

**HUMAN RIGHTS PROTECTION FOR THE MENTALLY ILL THROUGH  
MENTAL HEALTH LAW IN ENGLAND AND IRELAND**

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# **HUMAN RIGHTS PROTECTION FOR THE MENTALLY ILL THROUGH MENTAL HEALTH LAW IN ENGLAND AND IRELAND**

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## **Abstract**

This thesis aims to analyse the influence of human rights concerns on recent revisions of mental health legislation in England (Mental Health Act 2007) and Ireland (Mental Health Act 2001), and the extent to which human rights concerns assist in promoting human rights through mental health law.

This thesis demonstrates that human rights standards, as reflected in the European Convention on Human Rights and publications of the United Nations and World Health Organisation (WHO), played a critical role in shaping revisions of mental health law in England (where public safety was also influential) and Ireland (where human rights concerns dominated single-handedly).

Mental health legislation in England meets 92 (55.4%) of the 166 relevant human rights standards outlined by the WHO; mental health legislation in Ireland meets 81 (48.8%).

Areas of high compliance include definitions of mental disorder, involuntary admission procedures and clarity regarding offences. Areas of medium compliance relate to capacity and consent (with a particular deficit regarding capacity legislation in Ireland), review procedures (which exclude long-term voluntary patients and lack robust complaint procedures), and rules governing special treatments. Areas of low compliance relate to economic and social rights, voluntary patients (especially non-protesting, incapacitated patients), vulnerable groups and emergency treatment.

Overall, mental health legislation provides substantial protection for some rights (e.g. liberty) but not others (e.g. economic and social rights). Additional protection is provided by mental health policy, social policy or other areas of law (e.g. human rights law).

Future research could usefully focus on the outcome of mental health legislation in the lives of the mentally ill; the relevance of the “third wave” of human rights, acknowledging the broad range of legal, health-care and social-care actors affecting the mentally ill; and values underpinning increased trans-national influences on national mental health law and policy (Council of Europe, European Union, WHO).

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## Chapter 1

### Introduction

#### 1.1 Background

In 1817, the House of Commons (of Great Britain, then including Ireland) established a committee to investigate the plight of the mentally ill in Ireland. The committee reported a disturbing picture:

When a strong man or woman gets the complaint [mental disorder], the only way they have to manage is by making a hole in the floor of the cabin, not high enough for the person to stand up in, with a crib over it to prevent his getting up. This hole is about five feet deep, and they give this wretched being his food there, and there he generally dies.<sup>1</sup>

The situation in nineteenth-century Ireland was not unique, as the majority of individuals with mental illness in Ireland, England and many other countries lived lives of vagrancy, destitution, illness and early death.<sup>2</sup>

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<sup>1</sup> Quoted in Shorter, E., *A History of Psychiatry*, New York: John Wiley and Sons, 1997; pp. 1-2.

<sup>2</sup> Porter, R., *Madness*, Oxford: Oxford University Press, 2002; Robins, J., *Fools and Mad*, Dublin: Institute of Public Administration, 1986; Torrey, E.F., Miller, J., *The Invisible Plague*, New Jersey: Rutgers University Press, 2001.

Two centuries later, in 2010, the *Guardian* newspaper reported on the death of a man with schizophrenia in central London:

Mayan Coomeraswamy was found dead on 9 January last year, having died from heart disease. Ulcers in his stomach were a strong sign of hypothermia. The 59-year-old, who had schizophrenia, lived in a dirty, damp and freezing flat, with mould growing on the floor and exposed electrical wires hanging off the walls. His boiler had broken, the bathroom ceiling had collapsed, and neighbours began to complain about the smell. His brother, Anthony Coombe, describing the scene as “squalor”, said: “Even an animal couldn't have lived in that.”

The disturbing circumstances of Coomeraswamy's death have exposed serious flaws in the way mental health law is implemented in the case of vulnerable people... Everyone knew the conditions Coomeraswamy was living in, but he refused to move for cleaning and refurbishment work to be done. Despite four years of pleading from his family, NHS [National Health Service] care staff would not intervene – wrongly thinking they would be violating his human rights.<sup>3</sup>

This thesis focuses on the two centuries between these two reports and examines two key research questions. First, to what extent, if any, have human rights concerns influenced recent revisions of mental health legislation in England and Ireland?<sup>4</sup>

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<sup>3</sup> Harding, E., “Acts of contradiction”, *Guardian (Society)*, 2010, 13 March.

<sup>4</sup> For the remainder of this thesis, “Ireland” refers to the Republic of Ireland except where specified otherwise.

Second, to what extent, if any, have recent developments in mental health law in both jurisdictions assisted in protecting and promoting the human rights of the mentally ill?

The remainder of this introductory chapter outlines the background to the exploration of these two questions throughout this thesis. Section 1.2 presents a discussion of the nature and burden of mental disorder. Section 1.3 presents research methodology and outlines thesis structure. Section 1.4 provides an exploration of key theoretical constructs underpinning this thesis, including human rights, human dignity (especially as it relates to human capabilities) and paternalism.

## **1.2 The nature and burden of mental disorder**

A medical *disorder* is an “ailment or disease”.<sup>5</sup> A *mental* disorder, according to the WHO, is “a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder”.<sup>6</sup>

Notwithstanding the emergence of this WHO definition of mental disorder toward the end of the twentieth century, the evolution of the concept of “mental disorder” has been a highly contested process.<sup>7</sup>

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<sup>5</sup> Pearsall, J., Trumble, B. (eds), *The Oxford Reference English Dictionary (Second Edition)*, Oxford and New York: Oxford University Press, 1996; p. 408.

<sup>6</sup> WHO, *International Classification of Mental and Behavioural Disorders*, Geneva: WHO, 1992; p. 5.

<sup>7</sup> Shorter, 1997; Stone, M.H. *Healing the Mind*, London: Pimlico, 1998.

Efforts to understand and resolve problems of the mind can be traced through many centuries in which solutions have taken unanticipated turns. They have become enmeshed in obscure beliefs and entangled alliances that unfolded without the care and watchful eye of scientific methods. [...] Many of these connections are intertwined in chance associations, primitive customs, and quasi-tribal quests. The path to the present is anything but a simple and straight line...<sup>8</sup>

Over the centuries, mental disorders have been variously conceptualised as spiritual or religious manifestations, legal conundrums, medical diseases, social issues, or all of the above, with the balance between competing conceptualisations varying over time.<sup>9</sup> In recent decades, re-definition and expansion of diagnostic categories have proven especially controversial.<sup>10</sup>

Since this thesis is primarily concerned with mental health law, there is a strong focus not on clinical definitions of mental disorder, such as that developed by the WHO, but on definitions provided in mental health legislation in England and Ireland. These definitional issues are extremely important, not least because involuntary detention of the mentally ill has been a long-standing feature of the management of mental disorder

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<sup>8</sup> Millon, T., *Masters of the Mind*, Hoboken, New Jersey: John Wiley & Sons, Inc., 2004; p. 2.

<sup>9</sup> Shorter, 1997; Stone, 1998; Millon, 2004; Porter, R. *Madmen: A Social History of Madhouses, Mad-Doctors and Lunatics*, Gloucestershire, UK: Tempus, 2004; Scull, A., *The Most Solitary of Afflictions*, Yale: Yale University Press, 2005.

<sup>10</sup> Horowitz, A.V., *Creating Mental Illness*, Chicago and London: University of Chicago Press, 2002; Watters, E., *Crazy Like Us*, New York: Free Press, 2010.

in almost all societies in which such matters are recorded.<sup>11</sup> As a result, various jurisdictions have developed dedicated mental health legislation to govern this practice.<sup>12</sup> Today, involuntary admission to psychiatric facilities under civil mental health legislation is relatively common: in the year from 1 April 2010 to 31 March 2011 there were 49,365 episodes of involuntary psychiatric admission in England.<sup>13</sup> In 2010, there were 1,602 involuntary admissions in Ireland.<sup>14</sup>

In the context of this long-standing history of involuntary treatment, it is clear that the legal definitions of mental illness are of considerable significance. Such definitions are examined in some depth later in this thesis (Sections 3.4.1, 4.3.1 and 5.3.1.1). It is important to note at the outset, however, that mental disorder, as defined by the WHO, is relatively common, and imposes considerable costs and burdens on individuals, families and societies. Worldwide, approximately 450 million people suffer from mental disorder at any given time.<sup>15</sup> The 12-month prevalence of mental disorder varies from 6% in Nigeria to 27% in the United States (US).<sup>16</sup>

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<sup>11</sup> Shorter, 1997; Stone, 1998; Millon, 2004; Porter, 2004; Scull, 2005; Gostin, L., McHale, J., Fennell, P., Mackay, R.D., Bartlett, P., “Preface”, in Gostin, L., McHale, J., Fennell, P., Mackay, R.D. and Bartlett, P. (eds), *Principles of Mental Health Law and Policy* (pp. v-viii), Oxford: Oxford University Press, 2010.

<sup>12</sup> Torrey & Miller, 2001; Kelly, B.D., “Mental health law in Ireland, 1821-1902: building the asylums”, *Medico-Legal Journal*, 2008, 76, 19-25.

<sup>13</sup> NHS Information Centre for Health and Social Care, *In-patients Formally Detained in Hospitals under the Mental Health Act 1983*, London: NHS/National Statistics, 2011; p. 9.

<sup>14</sup> Daly, A., Walsh, D., *HRB Statistics Series 15: Activities of Irish Psychiatric Units and Hospitals 2010*, Dublin: Health Research Board, 2011; p. 47.

<sup>15</sup> O’Donovan, D., *The Atlas of Health*, London: Earthscan, 2008.

<sup>16</sup> Twelve-month prevalence means that the individual has suffered from a mental disorder within the past twelve months (Kessler, R.C., Üstün, T.B., *WHO World Mental Health Surveys*, Cambridge: Cambridge University Press, 2008).

Mental disorder exerts considerable economic costs. In England, the annual economic cost of mental illness is approximately £77 billion, of which 16% is attributable to care provision, 30% to lost productivity, and the remainder to reduced quality and quantity of life.<sup>17</sup> In Ireland, the annual cost of mental health problems exceeds €3 billion (£2.6 billion), or 2% of gross national product.<sup>18</sup> This figure includes over €1 billion (£0.9 billion) for health and social care, and over €2 billion (£1.7 billion) from lost economic output.

Clearly, mental disorder is common, costly and complex. In light of this complexity and long-standing practices of involuntary treatment, this thesis focuses on mental health law in relation to human rights. Research methodology is outlined next.

### **1.3 Research methodology**

This thesis examines two key research questions. First, to what extent, if any, have human rights concerns influenced recent revisions of mental health legislation in England and Ireland? The hypothesis is that human rights concerns have indeed influenced such revisions. Second, to what extent, if any, have recent developments in mental health law in both jurisdictions assisted in protecting and promoting the human rights of the mentally ill? The hypothesis is that recent developments in mental health law have indeed assisted in protecting and promoting such rights in both jurisdictions.

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<sup>17</sup> Sainsbury Centre for Mental Health, *Mental Health At Work*, London: Sainsbury Centre for Mental Health, 2007; Knapp, M., “Mental ill-health: cost implications”, in Cooper, C.L., Field, J., Goswami, U., Jenkins, R. and Sahakian, B.J. (eds), *Mental Capital and Wellbeing* (pp. 515-527), Chichester, West Sussex: Wiley-Blackwell, 2010.

<sup>18</sup> O’Shea, E., Kennelly, B., *The Economics of Mental Health Care in Ireland*, Dublin: Mental Health Commission/Irish Centre for Social Gerontology/Department of Economics, NUI Galway, 2008; p. ix.

This work is rooted not only in an awareness of the burden of mental disorder (Section 1.2) but also in three key theoretical concepts which underpin many of its arguments: human rights, human dignity (especially as it relates to human capabilities) and paternalism. These concepts are explored in the next section of this thesis (Section 1.4) which provides definitions of all three terms, and uses key literature sources to outline essential elements within these concepts as they relate to the mentally ill. Particular emphasis is placed upon the idea of human capabilities as a key component of dignity, and the nature and meaning of paternalism in the interpretation of mental health legislation.

Chapter 2 moves on to examine the emergence of the idea of human rights with particular reference to the *Universal Declaration of Human Rights* (UDHR)<sup>19</sup> and *European Convention on Human Rights* (ECHR).<sup>20</sup> This chapter provides an historical background to the application of the idea of human rights to the mentally ill, based on published historical sources and looking at the extent to which institutional and legislative provisions were motivated by promotion of rights as opposed to welfare-based concerns or paternalism. This chapter uses case-law from the European Court of Human Rights to demonstrate key themes in mental health judgments to date and examines the emergent role of the EU in this area.

Chapter 2 concludes by examining expressions of human rights in national legislative form, chiefly through the Human Rights Act 1998 in England and European Convention

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<sup>19</sup> UN, *Universal Declaration of Human Rights*, Geneva: UN, 1948.

<sup>20</sup> Council of Europe, *European Convention on Human Rights (Convention for the Protection of Human Rights and Fundamental Freedoms)*, Strasbourg: Council of Europe, 1950.



on Human Rights Act 2003 in Ireland. Three reasons underlie this choice of jurisdictions. First, both England and Ireland have implemented significant reforms of mental health legislation over the past decade through the Mental Health Act (MHA) 2007 in England and MHA 2001 in Ireland. Second, human rights considerations were cited in both jurisdictions as important reasons underpinning change.<sup>21</sup> Third, England and Ireland are subject to similar international human rights standards: both jurisdictions are signatories to the ECHR and members of the European Union (EU), UN and WHO.<sup>22</sup> As a result, comparison of reforms in England and Ireland offers the possibility of exploring two jurisdictions' differing legislative responses to similar human rights standards in relation to the mentally ill.

Chapter 3 explores mental health legislation in England with a particular focus on the human rights of the mentally ill. From a methodological perspective, this chapter provides an account of the emergence of the MHA 1983 based on published historical sources, and outlines key provisions of the MHA 1983. It explores two central concerns stemming from the MHA 1983 (public safety and human rights). The latter concern, relating to human rights, is explored through examination of case-law from the English courts prior to the MHA 2007. The provisions of the MHA 2007 are then explored,

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<sup>21</sup> England: Expert Committee, *Review of the Mental Health Act 1983*, London: Department of Health, 1999; pp. 15, 127. Ireland: Department of Health, *White Paper: A New Mental Health Act*, Dublin: The Stationery Office, 1995; p. 15; *Croke v Smith* [1994] 3 IR 529; *Croke v Smith (No. 2)* [1998] 1 IR 101; *Croke v Ireland* (2000) ECHR 680.

<sup>22</sup> Menéndez, A.J., "Chartering Europe: legal status and policy implications of the Charter of Fundamental Rights of the European Union", *Journal of Common Market Studies*, 2002, 40, 471-90; EU, "Charter of Fundamental Rights of the European Union", *Official Journal*, 2007, C303; Division of Mental Health and Prevention of Substance Abuse, *Mental Health Care Law: Ten Basic Principles*, Geneva: WHO, 1996.

chiefly through the prism of human rights issues identified prior to the MHA 2007 as well as new human rights issues stemming from the MHA 2007 itself.

Chapter 4 provides a similar exploration of mental health legislation in Ireland (especially the Mental Treatment Act 1945 and MHA 2001) with particular focus on human rights. Like the previous chapter, this chapter provides an account of the emergence of the MHA 2001 based on published historical sources and outlines key provisions of the legislation itself. Human rights concerns stemming from the MHA 2001 are explored through examination of relevant Irish case-law. Like the previous chapter, this one concludes that recent reforms of mental health legislation address certain human rights issues (especially in areas of traditional concern, such as involuntary detention) but not others (e.g. the position of voluntary patients, and economic and social rights). In both jurisdictions, human rights concerns helped shape reform, although public safety was another key factor in England (but not, interestingly, Ireland).

Against this background, Chapter 5 examines the extent to which national mental health legislation in England and Ireland accords with international human rights standards,<sup>23</sup> with particular focus on the *WHO Resource Book on Mental Health, Human Rights and Legislation*<sup>24</sup> which presents a “Checklist for Mental Health Legislation” detailing human rights issues which, according to the WHO, need to be addressed at national

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<sup>23</sup> UN, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, New York: UN, Secretariat Centre For Human Rights, 1991.

<sup>24</sup> WHO, *WHO Resource Book on Mental Health, Human Rights and Legislation*, Geneva: WHO, 2005 (see also: Section 5.2).

level. This chapter commences with a careful consideration of the nature of the WHO checklist and, in particular, its usefulness for this kind of analysis.

The analysis itself is based on a systematic comparison of the contents of mental health legislation in England and Ireland with the standards outlined by the WHO. Compliance with each of these standards is provided in a “yes” or “no” fashion for each standard for each jurisdiction (Table 1). Overall, mental health legislation in England meets 92 (55.4%) of the 166 WHO standards and mental health legislation in Ireland meets 81 (48.8%).

Compliance with the WHO standards is examined in a more nuanced fashion in the text of Chapter 5, which identifies that areas of high compliance across both jurisdictions include definitions of mental disorder, involuntary admission procedures and clarity regarding offences. Areas of medium compliance relate to capacity and consent (with a particular deficit regarding capacity legislation in Ireland), review procedures (which exclude long-term voluntary patients and lack robust complaint procedures), and rules governing special treatments. Areas of low compliance relate to economic and social rights, voluntary patients (especially non-protesting, incapacitated patients), vulnerable groups and emergency treatment.

The conclusions stemming from this application of the WHO checklist in Chapter 5 are largely consistent with the conclusions of the preceding two chapters relating to each jurisdiction individually. One of the key merits of using the WHO checklist, however, is that it facilitates direct comparison between jurisdictions, and such a comparison of England and Ireland is presented in Chapter 6. This chapter commences with a

consideration of the relationship between England and Ireland based on published historical sources and the uses the analysis of mental health legislation in relation to WHO standards (Chapter 5 and Table 1) to identify areas of similarity and difference across the two jurisdictions. Key areas of difference relate to principles and objectives of mental health legislation, the balance between privacy and disclosure of information, treatment of vulnerable groups, specific aspects of clinical management, and issues related to capacity and consent.

Based on the findings and conclusions of Chapters 1 through 6, Chapter 7 focuses on three key themes in the context of recent reforms of mental health legislation in England and Ireland. These are: European influences on mental health law and policy, key values underpinning human rights (especially dignity), and the potential relevance of a “third wave”<sup>25</sup> of human rights in mental health. From a methodological perspective, this choice of themes is based in part on key concepts outlined at the outset of the thesis, especially human rights and dignity (Section 1.4), and in part on the analyses presented in Chapters 2 through 6, especially as they relate to trans-national influences on mental health legislation (e.g. ECHR, EU), values such as dignity and paternalism, and the challenges faced by myriad actors in the lives of the mentally ill.

Finally, Chapter 8 presents conclusions from the thesis as a whole and suggests useful directions for future research. Broadly, the thesis concludes that human rights concerns have played a significant role in revisions of mental health legislation in both jurisdictions, and that mental health legislation provides substantial protection for some

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<sup>25</sup> Klug, F., *Values for a Godless Age: The History of the Human Rights Act and Its Political and Legal Consequences*, London: Penguin, 2000; Klug, F., “The Human Rights Act – a ‘third way’ or ‘third wave’ Bill of Rights”, *European Human Rights Law Review*, 2001, 4, 361-372.

rights (e.g. liberty) but not others (e.g. economic and social rights). Additional protection and promotion of rights may be provided by mental health policy, social policy or other areas of law (e.g. human rights law). Future research could usefully focus on the outcome of mental health legislation in the lives of the mentally ill; the relevance of the “third wave” of human rights, acknowledging the broad range of legal, health-care and social-care actors affecting the mentally ill; and values underpinning increased trans-national influences on national mental health law and policy.

Before commencing, it is important to note that, for reasons of both space and focus, this thesis is primarily concerned with adults rather than children, and civil rather than criminal detention.<sup>26</sup> It is also important, before proceeding further, to outline the key theoretical constructs underlying this thesis, which are rooted in three key concepts: human rights, human dignity (especially as it relates to human capabilities) and paternalism. These are considered next.

#### **1.4 Human rights, human dignity and paternalism**

A *right* is an entitlement, “a thing one may legally or morally claim”.<sup>27</sup> The term *human rights* refers specifically to rights which a human being possesses by virtue of

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<sup>26</sup> Many of the arguments presented later in this thesis may, nonetheless, have certain relevance to mentally ill offenders. See: Laing, J.M., *Care or Custody? Mentally Disordered Offenders in the Criminal Justice System*, Oxford: Oxford University Press, 1999; Peay, J., “Civil admission following a finding of unfitness to plead”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 231-254), Oxford and Portland, Oregon: Hart Publishing, 2010.

<sup>27</sup> Pearsall & Trumble, 1996; p. 1240.

the fact that he or she *is* a human being.<sup>28</sup> Human rights do not need to be earned or granted; they are the birthright of all human beings simply because they are human beings.<sup>29</sup> Edmundson distinguishes human rights from other rights by stating that “human rights recognize *extraordinarily* special, basic interests, and this sets them apart from rights, even moral rights, generally”.<sup>30</sup>

In the early twenty-first century, the term “human rights” is most commonly understood by reference to statements of human rights dating from the twentieth century, including, most notably, the UDHR adopted by the United Nations (UN) General Assembly in 1948.<sup>31</sup> The concepts underlying human rights have a significantly longer history, however,<sup>32</sup> and this is explored in Chapter 2 in the particular context of mental disorder. Chapter 2 focuses primarily on the conceptualisations of human rights in the UDHR (because the UDHR explicitly informed WHO human rights criteria for mental health legislation, explored in Chapters 5 and 6)<sup>33</sup> and ECHR (because the ECHR led to significant case-law in relation to mental health law in England and Ireland, explored in Chapters 2, 3 and 4).

