest in community-based care. The U.K. should use its as yet unallocated £2 billion from the May Government¹⁶³ to improve wait times at existing care facilities and then invest in establishing rural care facilities. China should establish a civil commitment statute including the goals of “fusion legislation” in its legislative scheme.¹⁶⁴ China should then reinvest in and expand its successful 686 Programme,¹⁶⁵ first expanding the reach of its existing facilities and then establishing rural facilities.

Fusion legislation aims to create a legislative scheme combining the strengths of incapacity and civil commitment legislation to arrive at a consistent and ethical test for 1) honoring patient autonomy, and 2) recognizing unique cases where a guardian or alternate decision-maker is necessary for the care of a mentally disabled person.¹⁶⁶ The U.S. and U.K. have not adopted fusion-specific legislation; however, current law in both countries recognizes the same principles.¹⁶⁷ Where that law diverges from fusion legislation and the goals of the CRPD is under each country’s civil commitment standards.

Implementation of civil commitment statutes in both the U.S. and U.K. has led to involuntary commitment outside the supposed intents of the statutes by extended assessment and treatment periods, and even lengthy solitary confinement in the case of the mentally ill incarcerated population.¹⁶⁸

In China, the Mental Health Law is a first step toward codifying patient-centric principles; however, implementation of its law has faltered with respect to fusion law standards because the language of the Mental Health Law remains too broad and open to interpretation.

To achieve the CRPD’s goals of access to patient-centered, humane care without the threat of inhumane involuntary care, each target country should invest in and incentivize community-based care systems.

The numbers show that three out of five (or about fifty-six percent) Americans seek or want to seek mental health services, while 56.6 percent of

¹⁶³ Andrew Sparrow, *Mental Health Services to Get £2bn Funding Boost in Budget*, GUARDIAN (Oct. 28, 2018, 6:30 PM), <https://www.theguardian.com/uk-news/2018/oct/28/mental-health-services-to-get-2bn-funding-boost-in-budget>.

¹⁶⁴ See John Dawson & George Szmukler, *Fusion of Mental Health and Incapacity Legislation*, 188 BRIT. J. OF PSYCH. 504 (2018).

¹⁶⁵ See Liang, *supra* note 88.

¹⁶⁶ See Dawson & Szmukler, *supra* note 164.

¹⁶⁷ See *supra* Part III.

¹⁶⁸ See Gawron, *supra* note 4, at 94-95, 106.

adults with mental illness receive no treatment.¹⁶⁹ In the U.K., one in six Britons report a common mental health problem each year while wait times for first and second treatment appointments range between 16 and 167 days.¹⁷⁰ In China, 173 million people suffer from a mental disorder, while over ninety percent have not been treated.¹⁷¹

Each country has tried to implement community based care systems; however, lack of funding, high demand, and competing priorities have made it difficult for these programs to thrive.¹⁷² Funding community based care facilities at the start will be more cost effective than traditional care facilities in the long run.¹⁷³ Increased access in this way complements the goal of the CRPD to ensure humane, adequate, and accessible care for persons suffering from mental health challenges.

Norway offers a promising model for successful implementation of community—based care programs. In 2001, the government implemented a national plan establishing district psychiatric centers covering a district with a population between 30,000 to 60,000 people.¹⁷⁴ These district centers provide the most common treatment needs: outpatient services, day treatment, crisis intervention, short—term inpatient treatment, long—term inpatient treatment, rehabilitation, and services by mobile teams.¹⁷⁵ The more specialized care offerings are in the hands of the larger hospitals, commonly in the areas with more dense populations.¹⁷⁶ Like the U.K. and China which have largely government-controlled care systems, Norway offers both public and private insurance plans for individuals to access government and private-run

¹⁶⁹ *New Study Reveals Lack of Access as Root Cause for Mental Health Crisis in America*, NAT'L COUNCIL FOR BEHAV. HEALTH (Oct. 10, 2018), <https://www.thenationalcouncil.org/press-releases/new-study-reveals-lack-of-access-as-root-cause-for-mental-health-crisis-in-america/>; *2017 State of Mental Health in America-Access to Care Data*, MENTAL HEALTH AMERICA (last visited Nov. 10, 2019), <https://www.mhanational.org/issues/2017-state-mental-health-america-access-care-data>.

¹⁷⁰ Carl Baker, *Mental Health Statistics for England: Prevalence, Services and Funding: (Briefing Paper Number 6899)*, NAT'L GREY LITERATURE COLLECTION (May 2, 2018), <http://allcatsrgrey.org.uk/wp/wpfb-file/sn06988-1-pdf/>.