Many of the values underpinning these statements of rights are re-emphasised in the UN *Convention on the Rights of Persons with Disabilities* (CRPD), adopted by the UN

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<sup>28</sup> Edmundson, W., *An Introduction to Rights*, Cambridge: Cambridge University Press, 2004; Ishay, M.R., *The History of Human Rights*, Berkely and Los Angeles: University of California Press, 2004; Hunt, L., *Inventing Human Rights: A History*, New York and London: W.W. Norton and Company, 2007.

<sup>29</sup> Edmundson, 2004; p. 3.

<sup>30</sup> Edmundson, 2004; p. 191.

<sup>31</sup> UN, 1948.

<sup>32</sup> Hunt, 2007.

<sup>33</sup> WHO. *WHO Resource Book on Mental Health, Human Rights and Legislation*, Geneva: WHO, 2005.

General Assembly in 2006.<sup>34</sup> The CRPD commits signatory countries “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”.<sup>35</sup>

The UK signed the CRPD in 2007 and ratified it in 2009, while Ireland signed the CRPD in 2007 but has yet to ratify it. Even following ratification, detailed observance of *specific measures* within the CRPD may vary significantly amongst signatory countries.<sup>36</sup> Kämpf, however, highlights the importance of a set of more *general values* reflected in the CRPD, focussed on “respecting the dignity, worth and equality of human beings”.<sup>37</sup>

The observance of these values requires a dynamic balance between support and autonomy, and this balance may vary over time, especially (but not exclusively) amongst individuals with mental disorder: “Everyone needs support at times, and everyone also cherishes personal freedom”.<sup>38</sup> Kämpf’s emphasis on the importance of

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<sup>34</sup> UN, 2006; Bartlett, P., Lewis, O., Thorold, O., *Mental Disability and the European Convention on Human Rights (International Studies in Human Rights, Volume 90)*, Leiden/Boston: Martinus Nijhoff Publishers, 2007.

<sup>35</sup> CRPD, article 1.

<sup>36</sup> Lewis, O., “The expressive, educational and proactive roles of human rights”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 97-128), Oxford and Portland, Oregon: Hart Publishing, 2010; pp. 127-128.

<sup>37</sup> Kämpf, A., “Involuntary treatment decisions: using negotiated silence to facilitate change?”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 129-150), Oxford and Portland, Oregon: Hart Publishing, 2010; p. 150; Carozza, P., “Human dignity and judicial interpretation of human rights: a reply”, *European Journal of International Law*, 2008, 19, 931-944.

<sup>38</sup> Minkowitz, T., “Abolishing mental health laws to comply with the Convention on the Rights of Persons with Disabilities”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 151-177), Oxford and Portland, Oregon: Hart Publishing, 2010; p. 176.

dignity is underscored by Klug<sup>39</sup> and Osiatyński, who writes that “the protection of human dignity is one of the most important functions of all rights”,<sup>40</sup> consistent with the emphasis that the preamble of the UDHR places on the “inherent dignity” of all persons.<sup>41</sup> Maritain proposes that dignity is an inherent quality which *all* human beings possess by virtue of the fact of being human.<sup>42</sup>

Space constraints in the present thesis preclude a full investigation of the concept of dignity, but certain aspects are nonetheless important to outline at this point. In a detailed consideration of dignity in bioethics and biolaw, Beyleveld and Brownsword outline useful conceptualisations of “dignity as empowerment” and “dignity as constraint”.<sup>43</sup> The idea of dignity as empowerment centres on individual dignity as the key foundation for human rights, consistent with the UDHR. According to this conceptualisation, dignity reinforces claims to self-determination rather than limiting free choice.

By way of contrast, Beyleveld and Brownsword also “suggest that a conception of human dignity as constraint is implicated in much recent thinking about the limits to be placed on biomedicine, reflecting the belief that biomedical practice in the twenty-first century should be driven, not by the vagaries of individual choice, but by a shared

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<sup>39</sup> Klug, 2000; pp. 100-101.

<sup>40</sup> Osiatyński, W., *Human Rights and Their Limits*, Cambridge: Cambridge University Press, 2009; p. 189. See also: Edmundson, 2004; Ishay, 2004; Hunt, 2007; Boutros Boutros Ghali, quoted in: Tacket, A., *Health Equity, Social Justice and Human Rights*, London and New York, Routledge, 2012; p. 7.

<sup>41</sup> UDHR, preamble.

<sup>42</sup> Maritain, J. *The Rights of Man and Natural Law*, New York: Charles Scribner’s Sons, 1951; p. 65.

<sup>43</sup> Beyleveld, D., Brownsword, R., *Human Dignity in Bioethics and Biolaw*, Oxford: Oxford University Press, 2001; p. vii.



vision of human dignity that reaches beyond individuals”.<sup>44</sup> In the clinical context, “the settled wisdom of a paternalistic physician-centered ethics has given way to a patient-centered autonomy-based ethics, which in turn (at least in Europe) is now being challenged by a dignity-based ethics”.<sup>45</sup>

Beyleveld and Brownsword cite various examples of this trend relating to body parts,<sup>46</sup> genes<sup>47</sup> and clinical ethics committees,<sup>48</sup> all converging on the idea that “dignity represents an ‘objective value’ or good (reaching beyond the individual) such that, if an act violates this value, human dignity is compromised irrespective of whether the party so acting freely agrees to perform the act in question”.<sup>49</sup> Against this background, they conclude that “dignified conduct is action in accordance with the moral law performed out of commitment to obey the moral law”.<sup>50</sup>

While the idea of a common “moral law” admits of many interpretations, Ashcroft argues that Beyleveld and Brownsword nonetheless demonstrate “that what is important about dignity is actually autonomy, or the capacity for it” and “give a reasonably persuasive account of how to respect the capacity for autonomy of those who lack it and

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<sup>44</sup> Beyleveld & Brownsword, 2001; p. 29.

<sup>45</sup> Beyleveld, D., Brownsword, R., Wallace, S., “Clinical ethics committees: clinician support or crisis management?”, *HEC Forum*, 2002, 14, 13-25; p. 13.

<sup>46</sup> Beyleveld & Brownsword, 2001; p. 30. See also: Beyleveld, D., Brownsword, R., “My body, my body parts, my property?”, *Health Care Analysis*, 2000, 8, 87-99.

<sup>47</sup> Beyleveld & Brownsword, 2001; pp. 38-41. See also: Beyleveld, D., Brownsword, R., “Human dignity, human rights, and human genetics”, *Modern Law Review*, 1998, 61, 661-680.

<sup>48</sup> Beyleveld et al, 2002.

<sup>49</sup> Beyleveld & Brownsword, 2001; p. 34.

<sup>50</sup> Beyleveld & Brownsword, 2001; p. 138.

may never possess it, which is based in part on an account of the obligations and habits of a virtuous agent in respect of those who are vulnerable and marginal”.<sup>51</sup>

This is a useful approach in the context of mental disorder, in which dignity may be undermined by either mental illness itself or its treatment (e.g. involuntary detention), and interventions may display one or both of Beyleveld and Brownsword’s conceptualisations of dignity as empowerment and dignity as constraint. Many individuals with mental disorder may be socially “vulnerable and marginal”,<sup>52</sup> suggesting that a dynamic balance between Beyleveld and Brownsword’s two conceptualisations of dignity may be apparent.

In the context of clinical care, Seedhouse and Gallagher propose a conceptualisation of dignity largely consistent with Beyleveld and Brownsword’s idea of “dignity as empowerment”,<sup>53</sup> based on the capabilities and circumstances of the individual:

A person will have dignity if he is in a situation where his capabilities can be effectively applied. Dignity may be defined more specifically like this: This person’s capabilities are A, B, C ... X, Y, Z. She will have dignity in situations where she can exercise these capabilities effectively. Since ability is dependent on circumstances (it’s no use being a wonderful ball-player if you don’t have a ball) dignity promotion may best be summed up like this:

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<sup>51</sup> Ashcroft, R.E., “Making sense of dignity”, *Journal of Medical Ethics*, 2005, 31, 679-682; p. 681.

<sup>52</sup> Ashcroft, 2005; p. 681. See also: Kelly, B.D., “The power gap: freedom, power and mental illness”, *Social Science and Medicine*, 2006, 63, 2118-2128.

<sup>53</sup> Beyleveld & Brownsword, 2001; p. vii.

If a health worker wants to promote a person's dignity she must either expand her capabilities or improve her circumstances.<sup>54</sup>

Consistent with this, Shotton and Seedhouse link loss of dignity with the extent to which specific circumstances prevent exercise of capabilities.<sup>55</sup> They articulate various levels of loss of dignity including trivial loss (when dignity is easily restored), serious loss (when substantial effort is required to restore dignity) and devastating loss (when it is impossible to regain dignity without help). Creating appropriate circumstances to support dignity in clinical settings involves developing an awareness of the importance of respect, weighing the balance between independence and dependence, and promoting the individual's own priorities and interests, in the context of staff practices, clinical environments, health-care resources and various other aspects of care.<sup>56</sup>

Dworkin provides a less pro-active vision of dignity, arguing that "a person's right to be treated with dignity" is equivalent to "the right that others acknowledge his genuine critical interests".<sup>57</sup> Shotton and Seedhouse, however, describe Dworkin's concept of "genuine critical interests" as "rather vague", and his vision of dignity as generally inadequate: they argue that acknowledging "genuine critical interests" is not sufficient and that there is an obligation to pro-actively *protect* such interests, in order to maintain and promote dignity.<sup>58</sup>

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<sup>54</sup> Seedhouse, D., Gallagher, A., "Clinical ethics: undignifying institutions", *Journal of Medical Ethics*, 2002, 28, 368-372; p. 371.

<sup>55</sup> Shotton, L., Seedhouse, D., "Practical dignity in caring", *Nursing Ethics*, 1998, 5, 246-255.

<sup>56</sup> Gallagher, A., Seedhouse, D., "Dignity in care: the views of patients and relatives", *Nursing Times*, 2002, 98, 38-40.

<sup>57</sup> Dworkin, R., *Life's Dominion*, London: Harper Collins, 1995; p. 236.

<sup>58</sup> Shotton & Seedhouse, 1998; p. 253.

Gallagher argues that “dignity can and should also be explored as both an other-regarding and a self-regarding value: respect for the dignity of others and respect for one’s own personal and professional dignity. These two values appear to be inextricably linked”.<sup>59</sup> Gallagher suggests that dignity refers to the worth and value felt by *and* bestowed upon individuals. She argues that we are *all* vulnerable to loss of dignity throughout our lives and that an Aristotlean “ethic of aspiration” is required in order to acknowledge such vulnerability, aspire to be and do better, and develop awareness of the subtle effects of everyday activities on dignity.

In order to promote dignity in clinical practice, Gallagher points to the importance of people (e.g. clinicians), professional practice (what clinicians do), place (clinical environments) and processes (for patients, families and staff). This is consistent with the approach of Cass et al, who define dignity as “a state, quality or manner worthy of esteem or respect; and (by extension) self-respect”.<sup>60</sup> They argue that “dignity in care, therefore, means the kind of care, in any setting, which supports and promotes, and does not undermine, a person’s self-respect regardless of any difference”.

Against the background of these differing approaches, Häyry suggests that the existence of various competing conceptualisation of dignity can “be seen as an opportunity, given

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<sup>59</sup> Gallagher, A., “Dignity and respect for dignity – two key health professional values: implications for nursing practice, *Nursing Ethics*, 2004, 11, 587-599; p. 587.

<sup>60</sup> Cass, E., Robbins, D., Richardson, A. *Dignity in Care*, London: Social Care Institute for Excellence, 2006; p. 6. For an examination of philosophical underpinnings of various definitions of dignity, see: Rosen, M., *Dignity: Its History and Meaning*, Cambridge, MA: Harvard University Press, 2012.

that the parties could muster some conceptual leniency toward each other”.<sup>61</sup> In the context of mental health care, for example, which can be characterised by both provision of care and deprivation of liberty, there is likely to be a dynamic balance between Beyleveld and Brownsword’s conceptualisations of “dignity as empowerment” and “dignity as constraint”.<sup>62</sup> At the point of delivery of care, however, the conceptualisation of dignity provided by Seedhouse and Gallagher appears especially useful, based on the idea that “a person will have dignity if he is in a situation where his capabilities can be effectively applied” and “if a health worker wants to promote a person’s dignity she must either expand her capabilities or improve her circumstances”.<sup>63</sup> This is the chief approach to dignity applied throughout the remainder of this thesis.

This approach is also consistent with Nussbaum’s theory of human capabilities which proposes that human history demonstrates that certain human capabilities are essential to the very definition of a “human being”.<sup>64</sup> This human capabilities approach involves an open-ended list of necessary human functions, capabilities and limitations.

Developing such a list involves recognising a range of facts about being human, including that humans are born, have bodies, and die. We require food and shelter. We have the capabilities to drink, eat, move, work, play, reason, laugh, and so forth. All of these qualities and capabilities define our common humanity.

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<sup>61</sup> Häyry, M., “Another look at dignity”, *Cambridge Quarterly of Healthcare Ethics*, 2004, 13, 7-14; p. 11.

<sup>62</sup> Beyleveld & Brownsword, 2001; p. vii.

<sup>63</sup> Seedhouse, D., Gallagher, A., “Clinical ethics: undignifying institutions”, *Journal of Medical Ethics*, 2002, 28, 368-372; p. 371.

<sup>64</sup> Nussbaum, M.C., “Human functioning and social justice: In defence of Aristotelian essentialism”, *Political Theory*, 1992, 20, 202-246; Nussbaum, M.C., *Women and Human Development: The Capabilities Approach*, Cambridge: Cambridge University Press, 2000.

The human capabilities theory is, then, based on a common conception of humanity, combined with an awareness of cultural difference and a need for participatory dialogue amongst those who interpret its conception of humanity in different ways. In addition, according to Nussbaum, the human capabilities approach provides a basis for moral action because human capabilities, as conceptualised in the theory, provide a basis for respect, and the idea of shared vulnerabilities provides a similar basis for compassion.<sup>65</sup>

The human capabilities theory also suggests that certain *values* are of particular importance; e.g. by including the ability to reason as a fundamental human capability, this theory consequently respects the value of autonomy.<sup>66</sup> Nussbaum is, however, wary of linking capabilities directly with rights, believing that the idea of capabilities is clearer and more applicable across cultures. Nonetheless, Nussbaum acknowledges that her theory may provide a basis for certain rights claims; e.g. the ability to reason suggests a right to freedom of conscience.<sup>67</sup>

As a general basis for governing human conduct, the human capabilities theory presents some potential difficulties, including its minimal guidance for making difficult moral distinctions between what is “good” and “bad”, and the absence of a comprehensive method for reaching resolution when the needs of one person are incompatible with those of another.<sup>68</sup> Even in these circumstances, however, the human capabilities approach can provide at least some guidance. For example, by establishing minimal

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<sup>65</sup> Nussbaum, 1992.

<sup>66</sup> Freeman, M. *Human Rights*, Cambridge: Polity Press, 2002; p. 67.

<sup>67</sup> Nussbaum, 2000; pp. 96-101.

<sup>68</sup> Gray, J., *Liberalism*, Milton Keynes: Open University Press, 1986; pp. 47-49.

conditions for human flourishing, the theory can help to determine that art is more conducive to human flourishing than torture.<sup>69</sup> In situations of conflict between the rights of individuals, the theory can again assist by prioritising basic capabilities over more developed ones. Ultimately, according to this approach, justice requires the realization of fundamental human capabilities, and many dilemmas can be resolved by applying its principles in a flexible, considered and culturally-sensitive fashion.<sup>70</sup>

Most importantly for the present thesis, Nussbaum's human capabilities theory is notably consistent with the conceptualisation of dignity outlined by Seedhouse and Gallagher, who argue that "a person will have dignity if he is in a situation where his capabilities can be effectively applied".<sup>71</sup> This conceptualisation of the idea of dignity as being inextricably linked with capabilities is one of the key ideas throughout this thesis, along with the idea of human rights. There is, in addition, a third key concept which is central to this thesis: the concept of paternalism, especially in relation to the human rights implications of apparently paternalistic interpretations of mental health legislation in Ireland and elsewhere.

Paternalism involves a claim by government or others to take responsibility for defining someone else's welfare, so that paternalism is "not about what people want but about what is (or is thought to be) good for them".<sup>72</sup> In psychiatry, mental health legislation

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<sup>69</sup> Freeman, 2002; p. 67.

<sup>70</sup> Nussbaum, M.C., *Creating Capabilities: The Human Development Approach*, Cambridge, MA: Harvard University Press, 2011.

<sup>71</sup> Seedhouse & Gallagher, 2002; p.371.

<sup>72</sup> Feldman, D., *Civil Liberties and Human Rights in England and Wales (Second Edition)*, Oxford: Oxford University Press, 2002; p. 26. See also: McHale, J., Fox, M., Gunn, M., Wilkinson, S., *Health Care Law: Text and Materials (Second Edition)*, London: Sweet and Maxwell, 2006; p. 124.

can appear paternalistic by “tempering the upholding of all rights to autonomy” ostensibly owing to concerns for the patient’s mental health, the protection of others, and the patient’s right to treatment.<sup>73</sup> Paternalistic attitudes towards the mentally ill may also be evident in other settings; e.g. when employers insist that individuals may only return to work if they are monitored while taking medication.<sup>74</sup>

Ireland provides a good example of how paternalism can be enshrined in law, owing, in large part, to article 40 of the Constitution of Ireland (*Bunreacht na hÉireann*).<sup>75</sup> This article explicitly establishes equality before the law, but also acknowledges the need for “due regard” for certain differences between persons:

All citizens shall, as human persons, be held equal before the law. This shall not be held to mean that the State shall not in its enactments have due regard to differences of capacity, physical and moral, and of social function.<sup>76</sup>

The Constitution is even more explicit about the need to “protect” certain individuals:

The State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen.<sup>77</sup>

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<sup>73</sup> Rosen, A., Rosen, T., McGorry, P., “The human rights of people with severe and persistent mental illness”, in Dudley, M., Silove, D. and Gale, F. (eds), *Mental Health and Human Rights* (pp. 297-320), Oxford: Oxford University Press, 2012; p. 299.

<sup>74</sup> Sayce, L., *From Psychiatric Patient to Citizen*, Basingstoke: Palgrave, 2000; pp. 170-171.

<sup>75</sup> Hogan, G., Whyte, G., *J. M. Kelly: The Irish Constitution (Fourth Revised Edition)*, Dublin: Tottel Publishing, 2003.

<sup>76</sup> Constitution of Ireland, article 40(1).

<sup>77</sup> Constitution of Ireland, article 40(3).



The Irish Supreme Court made this approach explicit in *Re A Ward of Court*, a case involving medical treatment for an individual who lacked capacity, in which the Court determined that “the Court should approach the matter from the standpoint of a prudent, good and loving parent”.<sup>78</sup> Against this background, many argue that Irish courts have interpreted Ireland’s mental health legislation in an explicitly paternalistic fashion, resulting in significant criticism (see Section 4.4.6 of this thesis).<sup>79</sup>

It is also argued, however, that this criticism “arises from a mistaken translation of the legal Latin term *parens patriae*, the common law principle that the State (*patriae*), has parental (*parens*) obligations to care for the vulnerable amongst its citizens”,<sup>80</sup> as enshrined in the Constitution. Kennedy, an Irish professor of forensic psychiatry, argues that paternalistic interpretation of legislation “is a means for the judiciary to hold the executive to some limited welfare obligations towards vulnerable citizens, in the absence of a comprehensive health and welfare system for all.”

This issue, apparent paternalism in the content and interpretation of mental health legislation, especially in Ireland, forms the third key theme of this thesis, along with human rights and dignity (especially as linked with human capabilities). This thesis commences, however, with an overview of the emergence of the general idea of human rights, and its application to the particular position of the mentally ill.

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<sup>78</sup> *Re A Ward of Court (Withholding Medical Treatment) (No. 2)* [1996] 2 IR, [1995] 2 ILRM 40; p. 99.

<sup>79</sup> Whelan, D., *Mental Health: Law and Practice*, Dublin: Round Hall, 2009; pp. 26-31.

<sup>80</sup> Kennedy, H., “‘Libertarian’ groupthink not helping mentally ill”, *The Irish Times*, 2012, 12 September.

## Chapter 2

### Human rights and mental health

#### 2.1 Introduction

On 17 December 1991, the UN General Assembly formally adopted *Resolution 46/119, Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*.<sup>81</sup> These principles articulate a range of rights to which individuals with mental illness are entitled, including rights “to receive the best mental health care available”; “live, work and receive treatment in the community”; and access “mental health facilities” which are “appropriately structured and resourced”.

These principles recognize the idea that individuals with mental illness require the specific protection of human rights owing to the fact that they are mentally ill.<sup>82</sup> This Chapter begins by describing the gradual emergence of this idea, focussing initially on the relationship between mental illness and the emerging language of human rights in the nineteenth century. This is followed by considerations of the UDHR (1948) and ECHR (1950).

This thesis focuses on the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* and UDHR because they were the two key

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<sup>81</sup> UN, 1991.

<sup>82</sup> Goldman, H.H., “Implementing the lessons of mental health service demonstrations: human rights issues”, *Acta Psychiatrica Scandinavica*, 2000, 399 (suppl.), 51-54.

documents which explicitly informed the *WHO Resource Book on Mental Health, Human Rights and Legislation*,<sup>83</sup> which provides the framework for detailed examinations of mental health legislation in England and Ireland in Chapters 5 and 6. This thesis also focuses on the ECHR because both jurisdictions examined are signatories to the ECHR, and this thesis will argue that the ECHR played a significant role in informing recent revisions of mental health legislation in both jurisdictions.

## **2.2 Human rights and mental health in history**

While ideas underpinning current ideas about human rights have lengthy histories in many political and religious traditions,<sup>84</sup> there was renewed focus on human rights during the eighteenth-century Enlightenment, in the writings of Thomas Hobbes (1588-1679), amongst others, and England's Habeas Corpus Act 1679,<sup>85</sup> which built on the Magna Carta (1215), Petition of Rights (1628) and English Bill of Rights (1689).<sup>86</sup> In 1776, the concept of individual rights was further endorsed by the US *Declaration of Independence*.<sup>87</sup> In 1789, the French *Declaration of the Rights of Man and of the Citizen* (1789) "transformed everyone's language virtually overnight".<sup>88</sup>

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<sup>83</sup> WHO, 2005.

<sup>84</sup> Ishay, 2004.

<sup>85</sup> Adams, G.B., *The Origin of the English Constitution*, New Haven: Yale University Press, 1912.

<sup>86</sup> Hunt, 2007; p. 114.

<sup>87</sup> Hunt, 2007.

<sup>88</sup> Hunt, 2007; p. 133.

Notwithstanding these developments, the majority of individuals with mental illness in much of Europe and elsewhere continued to live lives of poverty, destitution and indignity, generally untouched by changing trends in political thought.<sup>89</sup>

In Ireland, a predominantly Roman Catholic country, the Roman Catholic Church, interestingly, played little role in providing for the mentally ill, although there is also evidence that the Church did *not* support witch-hunts against individuals with mental illness (as occurred in many European countries).<sup>90</sup> In England, by contrast, there is greater evidence of pro-active involvement of religious groups: in 1792, William Tuke, a Quaker, founded the York Retreat for individuals with mental illness, following the death of a Quaker woman in York Asylum.<sup>91</sup>

Notwithstanding the varying responses of religious groups to the apparently increasing numbers of mentally ill, philanthropic and governmental responses were remarkably consistent across Europe and the US, as public authorities moved swiftly to establish large institutions to accommodate this “hurried weight of human calamity”.<sup>92</sup> These changes, however, stemmed from paternalistic and welfare-based impulses rather than ideas about empowerment of the mentally ill, recognition of rights or enhancement of dignity.<sup>93</sup> The theme of paternalism as opposed to empowerment is one which emerges repeatedly throughout the histories of psychiatry in England and Ireland, from the 1700s up to the present day (see Sections 1.4 and 4.4.6).

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<sup>89</sup> Shorter, 1997: p. 2; Psychiatrist, “Insanity in Ireland”, *The Bell*, 1944, 7, 303-310; p. 304.

<sup>90</sup> Robins, 1986; pp. 18-22.

<sup>91</sup> Torrey & Miller, 2001; p. 28.

<sup>92</sup> Hallaran, W.S. *An Enquiry into the Causes producing the Extraordinary Addition to the Number of Insane*, Cork: Edwards and Savage, 1810; p. 10.

<sup>93</sup> Torrey and Miller, 2001; pp. 124-129

The nineteenth-century approach, centred on institutional provision, produced a dramatic growth in asylum populations in England and Ireland: in 1859, there were 1.6 asylum inmates per 1,000 population in England and by 1909 this had risen to 3.7.<sup>94</sup> In Ireland, there were 3,234 individuals in asylums in 1851, and by 1914 this had risen to 16,941.<sup>95</sup>

The relative absence of mental illness from human rights discourse throughout this period is likely related to a number of different factors, including the absence of clear definitions of “lunacy” or mental illness, paucity of effective treatments, stigma, and resultant exclusion of individuals with mental illness from most forms of political and societal discourse.<sup>96</sup> Ironically, it is likely that the era of institutionalisation was a time when there was a *particular* need to focus on the human rights of the mentally ill.<sup>97</sup>

This argument adds further importance to recognizing paternalism towards the mentally ill, rather than their empowerment or enhancement of dignity, as a key motivator in service provision, both in the 1800s and today. To what extent do today’s mental health laws in England and Ireland perpetuate this approach, and to what extent do they protect and promote the rights of the mentally ill? Have these two approaches – one based on paternalistic provision of care to the afflicted, the other based on empowerment through human rights – been reconciled? These themes emerge repeatedly throughout this

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<sup>94</sup> Shorter, 1997; p. 47.

<sup>95</sup> Walsh, D., Daly, A., *Mental Illness in Ireland 1750-2002*, Dublin: Health Research Board, 2004; p. 21.

<sup>96</sup> Shorter, 1997; Kelly, B.D., “Structural violence and schizophrenia”, *Social Science and Medicine*, 2005, 61, 721-730; Scull, 2005.

<sup>97</sup> Gostin, L., Gable, L., “The human rights of persons with mental disabilities”, *Maryland Law Review*, 2004, 63, 20-121; p. 27.

thesis, within the specific contexts of the mental health laws of England and Ireland and how they are interpreted by the courts.

In theory, the emerging interest in civil and political rights throughout the eighteenth and nineteenth centuries should have, automatically and without discrimination, included the rights of individuals with mental illness. The historical experiences of the mentally ill, however, and especially their increased rates of incarceration, highlight the need for pro-active consideration of protections of the human rights and dignity of this group, especially when they may lack capacity or opportunity adequately to assert these rights for themselves. The need to provide dedicated safeguards for the rights of the mentally ill was not to be formally recognised until well into the twentieth century, however, some decades after the UDHR was published.

### **2.3 The Universal Declaration of Human Rights**

The tumultuous events of the early decades of the twentieth century resulted in significant political change throughout Europe and directed increased attention to the concept of human rights.<sup>98</sup> In light of the unprecedented humanitarian atrocities of the Second World War, the UN was established in October 1945 in order to promote international peace and security, and reduce the possibility of further wars. One of the primary aims of the new organization was to articulate an intellectual and legal framework that would support the observance of human rights amongst member states and promote a culture of human rights throughout the world.

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<sup>98</sup> Ishay, 2004.

In order to promote these goals, the UDHR was adopted by the UN General Assembly at Palais de Chaillot in Paris on 10 December 1948.<sup>99</sup> The UDHR was presented as a non-binding statement of rights, the first stage in a process which continued with the drafting of the *International Covenant on Civil and Political Rights* and the *International Covenant on Economic, Social and Cultural Rights*, adapted by the UN General Assembly in 1966.

The UDHR comprises 30 articles, preceded by a short preamble which recognises that “the inherent dignity and...the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world” and that “it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law”.<sup>100</sup>

The first article of the UDHR states that “all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.”<sup>101</sup> The latter statement seems especially relevant to the mentally ill: does the link which the UN draws between “human beings” and being “endowed with reason” mean that the mentally ill, whose mental illness may impair their reason, do not necessarily possess the rights outlined? Such a conclusion would appear contrary to the spirit of the UDHR, especially article 2, which emphasizes the universal nature of rights:

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<sup>99</sup> Morsink, J., *The Universal Declaration of Human Rights*, Philadelphia: University of Pennsylvania Press, 1999; Ishay, 2004; p. 221.

<sup>100</sup> UDHR, preamble.

<sup>101</sup> UDHR, article 1.

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.<sup>102</sup>

This emphasis on universality is both useful and necessary, not least because previous declarations of rights had commonly been interpreted in such a way as to exclude certain groups. While mental illness was not mentioned explicitly in the list of factors which were *not* to form the basis of discrimination, it could be included under the term “other status”. In 1991, the UN made this more explicit in its *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*:

Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the *UDHR*, the *International Covenant on Economic, Social and Cultural Rights*, the *International Covenant on Civil and Political Rights*, and in other relevant instruments...<sup>103</sup>

Articles 3 to 19 of the UDHR went on to articulate a range of rights fundamentally rooted in the principle of liberty, including “the right to life, liberty, and security of person.”<sup>104</sup> The explicit articulation of this right, especially in the context of universal rights, is particularly relevant to the mentally ill, not least because of their increased risk

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<sup>102</sup> UDHR, article 2.

<sup>103</sup> UDHR, article 4.

<sup>104</sup> UDHR, article 3.



of lengthy involuntary detention in various institutions. Again, the need to respect the right to liberty, along with the other rights outlined in the UDHR, was strongly re-emphasised in 1991 in the UN's *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*.

Deprivation of liberty in the context of involuntary psychiatric treatment is considered in greater depth later in this thesis (Chapters 3, 4, 5 and 6). First, however, it is useful to consider briefly some of the more general controversies relating to the UDHR.

In the first instance, eight countries abstained from ratifying the UDHR in 1948, owing to concerns about specific rights (e.g. freedom of movement) and the possibility that the non-binding UDHR might “challenge the sanctity of domestic jurisdiction”.<sup>105</sup> This concern was compounded by perceived Western bias<sup>106</sup> and some Islamic commentators were especially concerned it failed adequately to reflect Islamic culture, religion and tradition, resulting in the *Cairo Declaration on Human Rights in Islam*.<sup>107</sup>

The UDHR also generated controversy owing to the exclusion of certain rights such as, for example, an explicit right to conscientious objection. The Irish politician Seán MacBride (1904-1988), emphasised this omission in his 1974 Nobel lecture and suggested “the right to refuse to kill” be added.<sup>108</sup> Various other rights which were not

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<sup>105</sup> Byelorussia, Czechoslovakia, Poland, Saudi Arabia, South Africa, Ukraine, the Soviet Union and Yugoslavia abstained. Ishay, 2004; p. 223.

<sup>106</sup> Cassese, A., “The General Assembly”, in Alston, P. (ed), *The United Nations and Human Rights* (pp. 25-54), Oxford: Clarendon Press, 1992.

<sup>107</sup> Organisation of the Islamic Conference, *Cairo Declaration on Human Rights in Islam*, Cairo: Organisation of the Islamic Conference, 1990.

<sup>108</sup> MacBride, S., “The Imperatives of Survival” in Abrams, I. and Frängsmyr, T. (eds), *Nobel Lectures: Peace, 1971-1980* (pp. 86-101), Singapore: World Scientific Publishing Company, 1997: p. 99.

accorded prominence also generated concern as the twentieth century progressed; e.g. the right to a clean environment<sup>109</sup> and rights of specific groups such as gays, lesbian and transgender individuals.<sup>110</sup> Many of these issues came to prominence in the later decades of the twentieth century, and reflect the ongoing evolution of both social concerns and concepts of rights.<sup>111</sup>

Other controversies surrounding the UDHR focussed on the inclusion of certain rights, such as economic and social rights, given their inevitable relationship with a state's political and economic situations.<sup>112</sup> Neier argues that “putting economic and social rights on the same plane as civil and political rights implicitly takes an area where compromise is essential and brings that into the process of rights adjudication”.<sup>113</sup> This issue had been the subject of considerable debate during initial drafting<sup>114</sup> and, in 1966, two separate covenants were adapted by the UN General Assembly: the *International Covenant on Civil and Political Rights* and the *International Covenant on Economic, Social and Cultural Rights*.

One of the key differences between these covenants was the immediacy with which these two categories of rights were to be observed: civil and political rights were to be implemented immediately, while social and cultural rights were to be implemented

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<sup>109</sup> Tomuschat, C., *Human Rights (Second Edition)*, Oxford: Oxford University Press, 2008; pp. 56-57.

<sup>110</sup> Smith, R.K.M., *Textbook on International Human Rights (Third Edition)*, Oxford: Oxford University Press, 2007; p. 191.

<sup>111</sup> Freeman, 2002; pp. 51-54.

<sup>112</sup> Freeman, 2002; pp. 164-166.

<sup>113</sup> Neier, A., “Social and economic rights”, *Human Rights Brief*, 2006, 13, 1-3: p. 2.

<sup>114</sup> Morsink, 1999; p. 2; Puta-Chekwe, C., Flood, N., “From division to integration” in Merali, I. and Oosterveld, V. (eds), *Giving Meaning to Economic Social and Cultural Rights* (pp. 39-51), Philadelphia: University of Pennsylvania Press, 2001.

“progressively, consistent with other specific programmes”.<sup>115</sup> In the meantime, however, the ECHR had been adopted by the Council of Europe (1950). This is considered next.

## **2.4 The European Convention on Human Rights**

In 1950, the Council of Europe adopted the *Convention for the Protection of Human Rights and Fundamental Freedoms*, also known as the *European Convention on Human Rights* (ECHR), which aimed to protect human rights and the fundamental freedoms “which are the foundation of justice and peace in the world and are best maintained on the one hand by an effective political democracy and on the other by a common understanding and observance of the human rights upon which they depend”.<sup>116</sup>

Consistent with the UDHR, section I of the ECHR outlined a range of individual rights including rights to life,<sup>117</sup> liberty, security and a fair trial<sup>118</sup>; respect for private and family life;<sup>119</sup> freedom of thought, conscience, religion,<sup>120</sup> expression,<sup>121</sup> assembly and association;<sup>122</sup> the right to marry;<sup>123</sup> and the right to “an effective remedy before a national authority notwithstanding that the violation has been committed by persons

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<sup>115</sup> Ishay, 2004; p. 224.

<sup>116</sup> ECHR, preamble.

<sup>117</sup> ECHR, article 2.

<sup>118</sup> ECHR, article 5.

<sup>119</sup> ECHR, article 8.

<sup>120</sup> ECHR, article 9.

<sup>121</sup> ECHR, article 10.

<sup>122</sup> ECHR, article 11.

<sup>123</sup> ECHR, article 12.

acting in an official capacity”.<sup>124</sup> There are prohibitions on torture,<sup>125</sup> slavery, forced labour,<sup>126</sup> discrimination<sup>127</sup> and abuse of rights.<sup>128</sup>

Under the ECHR, the European Court of Human Rights<sup>129</sup> was established in 1959, and by 2007 held jurisdiction over 47 states. The number of applications to the court increased steadily since the 1970s and in 2007 there were 49,750 applications.<sup>130</sup> By the end of 2007, there were some 80,000 cases pending;<sup>131</sup> this backlog developed despite a doubling of court resources since 2002: by 2008, the court employed 629 people and had a budget of €53 million (£46 million), almost a quarter of the budget of the Council of Europe.

Notwithstanding these resource limitations, the European Court of Human Rights, as “the frontrunner which predates other regional experiments” in legislating for human rights, “has quite naturally become the model which serves as the point of orientation for any similar initiative”.<sup>132</sup> There are, however, significant problems related to enforcement of judgments, especially when “many findings of a violation are attributable to a generally defective state of the domestic legal order and the related practices” in the relevant states.<sup>133</sup>

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<sup>124</sup> ECHR, article 13.

<sup>125</sup> ECHR, article 3.

<sup>126</sup> ECHR, article 4.

<sup>127</sup> ECHR, article 14.

<sup>128</sup> ECHR, article 17.

<sup>129</sup> ECHR, article 19.

<sup>130</sup> Tomuschat, 2008.

<sup>131</sup> Barber, L., “Spread of freedom leaves human rights court fighting fires”, *Financial Times*, 2008, 19/20 April; p. 9.

<sup>132</sup> Tomuschat, 2008; p 239.

<sup>133</sup> Tomuschat, 2008; p. 256.

Overall, there is some evidence that the ECHR has provided enhanced protection of basic human rights in ratifying states <sup>134</sup> and has “matured into the most sophisticated and effective human rights treaty in the world” and “through its consistent case-law has developed the most comprehensive jurisprudence on human rights”.<sup>135</sup> This positive assessment is not universally agreed and nor is it without caveats: the overall performance of the ECHR varies between issues<sup>136</sup> and it is a victim of its own popularity, as demands on the court increase, resulting in delays and inefficiencies.<sup>137</sup>

Notwithstanding these challenges, there is now a significant body of ECHR jurisprudence in relation to mental illness.<sup>138</sup> The European Court of Human Rights delivered its first significant decision in this area in 1979 and between 2000 and 2004 delivered forty judgments in this area.<sup>139</sup> In particular, a series of issues in relation to involuntary psychiatric treatment has been addressed, including matters relating to involuntary detention (2.4.1); conditions while detained (2.4.2); and review of involuntary detention (2.4.3).<sup>140</sup> These are considered next.

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<sup>134</sup> Smith, 2007.

<sup>135</sup> Smith, 2007; p. 106.

<sup>136</sup> Letsas, G., *A Theory of Interpretation of the European Convention on Human Rights*, Oxford: Oxford University Press, 2007.

<sup>137</sup> Helfer, L.R., “Redesigning the European Court of Human Rights”, *European Journal of International Law*, 2008, 19, 125-159; p. 125.

<sup>138</sup> In relation to international human rights instruments and mental disability, see: Perlin, M.L., Kanter, A.S., Treuthart, M.P., Szeli, E., Gledhill, K., *International Human Rights and Comparative Mental Disability Law*, Durham, NC: Carolina Academic Press, 2006; Perlin, M.L., Kanter, A.S., Treuthart, M.P., Szeli, E., Gledhill, K., *International Human Rights and Comparative Mental Disability Law: Documents Supplement*, Durham, NC: Carolina Academic Press, 2006. In relation to the ECHR and mental disability, see: Bartlett et al, 2007.

<sup>139</sup> Bartlett et al, 2007; p. 1.

<sup>140</sup> Many relevant cases are discussed and summarised by Bartlett et al, 2007; Perlin et al, 2006.

### 2.4.1 Involuntary detention owing to mental illness

A number of cases before the European Court of Human Rights have centred on alleged breaches of article 5(1) of the ECHR, which outlines the right to liberty save under certain, specific circumstances, one of which is the “lawful detention” of “persons of unsound mind” in “accordance with a procedure prescribed by law”.<sup>141</sup> One of the most widely-cited cases was *HL v UK (Bournewood)*, which centred on an individual with severe learning problems who was compliant while in hospital but not legally detained; i.e. HL was an “informal” patient, but had he tried to leave, he would have been detained.<sup>142</sup> HL lacked capacity to make decisions regarding treatment so the clinical team made decisions which it believed were in HL’s best interest. The court concluded there was a breach of article 5(1) when HL was an informal patient, on the basis that there was no protection against arbitrary detention as there would have been if HL had been legally detained.<sup>143</sup>

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<sup>141</sup> ECHR, article 5(1). The terminology used (“persons of unsound mind, alcoholics or drug addicts or vagrants”) is no longer considered appropriate for individuals with mental illness, problems related to substance misuse, or problems related to homelessness.

<sup>142</sup> *HL v UK (Bournewood)* (2004) 40 EHRR 761. See also: *HM v Switzerland* (2004) 38 EHRR 314; in this case, HM resided in an unlocked area of an institution and, unlike HL, had continued contact with the outside world, so the court ruled there was no deprivation of liberty; HM also, later, consciously agreed to stay at this residence.

<sup>143</sup> Eastman, E., Peay, J., “Bournewood: an indefensible gap in mental health law”, *British Medical Journal*, 1998, 317, 94-95; Morris, F., “Mental health law after *Bournewood*”, *Journal of Mental Health Law*, 1999, February, 41-47; Bartlett, P., McHale, J., “Mental incapacity and mental health: the development of legal reform and the need for joined-up thinking”, *Journal of Social Welfare and Family Law*, 2003, 25, 313-324; Laing, J.M., “Reforming mental health law and the ECHR”, *Journal of Social Welfare and Family Law*, 2003, 25, 325-340; Robinson, R., Scott-Moncrieff, L., “Making sense of *Bournewood*”, *Journal of Mental Health Law*, 2005, May, 17-25.

When considering whether or not there has been a breach of article 5(1) in relation to any admission (voluntary or involuntary) to a psychiatric facility, the court acknowledges a need to take account of a range of factors surrounding the admission:

In order to determine whether someone has been “deprived of liberty” within the meaning of Article 5, the starting point must be his concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question.<sup>144</sup>

In relation to deciding who is of “unsound mind” and who is not, the European Court of Human Rights has made it clear that a diagnosis of mental disorder cannot be based solely on the individual holding views that differ from societal norms: a diagnosis of “mental disorder” must be based upon “objective medical expertise”.<sup>145</sup> In that case, *Winterwerp v Netherlands*, an individual with brain damage and schizophrenia was detained in a psychiatric hospital under an emergency procedure following a theft, and later had the detention extended by a district court (supported by medical evidence). W challenged his detention on various grounds, including the alleged absence of opportunity for him to challenge medical evidence.

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<sup>144</sup> *Guzzardi v Italy* (1980) 3 EHRR 333; the patient was living at home subject to a curfew and limitation on geographical movements; the Court ruled this represented detention under article 5. See also: *Ashingdane v UK* (1985) 7 EHRR 528; in this case, there was a delay in the transfer of a detained individual from a high-secure hospital to local psychiatric hospital in which he would have likely enjoyed less severe circumstances of detention, but the court ruled article 5 concerned the *fact* of detention, and not the severity of the detention regime, so the delay in transfer did *not* represent a breach of article 5.

<sup>145</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387; See also *X v UK* (1981) 4 EHRR 188; the court stated “national authorities are better placed to evaluate the evidence adduced before them”; this is consistent with the court’s general reliance on national courts for the determination of facts and on medical doctors for medical opinions.