¹⁷¹ See Yu-Tao Xiang et al., *Mental Health in China: Challenges and Progress*, 380 LANCET 1715, 1715 (2012).

¹⁷² See *supra* section II(b).

¹⁷³ See Gawron, *supra* note 4, at 105.

¹⁷⁴ Torleif Ruud & Edvard Hauff, *Community Mental Health Services in Norway*, 31 INT'L J. MENTAL HEALTH 3, 7 (2002).

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

care facilities.¹⁷⁷ Among the countries spending the highest on healthcare (9.9 percent of GDP in 2015), Norway offers free mental health treatment through its state run facilities, along with access to private care facilities contracted by regional health care authorities.¹⁷⁸ Wait times for treatment in Norway average ten days with a sixty five percent post-treatment recovery rate.¹⁷⁹

While there is no one perfect solution to remedy lack of access to results-driven, humane care, Norway offers a sound preliminary model for the U.S., U.K., and China to build on. Each target country has a unique health care system, but each also possesses the structure to implement and fund community-based treatment centers similar to the Norwegian system.

In the U.S., the federal government sets standards and rules applicable across the nation, though more specific mental health care deliverables are left to individual states to implement. The ACA is still a hotly debated statute in the U.S., but it was successful in part by diverting funds from existing sources. The Trump Administration is largely opposed to new capital expenditures, but it is supportive of local, rather than federal, control over some public services. This in mind, the U.S. should take a first step toward establishing community-based care facilities by enacting a bill that allocates start-up funds to the states. Diverted funds from redundant government programs, and funds from programs the Administration wishes to cut, would comprise the initial expenditure.

In the U.K., former Prime Minister Teresa May was successful in allocating an additional £2 billion for mental health services while in office, but the resulting benefit to access to care has stalled on implementation.¹⁸⁰ To remedy that problem, the NHS should allocate those funds in two ways. First, to improve the wait times and available treatments at existing care facilities. Second, to establish new care facilities in more remote areas of the country where persons seeking care must travel distances and suffer through even longer wait times to access care.

¹⁷⁷ See Anne Karin Lindahl & Anen Ringard, Norwegian Centre for Health Service, *The Norwegian Health Care System*, 2013, in INTERNATIONAL HEALTH CARE SYSTEM PROFILES, 2013, at 103 (Sarah Thomson et al. eds., 2013).

¹⁷⁸ *Id.*

¹⁷⁹ Marit Knapstad et al., *Prompt Mental Health Care, the Norwegian Version of IAPT: Clinical Outcomes and Predictors of Change in a Multicenter Cohort Study*, 18 BMC PSYCHIATRY 260, 269 (2018).

¹⁸⁰ Sparrow, *supra* note 163; see also Alex Matthews-King, "Theresa May 'Ducked' Social Care Crisis with Mental Health Still a 'Disaster Zone', Experts Say of Her Legacy," INDEPENDENT (May 24, 2019) <https://www.independent.co.uk/news/health/theresa-may-resigns-social-care-mental-health-nhs-a8929291.html>.

China has the ability to shape a care system that can provide for the 173 million people there struggling with mental health problems because it is an economic powerhouse without a widely established health care network.¹⁸¹ The government should first adopt specific mental capacity legislation establishing a standard by which only persons who have been found by a court of law to pose a significant risk of danger to themselves and/or others may be involuntarily committed to a mental treatment facility. The legislation should also set out a narrow and specific set of circumstances, by which civil commitment may be allowed for a brief period of time, and subject to renewal only when a positive treatment plan is recognized or is underway. Finally, China's 686 Programme was successful in areas where it was implemented;¹⁸² however, many regions of China chose not to implement the program, tempering nationwide success.¹⁸³ The national government should first make participation in the 686 Programme mandatory and then reinvest in rural and remote areas that chose not to participate during the program's launch.

The CRPD requires equal access to humane care honoring the personal autonomy of individuals, specifically individuals with disabilities.¹⁸⁴ The target countries here are on their way to successfully implementing those goals, but without more, they remain unsuccessful in the endeavor. The solutions provided above, establishing and strengthening community-based treatment centers, will bring the U.S., U.K., and China further in line with the goals of the CRPD. Perhaps upon successful implementation the millions who find themselves weighed down by mental illness may find relief.

¹⁸¹ See Xiang, *supra* note 171.

¹⁸² See Liang et al., *supra* note 88, at 112 (stating that in 2016, 5.4 million patients were registered, of which 88.7 percent followed up to receive treatment under the 686 Programme).

¹⁸³ See *id.* (stating that hospitals at the county and township levels could choose not to participate in the 686 Programme).

¹⁸⁴ CRPD, *supra* note 2.