Following detailed consideration of the matter, the court concluded that the object and purpose of article 5(1)(a) of the ECHR is to ensure that nobody is dispossessed of liberty in an arbitrary fashion. As a result, the court concluded that its provisions require a narrow interpretation and, “in the court’s opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of ‘unsound mind’. The very nature of what has to be established before the competent national authority - that is, a true mental disorder - calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder”.<sup>146</sup>

In addition, “it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation... Mental illness may entail restricting or modifying the manner of the exercise of such a right, but it cannot justify impairing the very essence of the right. Indeed, special procedural safeguards may prove called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves.”<sup>147</sup> This acknowledges the need to protect the right to liberty.

The *Winterwerp* judgment strengthened greatly the requirement that detention on the grounds of mental illness required objective medical expertise to support such a detention in *the first instance*. It did not, however, specify such a requirement for *renewal* of such detention orders; this matter is now of increased relevance in relation to

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<sup>146</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387.

<sup>147</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387.



England's MHA 2007: under the MHA 1983, the making of a *renewal* order, like an admission order, required an examination and report by the "responsible medical officer",<sup>148</sup> but under the MHA 2007, the "responsible clinician" (who may or may not be a medical doctor) can make out a renewal order, although they must consult with another "professional" involved before doing so (Section 3.4.3).<sup>149</sup>

The *Winterwerp* judgment emphasized that an individual detained on grounds of mental illness should have access to a "court" to determine the appropriateness of detention, even if the mental illness required modifications in the manner of exercising this right. The court was especially emphatic that if an individual is detained, "the mental disorder must be of a kind or degree warranting compulsory confinement" and "the validity of continued confinement depends upon the persistence of such a disorder".<sup>150</sup>

In emergency situations, which do not necessarily involve dangerousness, it may be difficult to obtain "objective medical expertise" and the court has determined that, in such situations, the protections of article 5 are reduced; i.e. it may be neither feasible nor necessary to obtain "objective medical expertise" prior to detention, although such detentions still must be in accordance with domestic law.<sup>151</sup> The rights to review of emergency detention under article 5(4) are also reduced,<sup>152</sup> although it appears likely

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<sup>148</sup> MHA 1983, sections 20(3) and (4).

<sup>149</sup> MHA 2007, section 9(4)(b); amending MHA 1983, section 20(5A).

<sup>150</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387.

<sup>151</sup> *X v UK* (1981) 4 EHRR 188.

<sup>152</sup> *X v UK* (1981) 4 EHRR 188; the only review of emergency detention available was the English *habeas corpus* procedure and the court ruled that this was sufficient to meet the requirements of article 5(4) in the emergency situation.

that the duration of the emergency situation should be minimised, and non-emergency detention procedures instigated in a timely fashion.<sup>153</sup>

The determination of whether or not an individual's mental disorder is "of a kind or degree warranting compulsory confinement" may be based on the individual's need for treatment and/or apparent dangerousness; i.e. apparent dangerousness may be sufficient to warrant detention of an individual with mental disorder, even if there is no treatment available while detained.<sup>154</sup> In either case, individuals who are detained pursuant to article 5(1)(e) have the right to be informed promptly of the reasons for their "arrest".<sup>155</sup>

#### **2.4.2 Conditions while detained**

The European Court of Human Rights has articulated a need for detention to occur in a location that bears some relationship to the reason for detention; e.g. an individual who is detained because he or she is deemed to be of "unsound mind" must be detained in a therapeutic environment, such as a hospital; the hospital wing of a prison, for example, will *not* suffice.<sup>156</sup> In such locations, once a specific treatment is based on medical

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<sup>153</sup> The precise duration of an "emergency" situation has not been determined by the court; see: *Winterwerp v Netherlands* (1979) 2 EHRR 387 (in which the court tolerated a 6-week emergency "with hesitation"); Bartlett et al, 2007; p. 56.

<sup>154</sup> *Hutchison Reid v UK* (2003) 37 EHRR 211; the applicant had a psychopathic disorder and national law stated that detention was only warranted if medical treatment could alleviate or prevent deterioration of his condition; domestic courts determined that the availability of treatments that could alleviate *symptoms or manifestations* of the disorder (if not the disorder itself) was sufficient to justify detention, and the court upheld this decision.

<sup>155</sup> *Van der Leer v Netherlands* (1990) 12 EHRR 567; *Ashingdane v UK* (1985) 7 EHRR 528; *Fox, Campbell and Hartley v UK* (1990) 13 EHRR 157.

<sup>156</sup> *Aerts v Belgium* (1998) 29 EHRR 50; Aerts, who had substance misuse problems and borderline personality disorder, committed assault and was detained under the Belgian Social Protection Act for

necessity and shown to be in the best interest of the patient, certain procedures such as force-feeding or placing in isolation, may not constitute breaches of article 3.<sup>157</sup>

A number of cases relating to detained individuals have referred to the ECHR right to respect for “private and family life”.<sup>158</sup> From a psychiatric perspective, it is conceivable that the psychiatric condition of certain individuals with mental disorder might deteriorate as a result of stimulation stemming from visits to them by family or friends, suggesting there may be medical grounds for certain limitations on visits, for the “protection of health”.<sup>159</sup> From a human rights perspective, however, any such “interference” must be proportionate to demonstrated need: in *Nowicka v Poland*, for example, the court ruled that restricting family visits to once per month was not proportionate to, and did not pursue, any legitimate aim and breached article 8.<sup>160</sup>

Regarding duration of detention necessitated by mental disorder, the court has ruled that “the validity of continued confinement depends upon the persistence of such a

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treatment, but sent to a prison, where therapeutic facilities were not available; the court concluded there had been a breach of article 5(1)(e) owing to non-availability of treatment *in this setting*.

<sup>157</sup> *Herczegfalvy v Austria* (1991) 15 EHRR 437.

<sup>158</sup> ECHR, article 8.

<sup>159</sup> There is evidence that violent incidents amongst individuals with mental disorder in psychiatric facilities are associated with recent exposure to staff members, other patients and visitors; this evidence is somewhat inconsistent, although this inconsistency is likely attributable to the small size, limited statistical power, and low number of relevant studies. See: Bernstein, R.A., Manchester, R.A., Weaver, L.A., “The effect of visiting on psychiatric patients in a general hospital”, *Community Mental Health Journal*, 1980, 16, 235-240; Phillips, P., Nasr, S.J., “Seclusion and restraint and prediction of violence”, *American Journal of Psychiatry*, 1983, 140, 229-232; Powell, G., Caan, W., Crowe, M., “What events precede violent incidents in psychiatric hospitals?”, *British Journal of Psychiatry*, 1994, 165, 107-112.

<sup>160</sup> In *Nowicka v Poland* (2003) 1 FLR 417, the applicant was arrested on the order of a Polish District Court and placed in prison for the purpose of psychiatric examination; her daughter requested visiting rights and the District Court granted one visit per month; the court ruled that while detention could be considered to pursue legitimate aims, this restriction on visiting rights violated article 8.

disorder”.<sup>161</sup> This is not an absolute requirement, however, as the court recognises it may not be appropriate to “order the immediate and absolute discharge of a person who is no longer suffering from the mental disorder which lead to his confinement” but that such discharge might best occur in a phased fashion, subject to conditions.<sup>162</sup> In addition, if a patient remains detained for longer than necessary owing to the absence of community treatment resources, the court has not ruled against such detentions, consistent with its general reluctance to generate rulings with substantial resource implications in various countries (with differing models and levels of care).<sup>163</sup> In the event, however, that a tribunal authorises discharge subject to certain conditions, and such a discharge does not occur (e.g. for resource reasons), that individual’s continued detention is regarded by the court as a fresh detention which must then be reviewed with “requisite promptness”.<sup>164</sup> This is a measure protective of both liberty and dignity.

### **2.4.3 Review of involuntary detention**

Article 5(4) of the ECHR states that “everyone who is deprived of his liberty by arrest or detention” shall be entitled to “take proceedings by which the lawfulness of his

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<sup>161</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387. See also *X v UK* (1981) 4 EHRR 188.

<sup>162</sup> *Johnson v UK* (1997) 27 EHRR 296; Johnson was diagnosed with schizophrenia and personality disorder (later revised to “drug-induced psychosis”) and although tribunals recommended phased discharge, he remained detained in hospital for many years despite medical opinion that he was no longer suffering from a mental disorder; the court found a violation of article 5(1) owing to the indefinite deferral of release.

<sup>163</sup> *Kolanis v UK* (2006) 42 EHRR 12; Kolanis was detained but discharge was recommended by a Mental Health Review Tribunal provided certain community conditions were met; these conditions were not met, the applicant was not discharged, and the applicant appealed; the court ruled that discharge was not appropriate in the absence of resources to meet the conditions under which discharge had been approved.

<sup>164</sup> *Kolanis v UK* (2006) 42 EHRR 12; once the tribunal authorised discharge subject to certain conditions, the next date for tribunal review was one year later, which, the court concluded, did not meet the requirement for “promptness”.

detention shall be decided speedily by a court”.<sup>165</sup> In the case of detention in mental health institutions, the meaning of the word “court” is relatively wide:

It does not matter whether the body is called a ‘tribunal’ as opposed to a ‘court’ as long as it has three essential attributes: independence from the executive; independence from the parties to the case; and a judicial character.<sup>166</sup>

The European Court of Human Rights regards this requirement for review under article 5(4) as separate to the question of the legality of detention, under article 5(1); i.e. there can be a violation of article 5(4) *as well as* a violation of article 5(1).<sup>167</sup> For example, the court declared a breach of article 5(4) in *HL v UK (Bournewood)*, on the grounds that, while HL was an informal patient, there was no adequate procedure for HL to challenge his *de facto* detention at that time.<sup>168</sup>

The court has placed particular emphasis on the necessity for Mental Health Review Tribunals to have the power to discharge formally detained patients, if they see fit. In the case of forensic patients in the UK, tribunals, under the MHA 1983, had the power to recommend release but could not discharge patients themselves; the European Court of Human Rights ruled that these powers were insufficient and tribunals were

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<sup>165</sup> ECHR, article 5(4).

<sup>166</sup> Bartlett et al, 2007; p. 62. See also *Winterwerp v Netherlands* (1979) 2 EHRR 387; in this case, hearings held by the Dutch District and Regional Courts fulfilled the first two of these criteria but lacked “judicial character”: Winterwerp had not been notified of various hearings, nor been afforded opportunity to question evidence against him.

<sup>167</sup> *De Wilde, Ooms and Versyp v Belgium* (1972) 1 EHRR 438.

<sup>168</sup> *HL v UK (Bournewood)* (2004) 40 EHRR 761.

subsequently given the power to discharge forensic patients.<sup>169</sup> Following this ruling, the government enacted the Mental Health (Amendment) Act 1982 giving restricted patients the right to a binding Mental Health Review Tribunal.<sup>170</sup>

The European Court of Human Rights has specified that certain procedural safeguards are necessary in order to ensure that such reviews are effective (e.g. there may need to be a lawyer involved, even if the patient does not want one).<sup>171</sup> The court has, in addition, provided guidance on the ECHR requirement that “the lawfulness of... detention shall be decided speedily”.<sup>172</sup> It has found that delays of 55 days<sup>173</sup> and 24 days<sup>174</sup> are not sufficiently speedy, suggesting that a maximum delay of approximately two or three weeks is likely to be acceptable, in the absence of specific requests by the patient for deferral (e.g. in order to seek independent medical opinion).<sup>175</sup>

Overall, the mental health topics dealt with by the European Court of Human Rights have generally focussed on involuntary detention and treatment, both of which are topics of traditional concern in asylum-based mental health services.<sup>176</sup> Many of these judgments support specific human rights (e.g. requiring objective medical evidence of

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<sup>169</sup> *X v UK* (1981) 4 EHRR 188; discharge may, however, be delayed in order to ensure the safety of the patient or public (*Johnson v UK* (1997) 27 EHRR 296).

<sup>170</sup> Gostin & Gable, 2004.

<sup>171</sup> *Megyeri v Germany* (1992) 15 EHRR 584; *Nikolova v Bulgaria* (2001) 31 EHRR 3; *Pereira v Portugal* (2003) 36 EHRR 49.

<sup>172</sup> ECHR, article 5(4).

<sup>173</sup> *E v Norway* (1990) 17 EHRR 30; E was transferred to a secure psychiatric setting on 21 July 1988; applied for a court hearing on 3 August 1988; and judgment was delivered on 27 September 1988.

<sup>174</sup> *LR v France* App no 33395/96 (ECHR, 27 June 2002).

<sup>175</sup> Bartlett et al, 2007; pp. 66-67.

<sup>176</sup> Bartlett et al, 2007; p. 254; Prior, P.M., “Mentally disordered offenders and the European Court of Human Rights”, *International Journal of Law and Psychiatry*, 2007, 30, 546-557; p. 556.

“unsound mind” to justify detention, and requiring that tribunals be held promptly) and also facilitate the exercise of specific capabilities (e.g. challenging detention).

Certain judgments also support respect for dignity; e.g. requiring that detention occur in therapeutic facilities and restrictions on visits be proportionate. Some appear somewhat paternalistic, however, such as permitting phased discharge subject to certain conditions; this, however, appears balanced, at least in part, by a requirement that delayed discharge be reviewed promptly by tribunal. The broader context of these trends in judgments is considered next, and the themes of dignity and paternalism recur repeatedly throughout the remainder of this thesis (especially in Section 7.3).

## **2.5 Mental health-care and human rights in the twentieth century**

Notwithstanding the articulation of a range of human rights in the UDHR and ECHR, the numbers detained in psychiatric institutions continued to grow throughout the twentieth century, although there was increased public and governmental recognition that many asylums lacked appropriate, non-restrictive, therapeutic facilities.<sup>177</sup> There was also evidence of renewed emphasis on the search for new treatments and management strategies, rather than simple, interminable institutionalisation.<sup>178</sup>

In addition, there were significant developments in relation to legislation, even in advance of the UDHR and ECHR. In Ireland, the Mental Treatment Act 1945

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<sup>177</sup> Walsh & Daly, 2004.

<sup>178</sup> Not all of these treatments have stood the test of time and some, such as lobotomy, were undoubtedly used with unjustified enthusiasm and tragic results (Shorter, 1997; El-Hai, J., *The Lobotomist*, Hoboken, NJ: Wiley and Sons, 2005).

established a process of voluntary admission, strengthened the role of medical practitioners in involuntary detention and made myriad changes to governance of psychiatric facilities.<sup>179</sup> By this time, Great Britain (1930) and Northern Ireland (1932) had already introduced procedures for voluntary admission.<sup>180</sup> Consistent with these relatively enlightened reforms, the 1950s saw Jean Delay and Pierre Deniker introduce chlorpromazine as the first effective medication for schizophrenia.<sup>181</sup>

Notwithstanding these developments, many countries saw asylum populations continue to rise. In Ireland, the number of psychiatric inpatients peaked in 1958 and was notably slow to decline even after that: even in 1961, one in every 70 Irish people above the age of 24 was in a psychiatric hospital.<sup>182</sup> Faced with similar problems in the UK, the 1957 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency attempted to open a new era of “community care”.<sup>183</sup>

Over the following decades, considerable progress was made dismantling traditional institutional care structures, although the development of community-based alternatives was criticised as too slow.<sup>184</sup> In Ireland, a similar process of de-institutionalisation

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<sup>179</sup> Kelly, B.D., “The Mental Treatment Act 1945 in Ireland: An historical enquiry”, *History of Psychiatry*, 2008, 19, 47-67.

<sup>180</sup> O’Neill, A.-M., *Irish Mental Health Law*, Dublin: First Law Ltd., 2005.

<sup>181</sup> Shorter, 1997; pp. 248-255.

<sup>182</sup> Lyons, F.S.L., *Ireland Since the Famine*, London: Fontana, 1985.

<sup>183</sup> Department of Health and Social Security, *Royal Commission On The Law Relating To Mental Illness And Mental Deficiency. Cmnd 169*. London: Her Majesty’s Stationery Office, 1957.

<sup>184</sup> Fadden, G., Bebbington, P., Kuipers, L., “The burden of care”, *British Journal of Psychiatry*, 1987, 150, 285-292; Dyer, J.A.T., “Rehabilitation and community care” in, Kendell, R.E. and Zealley, A.K. (eds) *Companion to Psychiatric Studies (Fifth Edition)* (pp. 927-941), Edinburgh: Churchill Livingstone, 1996.



commenced, although concern was consistently expressed about the adequacy of community provision, thus undermining the potential to promote patient dignity.<sup>185</sup>

Notwithstanding these generally positive developments, the first half of the twentieth century did *not* see the emergence of any explicit, systematic or binding recognition of a need for specific protections for the human rights or dignity of individuals with mental disorder. Indeed, for much of the early twentieth century, large numbers of individuals remained detained in psychiatric institutions; certain treatment initiatives were deployed excessively or inappropriately;<sup>186</sup> there was little evidence of social reintegration, political empowerment or enhancement of dignity of individuals released from asylums; and – to this day - there remain large parts of the world in which psychiatric practices are largely untouched by any of these advances.<sup>187</sup>

Notwithstanding these trends, the advents of the UDHR and, especially, ECHR did bring *some* increased attention to the human rights and dignity of the mentally ill, albeit that, as discussed in Section 2.4, the mental health topics dealt with by the European Court of Human Rights tended to focus exclusively on very specific issues (involuntary admission and treatment).<sup>188</sup> While these issues are certainly important, certain other issues are also significant, especially as they relate to patient dignity.

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<sup>185</sup> Mollica, R.F., “From asylum to community”, *New England Journal of Medicine* 1983, 308, 367-373; Fadden et al, 1987; Dyer, 1996; Kelly, B.D., “Mental health policy in Ireland, 1984-2004”, *Irish Journal of Psychological Medicine*, 2004, 21, 61-68; Kelly, 2005.

<sup>186</sup> El-Hai, 2005.

<sup>187</sup> Bloch, S., Reddaway, P., *Soviet Psychiatric Abuse*, Boulder, CO: Westview Press, 1985; Munro, R., *Dangerous Minds*, New York: Human Rights Watch and Geneva Initiative on Psychiatry, 2002.

<sup>188</sup> Bartlett et al, 2007; p. 254; Prior, 2007; p. 556.

The position of voluntary inpatients, for example, has been relatively absent from the range of issues addressed by the court. This may stem, at least in part, from the absence of assertive legal advocacy for voluntary as opposed to involuntary patients: in certain countries, such as England and Ireland, detained patients receive free legal representation (chiefly for mental health tribunals) but voluntary patients, who do not have tribunals, do not automatically receive legal representation or, necessarily, advocacy services. The issue of advocacy could be addressed, at least in part, through pro-active provision of advocacy services for all individuals with mental illness, reflecting a positive obligation on states in respect of certain human rights under the ECHR (see Section 3.3.2.4 for a discussion of such positive obligations).<sup>189</sup>

In any case, the human rights and dignity of the mentally ill only achieved substantial attention at international level towards the end of the twentieth century, with the publication of *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* by the UN in 1991 (see above).<sup>190</sup> The UN and WHO are not, however, the only international actors relevant to human rights and, in order to outline fully the human rights background to the present thesis, it is necessary to examine developments in relation to human rights at the level of the EU (Section 2.6) and at national level in England and Ireland (Section 2.7).

## **2.6 The European Union**

The European Court of Justice is the highest court of the EU and has the primary aims of ensuring equitable application of EU law across member states and reconciling

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<sup>189</sup> Feldman, 2002; pp. 53-55.

<sup>190</sup> UN, 1991.

provisions of EU law with national law within member states.<sup>191</sup> Despite an initial reluctance to become involved in human rights issues, the European Court of Justice has now developed a “body of jurisprudence on human rights” and “respect for fundamental human rights” is now “regarded as an integral part of the general principles of law which the Court is pledged to uphold”.<sup>192</sup>

This commitment to human rights and consequent importance of the European Court of Justice in terms of human rights, were enhanced in 1992 in the Treaty on European Union 1992 (“Maastricht Treaty”) which stated that “the Union shall respect fundamental rights, as guaranteed by the *European Convention for the Protection of Human Rights and Fundamental Freedoms*”.<sup>193</sup> Again, in 1997, the Treaty of Amsterdam further extended the role of the European Court of Justice in relation to human rights by bringing more provisions of the Treaty on European Union under the jurisdiction of the European Court of Justice.<sup>194</sup>

In 2000, at the EU Summit in Nice, the *Charter of Fundamental Rights of the European Union* was adopted in order to “to strengthen the protection of fundamental rights in the light of changes in society, social progress and scientific and technological

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<sup>191</sup> The European Court of Justice was founded in Luxembourg in 1952, as part of the European Coal and Steel Community (founded in 1951). In 1967, all institutions of the European Coal and Steel Community were merged into the European Economic Community (founded in 1957). In 1993, the European Economic Community was renamed the European Community, and the European Community was, in turn, replaced by the EU in 2009.

<sup>192</sup> Smith, 2007; p. 103.

<sup>193</sup> EU, “Treaty on European Union”, *Official Journal*, 1992, C191: article F2.

<sup>194</sup> EU, “Treaty of Amsterdam amending the Treaty of the European Union, the Treaties establishing the European Communities and certain related acts”, *Official Journal*, 1997, C340; Smith, 2007.

developments by making those rights more visible in a Charter”.<sup>195</sup> De Búrca notes that the Charter emerged from an EU drafting process which was “experimental, relatively deliberative and open” and “contrasts quite sharply and favourably with the traditional state-dominated and secretive” processes of the EU.<sup>196</sup> The contents of the Charter demonstrate a number of different influences including *The Council of Europe Convention on Human Rights and Biomedicine*<sup>197</sup> and the revised version of the *EU Social Charter*, which came into effect in 1999.<sup>198</sup>

The rights and prohibitions outlined in the *Charter of Fundamental Rights of the European Union* are generally consistent with those outlined in other comparable documents, most notably the ECHR. Chapter 1, devoted to dignity, outlines rights to “human dignity”, life and “integrity of the person” and includes prohibitions on “torture and inhuman or degrading treatment or punishment” and “slavery and forced labour.” Chapter 2, devoted to freedoms, outlines rights to “liberty and security”, “respect for private and family life”, “protection of personal data” and “freedom of thought, conscience and religion”, amongst others. Chapters 3 to 6 outline further rights on the themes of equality, solidarity, citizens’ rights and justice.

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<sup>195</sup> EU, “Charter of Fundamental Rights of the European Union”, *Official Journal*, 2007, C303; preamble.

<sup>196</sup> De Búrca, G., “The drafting of the European Union Charter of Fundamental Rights”, *European Law Review*, 2001, 26, 126-138; p. 126.

<sup>197</sup> Council of Europe. *ETS 164 Convention on Human Rights and Biomedicine 4, IV*. Strasbourg: Council of Europe, 1997; see also: Hervey, T.K., Kenner, J. (eds), *Economic and Social Rights under the EU Charter of Fundamental Rights: A Legal Perspective*, Oxford: Hart Publishing, 2003; Peers, S., Ward, A. (eds), *The EU Charter of Fundamental Rights*, Oxford: Hart Publishing, 2004.

<sup>198</sup> Hervey, T.K., “We don’t see a connection: the ‘right to health’ in the EU Charter and European Social Charter”, in De Búrca, G. and de Witte, B. (eds), *Social Rights in Europe* (pp. 305-338), Oxford: Oxford University Press, 2005.

The implications of the Charter in terms of health care law and policy are not yet fully clear. In particular, while it is apparent that the Charter may raise awareness of issues related to rights and provide a context for subsequent debate, it is not at all clear whether the Charter will drive or facilitate the development of policy-based solutions to health care problems in the EU.<sup>199</sup> Menéndez argues that the Charter has “symbolic value” in the EU, and “legal value, despite the fact that it has not been incorporated into Community law. This is so to the extent that it consolidates existing law”.<sup>200</sup> Lord Goldsmith highlights the Charter’s intention to protect human rights through limiting the powers of EU institutions “by making clear the restrictions on what they do – emphasizing that they cannot trample on fundamental rights of citizens in doing so”.<sup>201</sup>

In article 52, the Charter attempts explicitly to optimize consistency with the ECHR:

In so far as this Charter contains rights which correspond to rights guaranteed by the *Convention for the Protection of Human Rights and Fundamental Freedoms*, the meaning and scope of those rights shall be the same as those laid down by the said *Convention*. This provision shall not prevent Union law providing more extensive protection.<sup>202</sup>

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<sup>199</sup> McHale, J., “Fundamental rights and health care”, in Mossialos, E., Permanand, G., Baeten, R. and Hervey, T. (eds), *Health Systems Governance in Europe: The Role of EU Law and Policy* (pp. 282-314), Cambridge: Cambridge University Press, 2009.

<sup>200</sup> Menéndez, 2002; p. 471.

<sup>201</sup> Lord Goldsmith, Q.C., “A charter of rights, freedoms and principles”, *Common Market Law Review*, 2001, 38, 1201-1216; p. 1206.

<sup>202</sup> EU, “Charter of Fundamental Rights of the European Union”, *Official Journal*, 2007, C303; article 52.

This issue of consistency is an important one. While the European Court of Justice is part of the EU, and the European Court of Human Rights part of the Council of Europe, the European Court of Justice may, nonetheless, refer to case-law derived from the European Court of Human Rights. While all EU member states have ratified the ECHR and are therefore under the jurisdictions of both the European Court of Justice and the European Court of Human Rights, the Treaty of Lisbon (“Reform Treaty”)<sup>203</sup> makes the EU itself a signatory to the ECHR and, as a result, the European Court of Justice becomes formally subject to the rulings of the European Court of Human Rights. This has the merit of possibly improving consistency in human rights case-law in Europe, but the demerit of constricting and homogenizing avenues of redress following alleged violations of human rights.

Increasingly, however, matters relating to rights may be resolved at national level owing to the incorporation of human rights standards into national legislation. These developments are considered next.

## **2.7 Human rights in national legislative form**

### **2.7.1 The Human Rights Act 1998 in England**

The Human Rights Act 1998 was introduced in the UK in order to “give further effect to rights and freedoms guaranteed under the European Convention on Human Rights”.<sup>204</sup> In summary, the Act makes a remedy for breach of the ECHR available in

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<sup>203</sup> EU, “Consolidated versions of the Treaty on European Union and the Treaty on the Functioning of the European Union”, *Official Journal*, 2008, C115.

<sup>204</sup> Human Rights Act 1998, preamble.

UK courts;<sup>205</sup> abolishes the death penalty;<sup>206</sup> and requires judges in the UK to take account of decisions of the European Court of Human Rights.<sup>207</sup> In addition, the Act makes it unlawful for public bodies in the UK to act in a way that is incompatible with the ECHR.<sup>208</sup>

More specifically, the Human Rights Act 1998 requires that a UK “court or tribunal determining a question which has arisen in connection with a Convention right must take into account” the jurisprudence of the European Court and Commission on Human Rights and the Committee of Ministers (of the Council of Europe) in “so far as, in the opinion of the court or tribunal, it is relevant to the proceedings”.<sup>209</sup> Section 3 requires that national legislation be interpreted in accordance with the ECHR in so far as possible.<sup>210</sup> This requirement applies not only to courts and tribunals, but all “public authorities”<sup>211</sup>; this “strong interpretative obligation is one of the most important provisions in the Human Rights Act” (see Sections 3.3.2.4 and 7.4).<sup>212</sup>

Section 4 states that if a higher “court is satisfied that [a provision of primary legislation] is incompatible with a Convention right, it may make a declaration of that incompatibility”, although such a declaration “does not affect the validity, continuing operation or enforcement of the provision”.<sup>213</sup> Section 19 requires that a “minister of

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<sup>205</sup> Human Rights Act 1998, section 8.

<sup>206</sup> Human Rights Act 1998, section 21.

<sup>207</sup> Human Rights Act 1998, section 2.

<sup>208</sup> Human Rights Act 1998, section 6(1).

<sup>209</sup> Human Rights Act 1998, section 2.

<sup>210</sup> Human Rights Act 1998, section 3.

<sup>211</sup> Human Rights Act 1998, section 6(1).

<sup>212</sup> Wadham et al, 2007; p. 52.

<sup>213</sup> Human Rights Act 1998, section 4.

the Crown in charge of a Bill in either House of Parliament must, before Second Reading of the Bill” either make a “statement of compatibility” with the ECHR or else explicitly acknowledge that “he is unable” to do so but “nevertheless wishes the House to proceed with the Bill”.<sup>214</sup> In the event that a “declaration of incompatibility” is ultimately made by a court and “if a Minister of the Crown considers that there are compelling reasons for proceeding under this section, he may by order make such amendments to the legislation as he considers necessary to remove the incompatibility”.<sup>215</sup>

Overall, the Human Rights Act 1998 represented a significant recognition of the importance of human rights in the UK. Subsequent case-law has involved a range of themes including individual rights to privacy, objections against eviction from public lands by public authorities, and various issues related to immigration.<sup>216</sup> Overall, Fenwick describes the impact of the Act as “immensely variable” but argues “it provides a means of reversing the erosion of fundamental freedoms which occurred under the Thatcher, Major, and now Labour Governments in the context of public protest, state surveillance and suspects’ rights, especially those of terrorist suspects”.<sup>217</sup>

There are still, however, several important issues outstanding. Wadham et al lament the perceived failure of the Act to create “a culture of respect for human rights” and suggest

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<sup>214</sup> Human Rights Act 1998, section 19.

<sup>215</sup> Human Rights Act 1998, section 10.

<sup>216</sup> Overviews of case-law relating to the Human Rights Act 1998 are provided by: Fenwick, H., *Civil Liberties and Human Rights (Fourth Edition)*, Oxon and New York: Routledge-Cavendish, 2007; Wadham et al, 2007; McHale et al, 2006; Wicks, E., *Human Rights and Healthcare*, Portland, OR: Hart, 2007.

<sup>217</sup> Fenwick, 2007; p. 295.



it is “widely misunderstood and mistrusted by the public”.<sup>218</sup> The future of the legislation is also somewhat uncertain, owing to a diversity of opinion within the current (2013) coalition government<sup>219</sup> and the establishment, in 2011, of a commission to review the legislation.<sup>220</sup> Fenwick highlights another important, unresolved issue by drawing attention to the extent to which the Act constitutes a bill of rights as opposed to a means of giving “further effect” to the ECHR and “affording readier access to Strasbourg principles in domestic courts”.<sup>221</sup> These matters are illustrated, at least in part, through examination of issues relating to human rights and mental health in English courts since the Human Rights Act 1998 (Section 3.3.2). The incorporation of the ECHR into national legislative form in Ireland is, however, considered first.

### **2.7.2 The European Convention on Human Rights Act 2003 in Ireland**

Irish law is rooted in the Constitution of Ireland<sup>222</sup> which states that “all citizens shall, as human persons, be held equal before the law”.<sup>223</sup> The State “guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen” and “no citizen shall be deprived of his personal liberty save in accordance with law”.<sup>224</sup> Article 42 deals with the “right” to education,<sup>225</sup> article 43

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<sup>218</sup> Wadham et al, 2007; pp. 12-13.

<sup>219</sup> Kettle, M., “Britain must beware the dystopic drift towards a US-style judiciary”, *Guardian*, 2012, 28 March; Rausing, S., “Yes to reforming the European court of human rights. No to overriding it”, *Guardian*, 2011, 7 December.

<sup>220</sup> Travis, A., Wintour, P., “Deadlock likely on commission pondering a British bill of rights”, *Guardian*, 2011, 18 March; Pinto-Duschinsky, M., “The hijacking of the human rights debate”, *Standpoint*, 2012, 42, 34-37.

<sup>221</sup> Fenwick, 2007; p. 297.

<sup>222</sup> Hogan & Whyte, 2003.

<sup>223</sup> Constitution of Ireland, article 40.

<sup>224</sup> Constitution of Ireland, article 40.

outlines the right to “private property”;<sup>226</sup> and article 44 outlines the right to “freedom of conscience and the free profession and practice of religion”.<sup>227</sup>

Economic and social rights are not mentioned in the Constitution, but article 45 deals with “directive principles of social policy”:

The State shall strive to promote the welfare of the whole people by securing and protecting as effectively as it may a social order in which justice and charity shall inform all the institutions of the national life.<sup>228</sup>

When the Constitution was published, little attention was paid to the rights outlined in it, “possibly because the framers of the 1937 Constitution expressly intended them as mere ‘headlines to the legislature’ rather than as an essential part of the mechanism of a vigorous judicial review”, although “in practice they have contributed significantly to the protection of the rights of the individual”.<sup>229</sup> Bacik, by contrast, notes that “it can be argued that the effect of constitutional rights in achieving improvement in the lives of ordinary people has been minimal. This is due in part to the type of belief-systems underlying the Constitution, and in part to the mostly conservative interpretation of these rights by judges”.<sup>230</sup>

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<sup>225</sup> Constitution of Ireland, article 42.

<sup>226</sup> Constitution of Ireland, article 43.

<sup>227</sup> Constitution of Ireland, article 44.

<sup>228</sup> Constitution of Ireland, article 45.

<sup>229</sup> Hogan and Whyte, 2003; p. 1245.

<sup>230</sup> Bacik, I., “A human rights culture for Ireland?”, in Bacik, I. and Livingstone, S. (eds), *Towards a Culture of Human Rights in Ireland* (pp. 1-45), Cork: Cork University Press in association with the Centre for Cross Border Studies (Armagh), 2001; p. 23.

Relevant case-law in relation to Irish Constitutional rights,<sup>231</sup> however, demonstrates growing judicial activism throughout the 1970s, strengthened by the increasing influence of the ECHR and Ireland's accession to the European Economic Community (1973), both of which moved Ireland towards a "human rights culture" by the 1990s.<sup>232</sup> This trend took a significant step forward in 2000 with the Human Rights Commission Act 2000. This Act found its roots not only in the emerging emphasis on human rights in Irish and European courts, but also the "Northern Ireland Peace Agreement" of 10 April 1998 in which the Irish Government agreed to "take steps to further strengthen the protection of human rights in its jurisdiction", "establish a Human Rights Commission" and "introduce equal status legislation".<sup>233</sup>

The resultant Human Rights Commission Act 2000 aimed "to provide further protection for human rights and, for that purpose, to establish a body to be known as an *Coimisiún um Chearta an Duine*"<sup>234</sup> (Human Rights Commission). Section 2 defined "human rights" as:

- (a) The rights, liberties and freedoms conferred on, or guaranteed to, persons by the Constitution, and
- (b) The rights, liberties or freedoms conferred on, or guaranteed to, persons by any agreement, treaty or convention to which the State is a party.<sup>235</sup>

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<sup>231</sup> Hogan and Whyte, 2003.

<sup>232</sup> Bacik, 2001; p. 1.

<sup>233</sup> Northern Ireland Peace Agreement, section 6, paragraph 9.

<sup>234</sup> Human Rights Commission Act 2000, preamble.

<sup>235</sup> Human Rights Commission Act 2000, section 2.

The Irish Human Rights Commission was founded by the Act<sup>236</sup> and its functions are to review State laws and practices relating to the protection of human rights; examine legislative proposals; make relevant recommendations to government; and promote understanding and awareness of human rights.<sup>237</sup> The Human Rights Commission can also conduct enquiries, publish research and reports, apply to appear before the High Court or the Supreme Court as *amicus curiae*, and, under certain circumstances, institute proceedings relating to human rights.<sup>238</sup>

In 2006, five years after its establishment, the Irish Human Rights Commission had become active in a range of areas related to human rights, and, throughout 2006, received 242 communications from members of the public and 64 communications from organisations or in respect of legal proceedings.<sup>239</sup> Almost one-third of communications related to the administration of justice (32.3%) while issues related to economic and cultural rights accounted for just 12%.

Consistent with this increased emphasis on human rights in Irish public life from the 1970s onwards, the ECHR was finally, formally incorporated into Irish law in 2003, with the European Convention on Human Rights Act 2003. This Act aimed, primarily, “to enable further effect to be given, subject to the Constitution, to certain provisions of the Convention for the Protection of Human Rights and Fundamental Freedoms”.<sup>240</sup>

Using wording similar to the Human Rights Act 1998 in the UK, section 2 states:

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<sup>236</sup> Human Rights Commission Act 2000, sections 3 and 4.

<sup>237</sup> Human Rights Commission Act 2000, section 5.

<sup>238</sup> Human Rights Commission Act 2000, section 9.

<sup>239</sup> Irish Human Rights Commission, *Annual Report 2006*, Dublin: Irish Human Rights Commission, 2007; p. vi.

<sup>240</sup> European Convention on Human Rights Act 2003, preamble.

In interpreting and applying any statutory provision or rule of law, a court shall, in so far as is possible, subject to the rules of law relating to such interpretation and application, do so in a manner compatible with the State's obligations under the Convention provisions.<sup>241</sup>

Section 3 outlines the duty of all public bodies to adhere to the ECHR stating that “every organ of the State shall perform its functions in a manner compatible with the State's obligations under the Convention provisions”.<sup>242</sup> Section 4 states that “judicial notice shall be taken of the Convention provisions” and of the jurisprudence of the European Court of Human Rights, European Commission of Human Rights and Council of Ministers.<sup>243</sup>

The High Court or Supreme Court may make a “declaration of incompatibility” when “a statutory provision or rule of law is incompatible with the State's obligations under the Convention provisions”.<sup>244</sup> Following a “declaration of incompatibility”, a copy of the declaration will “be laid before each House of the Oireachtas” (Irish parliament) and “the Government may request an adviser appointed by them to advise them as to the amount of...compensation (if any)”.<sup>245</sup>

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<sup>241</sup> European Convention on Human Rights Act 2003, section 2.

<sup>242</sup> European Convention on Human Rights Act 2003, section 3. The definition of “organ of the State”, however, explicitly excludes the courts: ““Organ of the State” includes a tribunal or any other body (other than the President or the Oireachtas or either House of the Oireachtas or a Committee of either such House or a Joint Committee of both such Houses or a court) which is established by law or through which any of the legislative, executive or judicial powers of the State are exercised” (section 1(1)).

<sup>243</sup> European Convention on Human Rights Act 2003, section 4.

<sup>244</sup> European Convention on Human Rights Act 2003, section 5.

<sup>245</sup> European Convention on Human Rights Act 2003, section 5.

The formal incorporation of the ECHR into Irish law represented a significant enhancement of the importance accorded to human rights in Irish law. It is notable that the European Convention on Human Rights Act 2003 has much in common with the Human Rights Act 1998 in the UK, especially in terms of its aim to give “further effect” to the ECHR in domestic law;<sup>246</sup> the direction that interpretation of any “statutory provision or rule of law” be consistent with the ECHR;<sup>247</sup> the direction that “every organ of the State” shall “perform its functions” in a fashion consistent with the ECHR (although the courts are excluded in Ireland);<sup>248</sup> the direction that national courts shall take “judicial notice” of relevant ECHR jurisprudence;<sup>249</sup> and establishment of a procedure for a “declaration of incompatibility” to be made by higher courts, when national legislation is incompatible with the ECHR.<sup>250</sup>

There are, however, significant differences between the incorporation of the ECHR into national legislation in Ireland and the UK. In the UK, but not Ireland, there is a legislative requirement that ministers outline to parliament whether or not proposed legislation is compatible with the ECHR; although this mechanism is unlikely to provide an absolute assurance of compatibility in the UK, bills in the UK can also be scrutinised by the Joint Committee on Human Rights in order to optimise compatibility.

More significantly, while the Human Rights Act 1998 in the UK presents clear outline of the procedure to be followed in making a “remedial order” following a “declaration

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<sup>246</sup> European Convention on Human Rights Act 2003, preamble.

<sup>247</sup> European Convention on Human Rights Act 2003, section 2.

<sup>248</sup> European Convention on Human Rights Act 2003, section 3.

<sup>249</sup> European Convention on Human Rights Act 2003, section 4.

<sup>250</sup> European Convention on Human Rights Act 2003, sections 5 and 6.

of incompatibility”,<sup>251</sup> there are no similar guidelines in Ireland, apart from a procedure to award compensation to any “injured party”.<sup>252</sup> In addition, there is no provision for Irish courts to quash legislation which is found to be incompatible with the ECHR.<sup>253</sup> As a result, if an Irish judge finds that a law is contrary to the ECHR but is without means to act upon this finding, it is likely that judges (of superior courts) will prefer to declare such a law to be contrary to the Constitution, with the usual consequent effect that it is struck down.<sup>254</sup>

In Ireland, experience to date confirms that, while the principles of the ECHR are increasingly discussed in Irish courts, there is a tendency for cases to be decided by reference to the Constitution or domestic law rather than the ECHR or European Convention on Human Rights Act 2003. In *TH v DPP* [Director of Public Prosecutions], for example, the applicant argued that a series of alleged irregularities during his trial had violated both his constitutional and ECHR rights, but when the High Court found that the delay violated his constitutional right to a reasonably expeditious trial, the court did not deem it necessary to proceed to consider arguments based on the ECHR.<sup>255</sup>

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<sup>251</sup> Human Rights Act 1998, schedule 2.

<sup>252</sup> European Convention on Human Rights Act 2003, section 5.

<sup>253</sup> Mullan points out that the “reason given for such exclusions is that this was necessary to avoid a clash between the provisions of the ECHR and the Constitution. However it is suggested that this difficulty could have been circumvented by providing that any such power must be exercised subject to the requirements of the Constitution” (Mullan, G., “Incorporation of the ECHR into Irish Law”, in Moriarty, B. Massa, E. (eds), *Human Rights Law (Second Edition)* (pp. 69-81), Oxford: Oxford University Press/Law Society of Ireland, 2008; p. 75).

<sup>254</sup> Mullan, 2008; p. 76.

<sup>255</sup> *TH v DPP* [2006] 3 IR 520.

Similarly, in *JF v DPP* the court found that there had been a breach of the constitutional right to a fair trial and went on to state that the ECHR did not provide additional rights above those already contained in domestic law in this matter.<sup>256</sup> One notable exception is the case of *TS*, a High Court appeal in relation to the MHA 2001, in which the judge took explicit and apparently decisive account of relevant ECHR case-law.<sup>257</sup> This case is considered in greater depth following discussion of the MHA 2001 (Section 4.4.2).

Overall, the advent of the European Convention on Human Rights Act 2003 has resulted in ECHR principles being discussed in an increasing number of cases in Irish courts; increased consideration of ECHR-related jurisprudence from other jurisdictions (e.g. UK) in Irish courts; and increased public awareness of the ECHR.<sup>258</sup> Further experience is necessary in order to determine the precise inter-relationship between ECHR rights and the Irish Constitution, and the extent to which the European Convention on Human Rights Act 2003 represents an effective incorporation of ECHR principles into Irish law.

## **2.8 Conclusions**

As the ideas and language of human rights developed throughout the eighteenth and nineteenth centuries, individuals with mental illness still lived lives of poverty and destitution, poorly supportive of human dignity and capabilities. The dramatic increase in numbers detained in asylums during the nineteenth century and first half of the

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<sup>256</sup> *JF v DPP* [2005] 2 IR 174.

<sup>257</sup> *TS v Mental Health Tribunal, Ireland, The Attorney General, The Minister for Health and Children, The Mental Health Commission, Bola Oluwole and Ciaran Power* [2007] JR 1562.

<sup>258</sup> Mullan, 2008; pp. 80-81.



twentieth century was generally motivated by paternalistic impulses rather than empowerment of the mentally ill, and brought myriad problems related to lengthy detentions in large, overcrowded institutions.

While the 1960s and 1970s saw significant psychiatric de-institutionalisation, there was still little emphasis on promoting the rights, dignity or capabilities of the mentally ill.

The absence of adequate community support in many areas also undermined the potentially empowering effects of de-institutionalisation and, like the poorly-conceived institutional care which preceded it, continued to undermine the dignity of the mentally ill, now in the more public sphere of the community rather than the asylum.

The UDHR and ECHR represented substantial steps forward for human rights and, potentially, dignity. The ECHR even included specific provisions regarding the right to liberty for individuals with mental illness, and the right to a court review of deprivation of liberty on the grounds of mental illness. There was a further step forward in 1991, with the UN's *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, which affirmed that all of the rights outlined in the UDHR applied equally to the mentally ill. These developments, at least in theory, held real potential to advance the human rights, dignity and capabilities of the mentally ill.

Over the past fifty years, the European Court of Human Rights has duly delivered judgments emphasising that deprivation of liberty owing to mental disorder must be in accordance with national law, informed by medical opinion, and accompanied by timely access to a court for review. Psychiatric detention must occur in a therapeutic environment; interference “private and family life” must be proportionate to need; and,

in the event that discharge is indicated clinically or mandated by a tribunal and does not occur owing to lack of resources, continued detention must be reviewed appropriately.

Many of these cases represented advances in the protection of specific rights and the dignity of the mentally ill, albeit that these cases tended to focus on areas of traditional concern in asylum-based mental health services (involuntary detention and treatment) and not on other issues which are also important to the mentally ill, especially in community-based services (e.g. the position of voluntary patients, and economic and social rights).

Against this background, the incorporation of the ECHR into national legislation in both England and Ireland offers enhanced opportunity for the protection of ECHR rights and enhancement of dignity for the mentally ill, as well as all other citizens. These developments also form a key element of the backdrop against which mental health legislation was revised in England and Ireland over the past decade. The next chapter in this thesis focuses on this process of reform in England (Chapter 3) and the following chapter focuses on Ireland (Chapter 4).

## **Chapter 3**

### **Mental health legislation in England**

#### **3.1 Introduction**

Chapters 1 and 2 of this thesis provided a background to key concepts relating to mental disorder, human rights, dignity and paternalism, as well as the growing application of the idea of human rights to the mentally ill throughout the late twentieth century.

This chapter moves this examination forward by focussing on mental health legislation in England. More specifically, this chapter examines the provisions of the MHA 1983 (Section 3.2); outlines specific issues stemming from the MHA 1983 (Section 3.3); and explores the provisions and human rights implications of the MHA 2007, which substantially amended, but did not replace, the MHA 1983 (Section 3.4). An overall assessment of current English mental health legislation is provided in Section 3.5.

#### **3.2 Background to current mental health legislation in England**

##### **3.2.1 Background to the Mental Health Act 1983**

There has been some form of statutory control or regulation of individuals with mental illness in England since at least the fourteenth century, when the *De Praerogativa Regis*

permitted the Crown to acquire the estates and lands of “lunatics” and “idiots”.<sup>259</sup> The first substantial, specific legislative recognition of the need for dedicated inpatient psychiatric care was the Vagrancy Act 1744 which permitted the detention of individuals with mental illness on the order of two Justices of the Peace.<sup>260</sup> The legislative framework underpinning asylum care evolved throughout the 1800s, with the Lunacy Acts of 1890 and 1891 substantially revising admission criteria.<sup>261</sup>

In 1926, the Royal Commission on Lunacy and Mental Disorder signalled a significant shift in emphasis by proposing a voluntary admission status and establishment of outpatient and after-care services.<sup>262</sup> The Mental Treatment Act 1930 duly introduced voluntary admission status, a development which coincided with the introduction of outpatient psychiatric services throughout France, Germany, England and elsewhere.<sup>263</sup>

In 1948 the National Health Service (NHS) was established, adding impetus to the move from institutional to community care.<sup>264</sup> In 1957, the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency declared that when any hospital in-patient was at a point where he or she could be discharged if he or she had a reasonably good home to go to, the provision of residential care became the responsibility of the local authority.<sup>265</sup> The Commission recommended that psychiatric

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<sup>259</sup> Bowen, P., *Blackstone's Guide to The Mental Health Act 2007*, Oxford: Oxford University Press, 2007; p. 10.

<sup>260</sup> Bowen, 2007; p. 11.

<sup>261</sup> Shorter, 1997; p. 231.

<sup>262</sup> Royal Commission, *Report of the Royal Commission on Lunacy and Mental Disorders (Cmd. 2700)*, London: Stationery Office, 1926.

<sup>263</sup> Shorter, 1997; p. 230.

<sup>264</sup> Mulholland, C., *A Socialist History of the NHS*, Saarbrücken: VDM Verlag, 2009.

<sup>265</sup> Department of Health and Social Security, 1957.

treatment should be provided with the minimum curtailment of liberty and as little legal formality as possible.

The MHA 1959 reinforced many key elements of the Mental Treatment Act 1930 and 1957 Commission, most notably by promoting voluntary as opposed to involuntary admission<sup>266</sup> and changing the decision process regarding involuntary admission from a judicial to clinical one.<sup>267</sup> Doctors and social workers were given discretionary powers to detain and treat individuals with mental illness where it was necessary for their health and safety, or the protection of others.<sup>268</sup>

Over the following decades, significant progress was made dismantling institutional care structures throughout England. While this had the welcome effect of promoting treatment in non-restrictive settings, the development of community-based facilities was commonly criticised as inadequate.<sup>269</sup> In 1975, a government White Paper, *Better Services for the Mentally Ill*, presented specific targets for improving community-based facilities.<sup>270</sup> Notwithstanding problems achieving those targets, the Department of Health published a further consultation document in 1981, *Care in the Community. A Consultative Document on Moving Resources for Care in England*, outlining a continued commitment to community care.<sup>271</sup>

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<sup>266</sup> Bowen, 2007; p. 13.

<sup>267</sup> Unsworth, C., *The Politics of Mental Health Legislation*, Oxford: Clarendon Press, 1987; Moncrieff, J., "The politics of a new Mental Health Act", *British Journal of Psychiatry*, 2003, 183, 8-9.

<sup>268</sup> Fennell, P., *Mental Health: The New Law*, Bristol: Jordan Publishing Limited, 2007; pp. 2-3.

<sup>269</sup> Fadden et al, 1987; Dyer, 1996.

<sup>270</sup> Department of Health and Social Security, *Better Services for the Mentally Ill. Cmnd 6233*, London: Her Majesty's Stationery Office, 1975.

<sup>271</sup> Department of Health and Social Security, *Care in the Community. A Consultative Document on Moving Resources for Care in England*, London: Her Majesty's Stationery Office, 1981.

Notwithstanding the emergence of community-based treatments for mental illness during the 1960s and 1970s, there was still a recognized need to strengthen safeguards for human rights in relation to admission, especially involuntary admission, to psychiatric hospitals.<sup>272</sup> Acknowledgement of this need stemmed from specific human rights concerns<sup>273</sup> as well as the broader growth of the civil rights movement and mental health service-user groups, such as the National Association of Mental Health.<sup>274</sup> In 1978, the government duly published a White Paper proposing increased safeguards for the liberties of individuals with mental illness, whilst also having regard for the safety of others.<sup>275</sup> These concerns were again reflected in a further White Paper in 1981, *Reform of Mental Health Legislation*,<sup>276</sup> which helped shape the MHA 1983.

### 3.2.2 The Mental Health Act 1983

The MHA 1983 introduced important reforms to mental health legislation, many of which had implications in terms of human rights. An understanding of key provisions of the MHA 1983 (in this section) and issues stemming from it (Section 3.3) helps

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<sup>272</sup> Gostin, L.O., *A Human Condition: The Mental Health Act from 1959 to 1975, Volume 1*, Leeds: National Association for Mental Health (MIND), 1975.

<sup>273</sup> *X v UK* (1981) 4 EHRR 181; Bowen, 2007; p. 14.

<sup>274</sup> Bluglass, R., “The origins of The Mental Health Act 1983”, *Bulletin of the Royal College of Psychiatrists*, 1984, 8, 127-134; p. 128; Gostin, L O., *A Human Condition: The Law Relating to Mentally Abnormal Offenders. Observations, Analysis and Proposals for Reform. Volume 2*, Leeds: National Association for Mental Health (MIND), 1975; Gunn, J., “Reform of mental health legislation”, *British Medical Journal*, 1981, 283, 1487-1488.

<sup>275</sup> Department of Health and Social Security, *Review of the Mental Health Act 1959*, London: Her Majesty’s Stationery Office, 1975.

<sup>276</sup> Department of Health and Social Security, *Reform of Mental Health Legislation*, London: Her Majesty’s Stationery Office, 1981.

contextualise the MHA 2007, which amended, but did not replace, the MHA 1983 (Section 3.4).

The MHA 1983 defined “mental disorder” to include “mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind”.<sup>277</sup> Definitions were also provided for “severe mental impairment”, “mental impairment” and “psychopathic disorder”, but there was no further definition of “mental illness”.<sup>278</sup> The Act stated that nobody was to be deemed to suffer from a mental disorder “by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs”.<sup>279</sup> This slightly vague but intentionally restrictive statement clarified the emphasis to be placed on medical diagnosis rather than societal judgment in determining who could be detained.<sup>280</sup>

The MHA 1983 permitted involuntary “admission for assessment” for individuals with mental disorder for up to 28 days, provided admission was supported by medical opinion.<sup>281</sup> “Admission for treatment” for up to six months<sup>282</sup> required two medical opinions, and assurance that, “in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition”,<sup>283</sup> and “it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment”.<sup>284</sup>

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<sup>277</sup> MHA 1983, section 1(2).

<sup>278</sup> MHA 1983, section 1(2).

<sup>279</sup> MHA 1983, section 1(3).

<sup>280</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387; *X v UK* (1981) 4 EHRR 188.

<sup>281</sup> MHA 1983, section 2(3); *Winterwerp v Netherlands* (1979) 2 EHRR 387; *X v UK* (1981) 4 EHRR 188.

<sup>282</sup> MHA 1983, section 3(2)(a).

<sup>283</sup> MHA 1983, section 3(2)(b).

The legislation also contained provisions for “guardianship”,<sup>285</sup> based on “the written recommendations in the prescribed form of two registered medical practitioners”.<sup>286</sup> Compared to involuntary admission, guardianship was “much more limited in its scope, simply giving the guardian (usually a local authority) the three essential powers of determining where a patient shall live, that he shall have treatment, and that he may be visited at home”.<sup>287</sup>

Regarding treatment of individuals detained or under guardianship:

The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being treatment falling within section 57 or 58 above, if the treatment is given by or under the direction of the responsible medical officer.<sup>288</sup>

Second opinions were required prior to administration of certain treatments to detained patients (e.g. psychosurgery).<sup>289</sup> If an individual was detained for more than three months, they had to either consent to continued “administration of medicine” (with the responsible medical officer documenting capacity) or be seen by another medical practitioner to certify that “that the patient is not capable of understanding the nature, purpose and likely effects of that treatment or has not consented to it but that, having

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<sup>284</sup> MHA 1983, section 3(2)(c).

<sup>285</sup> MHA 1983, section 7(2)(a).

<sup>286</sup> MHA 1983, section 7(3).

<sup>287</sup> Gunn, 1981; p. 1487

<sup>288</sup> MHA 1983, section 63.

<sup>289</sup> MHA 1983, section 57(1)-(2).



regard to the likelihood of its alleviating or preventing a deterioration of his condition, the treatment should be given”.<sup>290</sup> This requirement for consent for certain treatments recognized that the detained patient could retain capacity for certain matters and increased observance of patients’ autonomy and dignity.

Detained patients could apply to the Mental Health Review Tribunal following admission for assessment (within 14 days), admission for treatment (within six months) or being received into guardianship (within six months), amongst other circumstances.<sup>291</sup> The Tribunal could direct the discharge of a patient detained for assessment if they were not satisfied that the patient has a “mental disorder of a nature or degree which warrants his detention in a hospital for assessment” and “that his detention as aforesaid is justified in the interests of his own health or safety or with a view to the protection of other persons”.<sup>292</sup>

The Tribunal could direct the discharge of a patient otherwise detained if not satisfied “(i) that he is then suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment or from any of those forms of disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or (ii) that it is necessary for the health of safety of the patient or for the protection of other persons that he should receive such treatment; or (iii) in the case of an application by virtue of paragraph (g) of section 66(1) above, that the patient, if

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<sup>290</sup> MHA 1983, section 58(3)(b).

<sup>291</sup> MHA 1983, section 66).

<sup>292</sup> MHA 1983, section 72(1)(a).

released, would be likely to act in a manner dangerous to other persons or to himself.”<sup>293</sup>

While these provisions paternalistically permitted detention of individuals who “if released, would be likely to act in a manner dangerous to other persons or to himself”, the MHA 1983 also provided more subtle, discretionary powers to Tribunals: the Tribunal could, for example, “direct the discharge of a patient on a future date specified in the direction” or make recommendations that “he be granted leave of absence or transferred to another hospital or into guardianship”<sup>294</sup> or that “the responsible medical officer consider whether to make a supervision application”.<sup>295</sup> This reflected a modulated, nuanced and broadly realistic approach to cases which were likely to be complex and changeable over time. Overall, these Tribunals reflected the ECHR requirement that detention orders be independently reviewed by a “court”,<sup>296</sup> although it was less clear whether the time-frames involved were consistent with the ECHR requirement to hold reviews “speedily”.<sup>297</sup>

Finally, the MHA 1983 outlined a mechanism for “after-care under supervision” in the community, once certain conditions were met and it was supported by medical opinion.<sup>298</sup> Compulsory treatment in the community is, however, a deeply controversial topic and its clinical usefulness far from established.<sup>299</sup> In addition, while such orders

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<sup>293</sup> MHA 1983, section 72(1)(b).

<sup>294</sup> MHA 1983, section 72(3).

<sup>295</sup> MHA 1983, section 72(3A).

<sup>296</sup> ECHR, article 5(4).

<sup>297</sup> ECHR, article 5(4).

<sup>298</sup> MHA 1983, section 25B(5)-(6).

<sup>299</sup> Kisely, S., Campbell, L.A., Preston, N., “Compulsory community and involuntary outpatient treatment for people with severe mental disorders”, *Cochrane Database of Systematic Reviews*, 2005, 3,

may facilitate treatment in a setting less restrictive than hospital detention, they also support the idea that individuals who are not detained within an institution can be subject to restrictions and requirements which impinge significantly on their freedoms.<sup>300</sup> The human rights implications of such orders are discussed in greater depth in Section 3.4.5, after consideration of other issues stemming from the MHA 1983.

### **3.3 Issues stemming from the Mental Health Act 1983**

Owing to a long-acknowledged need for reform,<sup>301</sup> the MHA 1983 was “met with general approval, sometimes muted, from others with some enthusiasm”.<sup>302</sup> In the years between the 1983 and 2007 Acts, however, two key issues were to become the focus of concern: public safety (3.3.1) and human rights (3.3.2).

#### **3.3.1 Public safety**

There has long been an association between mental disorder and dangerousness in the public mind, even in advance of any systematic studies of the matter.<sup>303</sup> Research over recent decades has confirmed that individuals with mental disorders such as

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CD004408; Lawton-Smith, S., Dawson, J., Burns, T., “Community treatment orders are not a good thing”, *British Journal of Psychiatry*, 2008, 193, 96-100.

<sup>300</sup> Kelly, B.D., “Community treatment orders under the MHA 2007 in England and Wales: what are the lessons for Irish mental health legislation?”, *Medico-Legal Journal of Ireland*, 2009, 15, 43-48.

<sup>301</sup> Department of Health and Social Security, *Review of the Mental Health Act 1959*, London: Her Majesty’s Stationery Office, 1975; Department of Health and Social Security, *Reform of Mental Health Legislation*, London: Her Majesty’s Stationery Office, 1981.

<sup>302</sup> Bluglass, 1984; p. 133.

<sup>303</sup> Shorter, 1997.

schizophrenia are slightly more likely to engage in acts of violence than individuals without such illnesses.<sup>304</sup> At population level, however, the proportion of violent crime attributable to mental disorder is extremely low<sup>305</sup> and much is attributable to co-occurring drug misuse, which increases the risk of violence in individuals with and without mental disorder.<sup>306</sup>

Despite this increased risk, violence remains a rare event in mental disorder and is, therefore, extremely difficult to predict: the most detailed predictive models, which include almost all known risk factors for violence in schizophrenia, can only explain 28.3% of the variation in violence between individuals with schizophrenia.<sup>307</sup> Even if there was a predictive model that was 90% sensitive and 90% specific (both of which are unrealistically high levels in any field of medicine), the rarity of homicide by individuals with severe mental disorder means that such a predictive model would generate at least 2000 false positives for every true positive; i.e. 2001 mentally ill individuals would need to be detained in order to prevent (or delay) a single homicide.<sup>308</sup>

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<sup>304</sup> Torrey, E.F., *Surviving Schizophrenia (Fourth Edition)*, New York: Quill/HarperCollins, 2001; Foley, S., Kelly, B.D., Clarke, M., McTigue, O., Gervin, M., Kamali, M., Larkin, C., O'Callaghan, E., Browne, S., "Incidence and clinical correlates of aggression and violence in patients with first episode psychosis", *Schizophrenia Research*, 2005, 72, 161-168.

<sup>305</sup> Walsh, E., Buchannan, A., Fahy, T., "Violence and schizophrenia", *British Journal of Psychiatry*, 2001, 180, 490– 495.

<sup>306</sup> Steadman, H.J., Mulvey, E.P., Monahan, J., Clark Robbins, P., Applebaum, P.S., Grisso, T., Roth, L.H., Silver, E., "Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighbourhoods", *Archives of General Psychiatry*, 1998, 55, 393–401.

<sup>307</sup> Foley et al, 2005.

<sup>308</sup> Szmulker, G., "Homicide enquiries", *Psychiatric Bulletin*, 2000, 24, 6-10.

Notwithstanding these considerations, the issue of public safety has featured prominently in most considerations of mental health law in the UK in recent decades:

Since the 1990s successive governments have pursued a public safety agenda in relation to mental health services responding to concerns about homicides by mentally disordered people. These fears have had a profound impact on mental health law and policy and produce tensions between the agendas of public safety and social inclusion.<sup>309</sup>

Despite these “tensions”, public safety has remained a key consideration in the formulation of mental health legislation in England, even in an era of increased emphasis on human rights.<sup>310</sup>

The issue of public safety came to particular attention in 1992 when Christopher Clunis, a man with a history of mental disorder, killed Jonathan Zito, a musician, in London. Eight days earlier, Mr Clunis had been found wandering the streets and attacking people with a breadknife and screwdriver.<sup>311</sup> The subsequent enquiry was critical of the police, doctors, nurses, social workers and a general lack of resources required to monitor and treat patients who appeared to present a high risk to the public.<sup>312</sup> The enquiry recommended a national register for patients considered at high risk of violence,

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<sup>309</sup> Fennell, 2007; pp. 6-7. See also: Bartlett, P., Sandland, R., *Mental Health Law: Policy and Practice (Third Edition)*, Oxford: Oxford University Press, 2007; p. 151.

<sup>310</sup> Bowen, 2007; pp. 10-23.

<sup>311</sup> Court, C., “Clunis inquiry cites “catalogue of failure””, *British Medical Journal*, 1994, 308, 613.

<sup>312</sup> Ritchie, J.H., Dick, D., Lingham, R., *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. London: Her Majesty’s Stationery Office, 1994; Coid, J.W., “The Christopher Clunis enquiry”, *Psychiatric Bulletin*, 1994, 18, 449-452.

specialist services for their care, and procedures for supervised discharge orders, to permit patients to be recalled if non-compliant with treatment.

This concern with public safety became a key feature in the deliberations of the “Expert Committee”, chaired by Professor Geneva Richardson, charged with advising the government “on the degree to which current legislation needs updating to support effective delivery of modern patterns of clinical and social care for people with mental disorder and to ensure that there is a proper balance between safety (both of individuals and the wider community) and the rights of individual patients”.<sup>313</sup>

The Committee noted that a “small minority” believed that “a mental health act should authorise treatment in the absence of consent *only* for those who lack capacity” and “if a person with a mental disorder who refused treatment was thought to pose a serious risk to others then he or she should be dealt with through the criminal justice system, not through a health provision”.<sup>314</sup> There was, however, “a much larger body of opinion which was prepared to accept the overriding of a capable refusal in a health provision on grounds of public safety in certain circumstances”.<sup>315</sup>

The Committee inclined toward the latter view:

The reasons given were in part pragmatic and in part driven by principle.

Essentially most of those who commented accepted that the safety of the public must be allowed to outweigh individual autonomy where the risk is

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<sup>313</sup> Expert Committee, 1999; p. 127.

<sup>314</sup> Expert Committee, 1999; p. 19. Emphasis added.

<sup>315</sup> Expert Committee, 1999; p. 19.

sufficiently great and, if the risk is related to the presence of a mental disorder for which a health intervention of likely benefit to the individual is available, then it is appropriate that such intervention should be authorised as part of a health provision. Mental disorder unlike most physical health problems may occasionally have wider consequences for the individual's family and carer, and very occasionally for unconnected members of the public affected by the individual's behaviour, acts and omissions. The Committee supports this reasoning and in what follows we seek to describe a framework which adequately reflects it.<sup>316</sup>

This concern with public safety is evident throughout the recommendations of the Committee, including, for example, their suggestion that criteria for compulsory orders include not only that mental disorder is present, treatment is the least restrictive possible, and treatment is in the patient's best interests, but also (for patients who lack capacity) that treatment "is necessary for the health or safety of the patient or for the protection of others from serious harm" and (for patients with capacity) that "there is a substantial risk of serious harm to the health or safety of the patient or to the safety of other persons if s/he remains untreated".<sup>317</sup>

This concern with public safety was later reflected, to a certain extent, in the MHA 2007 in, for example, the Act's broadening of the definition of mental disorder<sup>318</sup> and requirement that individuals with learning disability "shall not be considered by reason of that disability" to be suffering from mental disorder "unless that disability is

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<sup>316</sup> Expert Committee, 1999; p. 19.

<sup>317</sup> Expert Committee, 1999; p. 70.

<sup>318</sup> MHA 2007, section 1(2).

associated with abnormally aggressive or seriously irresponsible conduct on his part”.<sup>319</sup> By the time the MHA 2007 was published, however, another key concern had emerged: the human rights of detained patients and the implications of the Human Rights Act 1998.<sup>320</sup>

### **3.3.2 Human rights**

Protecting the human rights of detained patients was the second key issue that became the focus of concern in relation to the MHA 1983, especially since the implementation of the Human Rights Act 1998. This issue can be usefully explored by examining relevant case-law since the Human Rights Act 1998 was implemented in 2000. These cases can be considered under four key headings: the burden of proof in the Mental Health Review Tribunal (3.3.2.1); the right to respect for a “private and family life” (3.3.2.2);<sup>321</sup> powers of tribunals to release patients (3.3.2.3); and various other matters (3.3.2.4).

#### **3.3.2.1 Burden of proof in the Mental Health Review Tribunal**

The first declaration of incompatibility made under the Human Rights Act 1998 related to the MHA 1983. The MHA 1983 outlined criteria to be used by the Mental Health Review Tribunal to make its decisions and indicated the Tribunal had to discharge the patient if satisfied criteria for detention were not met; i.e. the patient had to show that

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<sup>319</sup> MHA 2007, section 2(2).

<sup>320</sup> Richardson, 2005.

<sup>321</sup> ECHR, article 8.



the criteria were not met.<sup>322</sup> In *R (H) v Mental Health Review Tribunal*,<sup>323</sup> a man who was detained under the MHA 1983<sup>324</sup> sought his release from psychiatric hospital and argued that this provision of the MHA 1983 violated his ECHR rights because it placed the burden of proof on the patient to demonstrate that criteria for detention were not met.

The Court of Appeal concluded that these provisions of the MHA 1983 were indeed incompatible with articles 5(1) of the ECHR<sup>325</sup> and granted a declaration of incompatibility. As a result, the Mental Health Act 1983 (Remedial) Order 2001 (SI 2001/3712) amended the 1983 Act to the effect that unless the Tribunal finds the criteria for detention are met it must discharge the patient; i.e. broadly, shifts the burden of proof from patient to responsible authority and provides greater protection for the right to liberty, in accordance with the ECHR.

### **3.3.2.2 Right to respect for “private and family life”**

A number of relevant cases have centred on the ECHR right to respect for “private and family life”.<sup>326</sup> *R (M) v Secretary of State for Health*, for example, focussed on the fact that the MHA 1983 did not allow the patient to change their “nearest relative” which was defined in the MHA 1983.<sup>327</sup> The “nearest relative” has a range of important roles

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<sup>322</sup> MHA 1983, sections 72 and 73.

<sup>323</sup> *R (H) v Mental Health Review Tribunal* [2002] EWHC 1522 (Admin), [2002] QB 1; Dyer, C., “Ruling could free dozens of mentally ill offenders”, *Guardian*, 2001, 29 March.

<sup>324</sup> MHA 1983, section 3.

<sup>325</sup> Specifically, the ‘reverse burden of proof’ violated the ECHR right to liberty (article 5(1)).

<sup>326</sup> ECHR, article 8.

<sup>327</sup> *R (M) v Secretary of State for Health* [2003] EWHC 1094 (Admin), [2003] 1 MHLR 88; MHA 1983, section 26.

in relation to the 1983 Act and the Court ruled that the absence of a process by which the patient could apply to change their “nearest relative” constituted a breach of their right to respect for their “private and family life”. This breach was not rectified until the implementation of the MHA 2007 (Section 3.4.4).

The ECHR right to respect for “private and family life” was also the focus of *R (N) v Ashworth Special Hospital Authority*, in which the High Court ruled that monitoring and recording of telephone calls in a high secure setting was not a breach of this right.<sup>328</sup> In *R (Munjaz) v Mersey Care NHS Trust*, however, the Court of Appeal found that there was a breach of this right when the seclusion policy of Ashworth Hospital failed to adhere to the national Code of Practice for seclusion and mechanical restraint.<sup>329</sup> This Code, however, is designed for “guidance” purposes only<sup>330</sup> and “the Act does not impose a legal duty to comply” with it, although staff “must have regard to the Code”.<sup>331</sup> While the Court of Appeal acknowledged that there could be good reasons to depart from the Code in particular cases, the Court did not agree that a hospital could depart from it as a matter of policy.

On appeal, a majority in the House of Lords did not agree there had been a breach of this right.<sup>332</sup> The minority (Lords Steyn and Browne-Wilkinson), who supported the Court of Appeal decision, argued that because the ECHR states that any interference

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<sup>328</sup> *R (N) v Ashworth Special Hospital Authority* [2001] EWHC 339 (Admin), [2001] HRLR 46.

<sup>329</sup> *R (Munjaz) v Mersey Care NHS Trust* [2003] EWCA Civ 1036, [2004] QB 395. Department of Health, 2008.

<sup>330</sup> MHA 1983, section 118.

<sup>331</sup> Department of Health, 2008; p. 2. The Code meets many of the WHO requirements including P1 (pp. 120, 133), P2 (p. 114), P5 (pp. 112-116) and, in part, P6 (pp. 112-127).

<sup>332</sup> *R (Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58, [2006] 2 AC 148.

with the right to respect for “private and family life” must be “in accordance with the law”, and there is no statutory framework governing seclusion in England and Wales, the Code of Practice should have the force of law. The majority (Lords Bingham, Hope and Scott), however, did not agree that the Code had the force of law, and noted that Ashworth Hospital was a high security institution and, thus, significantly different to the majority of psychiatric institutions. Moreover, Ashworth Hospital had devoted considerable thought to devising its own seclusion policy to meet its particular clinical needs and although this placed Ashworth’s policy at variance with the Code of Practice it was, nonetheless, permissible.

This case went on to the European Court of Human Rights which stated that the practice of seclusion can indeed interfere with the right to respect for “private and family life” but that in this case Ashworth’s policy was sufficiently foreseeable to be in accordance with law and, as a result, the right to respect for “private and family life” had not been interfered with arbitrarily.<sup>333</sup> The European Court of Human Rights also ruled that there was no breach of Article 3 (relating to torture or inhuman or degrading treatment or punishment) or Article 5 (the right to liberty and security of person) in this case.<sup>334</sup> The possibility of a breach of Article 14 (prohibition of discrimination) remains unresolved.

Does this decision regarding seclusion undermine the role of the Code of Practice in relation to seclusion, a practice with serious implications for the dignity of the detained

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<sup>333</sup> *Munjaz v UK* App no 2913/06 (ECHR, 17 July 2012).

<sup>334</sup> The European Court of Human Rights did, however, acknowledge that there may be circumstances in which further deprivation of a detained individual’s residual liberty may engage Article 5 rights, in contrast to the position outlined in *R v Deputy Governor of Parkhurst Prison, ex parte Hague and Weldon* [1992] 1 AC 58. This ruling may have implications for advocates or lawyers challenging various specific additional restrictions placed upon detained patients.

individual? It is noteworthy that while the majority in the House of Lords did not agree that the right to respect for “private and family life” had been violated in this case, they went to great lengths to emphasise the importance of the Code. They stated that, notwithstanding their decision in this case, the Code always carries substantial weight and should be considered with great care. Although the Code is not a binding instruction it is more than mere advice. Departures from the Code should be rare and reasons for such departures should be spelt out clearly and logically in each case.

Notwithstanding these caveats, does this decision still reflect an over-emphasis on control and paternalism at the expense of dignity and respect for “private and family life”? In the first instance, one of the key ways of maintaining the dignity of the mentally ill is through effective treatment of mental illness. However, certain measures which are used as part of such treatment (e.g. seclusion) may have the potential to undermine such dignity in the short-term. There is, then, a need for vigilance in order to ensure that such interventions are proportionate, linked to therapeutic aims, implemented with minimum erosion of dignity, and performed in accordance with law. *Munjaz* demonstrates the difficulties inherent in striking such a balance between tailoring interventions to meet the needs of individual patients and ensuring that interventions such as seclusion are subject to sufficient regulation to prevent unjustified erosion of dignity and rights.

A solution may lie in devising a legally-binding code, such as that introduced in Ireland, where the MHA 2001 states that seclusion and restraint can only be used in accordance

with rules made under the Act, violation of which constitutes an offence.<sup>335</sup> In Ireland, these rules meet many of the WHO requirements for seclusion.<sup>336</sup> They apply in all psychiatry settings in Ireland, ranging from standard psychiatry admission facilities to secure forensic settings (Section 5.3.2.3). While this approach has the demerit of not tailoring the seclusion regime to the needs of the individual patient, it has the merits of ensuring accountability and equity of treatment for patients who are secluded and, arguably, minimising erosion of dignity and rights.

### 3.3.2.3 Powers of tribunals to release patients

A further declaration of incompatibility was granted in the UK in the case of *R (D) v Secretary of State for the Home Department* which focussed on a prisoner who was serving life imprisonment but was transferred to a psychiatric hospital; a Tribunal could not, however, release him, but only *recommend* release, because release of a life sentence prisoner is a matter for the Parole Board.<sup>337</sup> However, a life-sentence prisoner could not, when transferred to hospital, make an application to the Parole Board and it was up to the Home Secretary to decide whether or not the Parole Board should hear such a case. *D* argued that this violated his right to apply for a court order to challenge the lawfulness of his detention,<sup>338</sup> and the High Court agreed, granting a declaration of incompatibility. This was followed by an amendment of the relevant statute so as to

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<sup>335</sup> MHA 2001, section 69(1). Mental Health Commission, *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*, Dublin: Mental Health Commission, 2009.

<sup>336</sup> See Table 1: P2: Mental Health Commission, *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*, Dublin: Mental Health Commission, 2009; p. 15. P3: pp. 19, 27. P5 and 6: pp. 1-45.

<sup>337</sup> *R (D) v Secretary of State for the Home Department* [2002] EWHC 2805 (Admin), [2003] 1 WLR 1315; see also: *Benjamin v UK* (2002) 36 EHRR 1.

<sup>338</sup> ECHR, article 5(4).

permit the patient to apply to the Parole Board once a recommendation for release from hospital had been made.<sup>339</sup> Again, this provides further protection for the right to liberty for the detained individual, in accordance with the ECHR.

#### **3.3.2.4 Various other matters**

Declarations of incompatibility have been granted in relation to procedural and resourcing issues in connection with tribunals which were concluded to have significant implications for human rights. In *R (KB) v Mental Health Review Tribunal* the High Court found that inadequate resourcing of tribunals resulted in delays to hearings and, in respect of the test cases brought before it, granted a declaration as to a breach of article 5(4).<sup>340</sup> It has also been determined that the timing of tribunals must be flexible, in order to respond to individual patient's circumstances.<sup>341</sup> These judgments represented a clear articulation of the need for authorities to provide adequate resources for Mental Health Review Tribunals in order to ensure appropriately-timed hearings, consistent with the ECHR right to liberty.

Another case relating to the Tribunal focused on a woman with intellectual disability detained under the MHA 1983<sup>342</sup> and in respect of whom an application was lodged

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<sup>339</sup> Criminal Justice Act 2003; section 295.

<sup>340</sup> *R (KB) v Mental Health Review Tribunal* [2003] EWHC 193 (Admin), [2004] QB 936; Richardson, G., "The European convention and mental health law in England and Wales", *International Journal of Law and Psychiatry*, 2005, 28, 127-139.

<sup>341</sup> *R (C) v London South and West Region Mental Health Review Tribunal* [2001] EWCA Civ 1110, [2002] 1 WLR 176. In this case, automatically listing hearings to take place eight weeks after application was deemed to be a breach of article 5(4) of the ECHR as it did not permit flexibility in response to patient's circumstances. See also: Mandelstam, 2005.

<sup>342</sup> MHA 1983, section 2.

with the county court to change her “nearest relative”.<sup>343</sup> Once such an application is made, the patient’s detention order under section 2 is automatically extended until the matter is dealt with by the county court.<sup>344</sup> During this extension, the patient did not have the right to apply for a second time to the Tribunal.<sup>345</sup> In addition, for a patient detained under section 2 who lacked capacity, there was no facility for the patient to make their own application to Tribunal, and the Secretary of State for Health had to be asked to refer the matter to the Tribunal (as occurred in this case).

The Court of Appeal granted two declarations of incompatibility, stating that (a) the absence of a system to ensure referral to the Tribunal for individuals who lack capacity and are detained under section 2 was incompatible with the ECHR, and (b) the lack of a right to further challenge detention when it is extended owing to an application for displacement of the “nearest relative” was also incompatible with the ECHR. The House of Lords overturned both declarations on the grounds that (a) article 5(4) of the ECHR did not require a reference to capacity; the MHA 1983 required the patient be made aware of their right to apply to the Tribunal; and the test for capacity to make such an application is, in any case, low; and (b) the correct response following an extended detention owing to an application for displacement of “nearest relative” is for the courts to deal with the application for displacement swiftly; i.e. the existing system could be operated in a fashion consistent with the ECHR and granting of declarations of incompatibility was, therefore, not proper.

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<sup>343</sup> *R (M) v Secretary of State for Health* [2003] EWHC 1094 (Admin), [2003] 1 MHLR 88.

<sup>344</sup> MHA 1983, section 29(4).

<sup>345</sup> MHA 1983, section 66(2)(a).

The principles of the ECHR have also been evoked in relation to treatment, with rulings indicating that treatment, when provided, must be based on medical necessity and in the best interests of the patient,<sup>346</sup> although there is not an automatic right to treatment (e.g. for an individual with untreatable personality disorder who is detained on the basis of public protection).<sup>347</sup>

Finally, section 6(1) of the Human Rights Act 1998, which makes it “unlawful for a public authority to act in a way which is incompatible with a Convention right”,<sup>348</sup> has also proven relevant in a number of cases, although these were chiefly concerned with mental health care, as opposed to mental health legislation *per se*. The case of *Savage v South Essex Partnership NHS Foundation Trust*,<sup>349</sup> for example, involved the suicide of a detained psychiatric patient, and it was alleged that the NHS Trust had failed to protect the patient’s ECHR right to life.<sup>350</sup> The House of Lords concluded that the NHS Trust had a duty to reasonably protect psychiatric patients from taking their own lives, under the Human Rights Act 1998. The UK Supreme Court later declared that this obligation can extend to voluntary patients, even when on home leave.<sup>351</sup>

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<sup>346</sup> *R (PS) v Responsible Medical Officer* [2003] EWHC 2335 (Admin).

<sup>347</sup> *Hutchison Reid v UK* (2003) 37 EHRR 211. For a discussion of “dangerous and severe personality disorder”, see: Buchanan, A., Grounds, A., “Forensic psychiatry and public protection”, *British Journal of Psychiatry*, 2011, 198, 420-423; Duggan, C., “Dangerous and severe personality disorder”, *British Journal of Psychiatry*, 2011, 198, 431-433.

<sup>348</sup> Human Rights Act 1998, section 6(1).

<sup>349</sup> *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74; *Savage v South Essex Partnership NHS Foundation Trust* [2010] EWHC 865 (QB).

<sup>350</sup> ECHR, article 2(1).

<sup>351</sup> *Rabone and Anor v Pennine Care NHS Trust* [2012] UKSC 2. See also: Bowcott, O., “Hospital breached duty of care to psychiatric patient, supreme court rules”, *Guardian*, 2012, 8 February; Madden, E., “Important UK Supreme Court decision on human rights”, *Irish Medical Times*, 2012, 18, 26.



Overall, these cases demonstrate that, firstly, ECHR rights are having a significant effect on mental health case-law in England, especially since the Human Rights Act 1998. Second, English courts are applying ECHR rights to the situation of the mentally ill in very detailed ways, recognizing, for example, a need to balance the ECHR right to respect for “private and family life”<sup>352</sup> with monitoring of communications in secure settings.<sup>353</sup> This suggests that the Human Rights Act 1998 has, at the very least, modified the ways in which mental health legislation affects the rights of the mentally ill in England, apparently serving to protect ECHR rights and increase dignity. Third, by articulating strongly the relevance of human rights in mental disorder, these cases ensured that human rights were firmly on the agenda during the reform of England’s mental health legislation, which culminated in the MHA 2007. This process of reform is considered next.

### **3.3.3 Moving towards reform**

Against this background of growing human rights concerns throughout the 1980s, 1990s and 2000s, the Richardson Committee was “determined to include sufficient safeguards to ensure appropriate protection of the patient’s individual dignity, autonomy and human rights”.<sup>354</sup> In its final report, the Committee duly cited human rights considerations in relation to its conclusions on a range of issues, emphasizing “it is now accepted, and indeed demanded by the Human Rights Act, that an individual subject to

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<sup>352</sup> ECHR, article 8.

<sup>353</sup> *R (N) v Ashworth Special Hospital Authority* [2001] EWHC 339 (Admin), [2001] HRLR 46.

<sup>354</sup> Expert Committee, 1999; p. 44.

detention on the grounds of his or her mental disorder must have the right to test the legality of that detention before an independent ‘court’”.<sup>355</sup>

An emphasis on human rights was in clear evidence from other sources too, including psychiatrists, who emphasized the implications of not only the ECHR and Human Rights Act 1998,<sup>356</sup> but also the work of the Working Party on Human Rights in Psychiatry appointed by the European Council of Ministers in 1996.<sup>357</sup> This Working Party built on previous statements of the Council of Europe in relation to the legal protection of individuals with mental illness,<sup>358</sup> rules governing involuntary detention and judicial review,<sup>359</sup> and specific therapeutic issues, including electroconvulsive therapy, psychosurgery, isolation cells, mechanical restraint and matters related to research.<sup>360</sup> The Working Party included both psychiatric and legal experts, charged with formulating guidelines to further the protection of human rights in mental health settings owing to the “exceptional nature of involuntary procedures that can be used for

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<sup>355</sup> Expert Committee, 1999; p. 120.

<sup>356</sup> Bindman, J., Maingay, S., Szmukler, G., “The Human Rights Act and mental health legislation”, *British Journal of Psychiatry*, 2003, 182, 91-94; Curtice, M.J.R., “Medical treatment under Part IV of the MHA 1983 and the Human Rights Act 1998”, *Psychiatric Bulletin*, 2009, 33, 111-115.

<sup>357</sup> Kingdon, D., Jones, R., Lönnqvist, J., “Protecting the human rights of people with mental disorder”, *British Journal of Psychiatry*, 2004, 185, 277-279; Council of Europe, *White Paper Regarding a Draft Recommendation on Legal Protection of Persons Suffering from Mental Disorder*, Strasbourg: Council of Europe, 2000.

<sup>358</sup> Council of Europe, *Recommendation (818) on the Situation of the Mentally Ill*, Strasbourg: Council of Europe, 1977.

<sup>359</sup> Council of Europe, *Recommendation R(83)2 of the Committee of Ministers to Member States Concerning the Legal Protection of Persons Suffering from Mental Disorder Placed as Involuntary Patients*, Strasbourg: Council of Europe, 1983.

<sup>360</sup> Council of Europe, *Recommendation 1235 on Psychiatry and Human Rights*, Strasbourg: Council of Europe, 1994.

the placement and treatment of people with mental disorder and therefore the exceptional need for the protection of their rights”.<sup>361</sup>

The Working Party’s final recommendations aimed to “provide guidance in many areas, including national legislation, that could advance and harmonize mental health care substantially”.<sup>362</sup> The emergent recommendations are also consistent with a range of other concerns regarding mental health legislation throughout Europe, many of which reflect and highlight specific human rights issues, including concern about high rates of psychiatric detention amongst Black compared to White patients,<sup>363</sup> different rates of appeal after detention amongst different ethnic groups,<sup>364</sup> and relatively low levels of understanding amongst consultant psychiatrists regarding their roles at tribunals<sup>365</sup> and amongst general hospital doctors regarding their roles assessing capacity under the MHA 1983.<sup>366</sup>

These concerns are underpinned and magnified by a continued increase in the number of patients involuntarily detained during the opening years of the new century: in 2003/2004 there were 45,691 formal detentions under the MHA 1983 in England; by 2005/2006 this had increased to 47,394; and by 2010/2011 this had increased to

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<sup>361</sup> Kingdon et al, 2004; p. 277. See also: Council of Europe, *White Paper on the Protection of the Human Rights and Dignity of People Suffering from Mental Disorder*, Strasbourg: Council of Europe, 2000.

<sup>362</sup> Kingdon et al, 2004; p. 279.

<sup>363</sup> Singh, S.P., Greenwood, N., White, S., Churchill, R., “Ethnicity and the Mental Health Act 1983”, *British Journal of Psychiatry*, 2007, 191, 99-105.

<sup>364</sup> Nilforooshan, R., Amin, R., Warner, J., “Ethnicity and outcome of appeal after detention under the MHA 1983”, *Psychiatric Bulletin*, 2009, 33, 288-290.

<sup>365</sup> Nimmagadda, S., Jones, C.N., “Consultant psychiatrists’ knowledge of their role as representatives of the responsible authority at mental health review tribunals”, *Psychiatric Bulletin*, 2008, 32, 366-369.

<sup>366</sup> Richards, F., Dale, J., “The Mental Health Act 1983 and incapacity”, *Psychiatric Bulletin*, 2009, 33, 176-178.

49,365.<sup>367</sup> In North-East London, the period between 1997 and 2007 not only saw a significant increase in the use of the MHA 1983 to detain patients but also a substantial increase in the proportion of detentions that went to appeal (from 34% in 1997 to 81% in 2007), although the proportion of detentions upheld at appeal (66%) did not change.<sup>368</sup>

Overall, the years between 1983 and 2007 also saw greatly increased emphasis placed on public safety in the context of mental illness (Section 3.3.1), driven largely by public and political responses to specific tragedies, and crystallized in the report of the Richardson Committee.<sup>369</sup> This period also saw greatly increased emphasis placed upon the human rights of the mentally ill, both in England (largely in response to the Human Rights Act 1998 and ECHR) and throughout Europe (as reflected by the work of the Council of Europe) (Section 3.3.2).<sup>370</sup> At least some of the issues that emerged from these debates, and especially those related to public safety, human rights, or both, were addressed, at least in part, by the MHA 2007.

Before considering the MHA 2007 in detail, however, it is worth pausing to note certain issues which did *not* appear to play substantial roles in shaping the new legislation. The issue of dignity, for example, received just fleeting mention in the report of Richardson

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<sup>367</sup> Information Centre, *In-patients Formally Detained in Hospitals Under the MHA 1983 and Other Legislation; 1995-96 to 2005-06*, London: Information Centre/Government Statistical Service, 2007: p. 4; NHS Information Centre for Health and Social Care, 2011: p. 9.

<sup>368</sup> Singh, D.K., Moncrieff, J., “Trends in mental health review tribunal and hospital managers’ hearings in north-east London 1997-2007”, *Psychiatric Bulletin*, 2009, 33, 15-17.

<sup>369</sup> Expert Committee, 1999.

<sup>370</sup> Council of Europe, *White Paper on the Protection of the Human Rights and Dignity of People Suffering from Mental Disorder*, Strasbourg: Council of Europe, 2000.

Committee.<sup>371</sup> This is most likely because the report was largely centered on concerns about public safety (Section 3.3.1) and specific provisions of the Human Rights Act 1998 (Section 3.3.2), as opposed to broader conceptualisations of rights linked more clearly with dignity or capabilities.

During various other stages in the development of the MHA 2007, however, issues such as autonomy and paternalism were raised, in varying levels of detail, by various groups. Mental Health Alliance, a coalition of 75 organisations of service-users and service-providers, for example, articulated a need explicitly to “balance patients’ rights to autonomy and non-discrimination with paternalism and public protection”.<sup>372</sup> Notwithstanding, these kinds of concerns, the Richardson Committee did not engage in a detailed consideration of the merits and demerits of paternalism, presumably owing to its strong concern with public safety, which supports rather than challenges traditional interpretations of paternalism (see Sections 1.4, 4.4.6 and 7.3 for further discussions of paternalism and welfare-based approaches to mental health legislation).

Interestingly, even in its brief mentions of paternalism, the Richardson Committee did not dismiss it outright, simply noting that “few if any would wish to return to *unchallenged* paternalism” (my italics).<sup>373</sup> The Committee did not take its explicit consideration of the matter appreciably further than that and focussed instead on the concepts of dangerousness and public safety, as opposed to broader-based paternalism across mental health services. The provisions of the subsequent legislation, the MHA

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<sup>371</sup> Expert Committee, 1999; pp. 2, 28, 35, 44.

<sup>372</sup> Mental Health Alliance, *Mental Health Act 2007: Report Stage Briefing, House of Commons*, London: Mental Health Alliance, 2006; p. 1.

<sup>373</sup> Expert Committee, 1999; p. 20.

2007, which arguably reflects the Richardson Committee’s position on this, are examined next.

### **3.4 The Mental Health Act 2007**

The MHA 2007 is a piece of amending legislation which amends not only the MHA 1983 but also the Domestic Violence, Crime and Victims Act 2004 and the Mental Capacity Act 2005. The central amendments relate to:

- 3.4.1 Definition of mental disorder
- 3.4.2 Criteria for detention
- 3.4.3 Expansion of professional roles
- 3.4.4 Definition of nearest relative
- 3.4.5 Supervised community treatment
- 3.4.6 Safeguards regarding electroconvulsive therapy
- 3.4.7 Time-scales for the Mental Health Review Tribunal
- 3.4.8 Advocacy

#### **3.4.1 Definition of mental disorder**

The MHA 2007 removes the four categories of mental illness outlined in the MHA 1983<sup>374</sup> and re-defines “mental disorder” as “any disorder or disability of the mind”.<sup>375</sup> Individuals with a learning disability “shall not be considered by reason of that

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<sup>374</sup> MHA 1983, section 1(2).

<sup>375</sup> MHA 2007, section 1(2).

disability” to be suffering from mental disorder “unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part”.<sup>376</sup>

These changes are in line with recommendations of the Richardson Committee<sup>377</sup> and Mental Health Act Commission, which noted that “if there is widespread co-morbidity between personality disorders and mental illness irrespective of Mental Health Act classification, then the dichotomy imposed by legal classification is misleading and obscures the multiple problems shared by patients in the two categories. This would suggest that the Government is correct in seeking to abandon the legal classifications in the next Mental Health Act”.<sup>378</sup>

The exclusion criteria in the MHA 1983 are also amended. The MHA 1983 stated that nobody was to be deemed to suffer from a mental disorder “by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs”.<sup>379</sup> In the MHA 2007, these exclusion criteria are replaced by the following: “Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind”.<sup>380</sup> As a result, the exclusions for “promiscuity or other immoral conduct, [or] sexual deviancy” are repealed.

While this change may reflect the current apparent un-likelihood of anyone being diagnosed as mentally ill owing to “promiscuity or other immoral conduct [or] sexual

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<sup>376</sup> MHA 2007, section 2(2).

<sup>377</sup> Expert Committee, 1999.

<sup>378</sup> Mental Health Act Commission, *Placed Amongst Strangers*, London: The Stationery Office, 2003; para. 7.31, pp. 85-86.

<sup>379</sup> MHA 1983, section 1(3).

<sup>380</sup> MHA 2007, section 1(3).

deviancy”,<sup>381</sup> this amendment nonetheless means that it is no longer explicitly unlawful under mental health legislation to do so.<sup>382</sup> The effects of these changes have yet to be seen in practice, as it remains the case that, regardless of whether or not an individual fulfils the criteria for a mental disorder, there is still considerable clinical discretion about whether or not any provisions of the legislation are applied in a particular case;<sup>383</sup> i.e. not everyone with mental disorder is detained.

### **3.4.2 Criteria for detention**

Prior to the MHA 2007, the processes of civil commitment under the MHA 1983 included the section 2 process for admission for assessment for up to 28 days;<sup>384</sup> the section 3 process for admission for treatment for up to 6 months in the first instance;<sup>385</sup> and the section 4 process for admission “in any case of urgent necessity”.<sup>386</sup> The MHA 2007 introduces significant amendments to certain elements of all of these processes.

In the first instance, the MHA 1983 permitted the civil commitment of individuals with “psychopathic disorder or mental impairment” under section 3 only if “treatment is likely to alleviate or prevent a deterioration of his condition”,<sup>387</sup> and the same criterion applied to renewal orders for all forms of mental disorder.<sup>388</sup> If this condition was not

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<sup>381</sup> MHA 2007, section 1(3).

<sup>382</sup> MHA 2007, section 1(3).

<sup>383</sup> Hall, I., Ali, A., “Changes to the Mental Health and Mental Capacity Acts”, *Psychiatric Bulletin*, 2009, 33, 226-230.

<sup>384</sup> MHA 1983, section 2(2)(a).

<sup>385</sup> MHA 1983, section 3(2)(a).

<sup>386</sup> MHA 1983, section 4(1).

<sup>387</sup> MHA 1983, section 3(2)(b).

<sup>388</sup> MHA 1983, section 20(4)(b).



met, a renewal order could still be made in respect of a patient with “mental illness or severe mental impairment” if “the patient, if discharged, is unlikely to be able to care for himself, to obtain the care which he needs or to guard himself against serious exploitation”.<sup>389</sup>

The MHA 2007 replaces these notably paternalistic “treatability and care tests” with an “appropriate treatment test” which applies to all forms of mental disorder and states that orders<sup>390</sup> can be made or renewed only if “appropriate medical treatment is available”.<sup>391</sup> The MHA 2007 expands the areas of application of the new “appropriate treatment test” to include accused individuals on remand to hospital for treatment,<sup>392</sup> transfer directions for remand prisoners and other detainees,<sup>393</sup> and “hospital orders”.<sup>394</sup> Renewal orders must also meet this condition<sup>395</sup> and if this condition is not met, tribunals can discharge patients.<sup>396</sup> This criterion does not apply to those detained under sections 2 (“admission for assessment”), 35 (“remand to hospital for report on accused’s mental condition”), 135 (“warrant to search for and remove patients”) or 136 (“mentally disordered persons found in public places”). The provision to make a renewal order under section 20(4) of the MHA 1983 (i.e. “the patient, if discharged, is unlikely to be able to care for himself, to obtain the care which he needs or to guard himself against serious exploitation”) is repealed.<sup>397</sup>

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<sup>389</sup> MHA 1983, section 20(4).

<sup>390</sup> Under sections 3, 37, 45A and 47 (MHAs 1983 and 2007).

<sup>391</sup> MHA 2007, section 4; amending MHA 1983, sections 3(2)(b); 3(4)(b); 37(2)(a)(i); 45A(2)(c); 47(1).

<sup>392</sup> MHA 2007, section 5(2); amending MHA 1983, section 36(1).

<sup>393</sup> MHA 2007, section 5(3); amending MHA 1983, section 48(1).

<sup>394</sup> MHA 2007, section 5(4); amending MHA 1983, section 51(6)(a).

<sup>395</sup> MHA 2007, section 4(4); amending MHA 1983, section 20(4).

<sup>396</sup> MHA 2007, section 5(8); amending MHA 1983, section 72(1)(b)(ii).

<sup>397</sup> MHA 2007, section 4(4)(c).

The MHA 2007 also amends the definition of “medical treatment” to include, in addition to “nursing”,<sup>398</sup> “psychological intervention and specialist mental health habilitation, rehabilitation and care”.<sup>399</sup> “Medical treatment” refers only to “medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations”<sup>400</sup> and, for each patient, such treatment must be “appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case”.<sup>401</sup>

The implications of these changes are not yet fully clear. For example, the effects of the removal of the need for “abnormally aggressive or seriously irresponsible conduct” for a diagnosis of “psychopathic disorder”<sup>402</sup> are unclear, not least because detention can still only occur when “it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment”,<sup>403</sup> a similar provision applies to detention under section 2 (“admission for assessment”).<sup>404</sup>

The 2007 Act’s amendment of the “treatability test” proved especially controversial during the Act’s passage through parliament.<sup>405</sup> The resulting compromise removed the need to demonstrate that “treatment is likely to alleviate or prevent a deterioration” of

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<sup>398</sup> MHA 1983, section 145(1).

<sup>399</sup> MHA 2007, section 7(2).

<sup>400</sup> MHA 2007, section 7(3).

<sup>401</sup> MHA 2007, section 4(3).

<sup>402</sup> MHA 1983, section 1(2).

<sup>403</sup> MHA 1983, section 3(2)(c).

<sup>404</sup> MHA 1983, section 2(2)(b).

<sup>405</sup> Bowen, 2007; p. 47.

“psychopathic disorder or mental impairment”<sup>406</sup> and replaced it with the need to demonstrate that “appropriate medical treatment is available”,<sup>407</sup> the “purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations”.<sup>408</sup> Under these provisions, then, it is no longer necessary to demonstrate that treatment is “likely” to help, but rather that it has the “purpose” of helping, regardless of likely efficacy. Notwithstanding this limitation, the introduction and expansion of the “appropriate treatment test” appears to go beyond the requirements of the ECHR, which does not outline any treatability test for individuals of “unsound mind” who are detained, once the detention is “in accordance with a procedure prescribed by law”.<sup>409</sup>

Bowen argues that these amendments to the “treatability test” are unlikely to constitute a “charter for ‘preventive detention’” because “if ‘treatment’ is doing nothing for the patient, the doctor is obliged, both by law and by his own professional duty, to release him, or to argue for his release even if he continues to present a risk to public safety”.<sup>410</sup> It is possible, however, that widening the role of “responsible clinician”<sup>411</sup> to include other professionals (e.g. clinical psychologists) (see Section 3.4.3) may result in greater decision-making by individuals trained in settings with different priorities, such as prisons “where public safety overrides the duty to the prisoner”.<sup>412</sup>

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<sup>406</sup> MHA 1983, section 3(2)(b).

<sup>407</sup> MHA 2007, section 4(2)(b).

<sup>408</sup> MHA 2007, section 7(3). This applies to detention orders under sections 3, 37, 45A and 47 (MHAs 1983 and 2007), and to all forms of mental disorder.

<sup>409</sup> ECHR, section 5(1)(e).

<sup>410</sup> Bowen, 2007; p. 55.

<sup>411</sup> MHA 2007, sections 9-17.

<sup>412</sup> Bowen, 2007; p. 55.

Notwithstanding this concern, it remains possible that the new “appropriate treatment test” may set the threshold for detention *higher* than previously, as it is now necessary that the proposed treatment is available to the patient. It is no longer acceptable that an individual be detained in the anticipation of such treatment becoming available in the future, as a result of expansion of resources or advances in therapeutics.

### **3.4.3 Expansion of professional roles**

The MHA 2007 results in substantial expansions of the professional roles of a range of individuals in relation to involuntary admission and treatment. Under the MHA 1983, each detained patient came under the care of a “responsible medical officer”<sup>413</sup> who had to be a “registered medical practitioner”.<sup>414</sup> Under the MHA 2007, references to “responsible medical officer” are replaced by “responsible clinician”<sup>415</sup> who, in relation to a detained patient, is “the approved clinician with overall responsibility for the case”<sup>416</sup> and, in relation to guardianship, “the approved clinician authorised by the responsible local social services authority to act (either generally or in any particular case or for any particular purpose) as the responsible clinician”.<sup>417</sup>

The *Mental Health Act 2007 Explanatory Notes* point out that “approval need not be restricted to medical practitioners, and may be extended to practitioners from other

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<sup>413</sup> MHA 1983, section 34(1).

<sup>414</sup> MHA 1983, section 55(1).

<sup>415</sup> MHA 2007, section 9(9); amending MHA 1983, section 34(1).

<sup>416</sup> MHA 2007, section 12(7)(a); amending MHA 1983, section 64(1).

<sup>417</sup> MHA 2007, section 10; amending MHA 1983, section 34(1).

professions, such as nursing, psychology, occupational therapy and social work”.<sup>418</sup>

Under the MHA 2007, the “responsible clinician” will take over the roles previously performed by the “responsible medical officer”, as well as additional roles in relation to supervised community treatment

The MHA 2007 does not change the requirement of the MHA 1983 that “medical recommendations” to support *admission* for “assessment”<sup>419</sup>, “treatment”<sup>420</sup> or guardianship<sup>421</sup> be provided by “registered medical practitioners”.<sup>422</sup> This remains consistent with the requirement, outlined by the European Court of Human Rights, that there must be objective medical evidence that an individual is of “unsound mind” if he or she is to be deprived of liberty.<sup>423</sup>

The MHA 2007 does, however, change the position regarding *renewal* orders. Under the MHA 1983, the making of a *renewal* order, like an admission order, required an examination and report by the “responsible medical officer”,<sup>424</sup> but under the MHA 2007, the “responsible clinician” (who may or may not be a medical doctor) can make out a renewal order, although they must consult with another “professional” involved in the case before doing so.<sup>425</sup>

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<sup>418</sup> Department of Health and Social Security, *Mental Health Act 2007 Explanatory Notes*, London: Her Majesty’s Stationery Office, 2007; paragraph 48.

<sup>419</sup> MHA 1983, section 2.

<sup>420</sup> MHA 1983, section 3.

<sup>421</sup> MHA 1983, section 7.

<sup>422</sup> MHA 1983, section 12(2).

<sup>423</sup> ECHR, article 5(1). *Winterwerp v Netherlands* (1979) 2 EHRR 387.

<sup>424</sup> MHA 1983, sections 20(3) and (4).

<sup>425</sup> MHA 2007, section 9(4)(b); amending MHA 1983, section 20(5A).

The other significant revision of professional roles introduced by the MHA 2007 concerns the “approved social worker” who, under the MHA 1983, had a range of roles, most notably in making applications for detention for “assessment”<sup>426</sup>, “treatment”<sup>427</sup> or guardianship.<sup>428</sup> The MHA 2007 replaces the term “approved social worker” with “approved mental health professional”.<sup>429</sup> Prior to approving someone as an “approved mental health professional”, the “local social services authority shall be satisfied that he has appropriate competence in dealing with persons who are suffering from mental disorder”,<sup>430</sup> but the “local social services authority may not approve a registered medical practitioner to act as an approved mental health professional”.<sup>431</sup>

Overall, the expansion of professional roles in the MHA 2007, if implemented in practice, would represent a radical departure from the traditional dominance of psychiatrists in directing psychiatric care. The British Medical Association, which represents doctors (including psychiatrists), expressed strong concern about this “dilution of the role of psychiatrists” and stated that “no other country in the world has mental health laws where the psychiatrist is not in charge of the detained patient”.<sup>432</sup> (Broader reactions to this and other provisions of the MHA 2007 are considered in Section 3.5.)

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<sup>426</sup> MHA 1983, sections 2 and 11.

<sup>427</sup> MHA 1983, sections 3 and 11.

<sup>428</sup> MHA 1983, sections 7 and 11.

<sup>429</sup> MHA 2007, section 18.

<sup>430</sup> MHA 2007, section 18; amending MHA 1983, section 114(3).

<sup>431</sup> MHA 2007, section 18; amending MHA 1983, section 114(2).

<sup>432</sup> Bamrah, J.S., Datta, S., Rahim, A., Harris, M., McKenzie, K., “UK’s Mental Health Bill”, *Lancet*, 2007, 370, 1029; Hall and Ali, 2009; p. 228.

Most notably, the MHA 2007 indicates that a renewal order may be made out by a “responsible clinician” (who is not necessarily a medical doctor), after consultation with another professional (who may not be a medical doctor either), possibly resulting in a renewal without any evidence from a medical doctor at any point.<sup>433</sup> It is unclear whether or not this meets the requirement for objective medical evidence required by the ECHR, if liberty is lawfully to be denied on the grounds of “unsound mind”;<sup>434</sup> the issue will be whether or not this ECHR requirement applies to *renewal* orders as well as *admission* orders.

#### **3.4.4 Definition of nearest relative**

The MHA 1983 provided definitions of “relative” and “nearest relative”<sup>435</sup> with the results that patients did not have a choice in determining who was their “nearest relative”, and civil partners under the Civil Partnership Act 2004 were not included.<sup>436</sup> The MHA 2007 introduces several important reforms in this area, all of which appear to advance patient autonomy and address the incompatibility between the MHA 1983 and the ECHR right to respect for “private and family life”.<sup>437</sup> The key changes include a right for the patient to apply to displace their nearest relative<sup>438</sup> and, if the court decides to make an order on such an application, the following rules now apply:

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<sup>433</sup> MHA 2007, section 9(4)(b); amending MHA 1983, section 20(5A).

<sup>434</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387; Bowen, 2007; p. 134; ECHR, article 5(1).

<sup>435</sup> MHA 1983, sections 26-30.

<sup>436</sup> Bowen, 2007; p. 62.

<sup>437</sup> ECHR, article 8; *R (M) v Secretary of State for Health* [2003] EWHC 1094 (Admin), [2003] 1 MHLR 88.

<sup>438</sup> MHA 2007, section 23(2); amending MHA 1983, section 29(1); MHA 2007, section 23(4); amending MHA 1983, section 29(2).

- (a) If a person is nominated in the application to act as the patient's nearest relative and that person is, in the opinion of the court, a suitable person to act as such and is willing to do so, the court shall specify that person (or, if there are two or more such persons, such one of them as the court thinks fit);
- (b) otherwise, the court shall specify such person as is, in its opinion, a suitable person to act as the patient's nearest relative and is willing to do so.<sup>439</sup>

The MHA 2007 also expands the grounds upon which such an application can be made,<sup>440</sup> to include “that the nearest relative of the patient is otherwise not a suitable person to act as such”.<sup>441</sup> Other amendments in relation to the “nearest relative” include a right for the patient to apply to discharge or vary an order appointing an acting nearest relative<sup>442</sup> and inclusion of civil partners within the definition.<sup>443</sup> These changes represent a significant advance on the MHA 1983 in terms of patient autonomy and the right to respect for “private and family life”,<sup>444</sup> although it is notably paternalistic that the patient's nominee for “nearest relative” must be, “in the opinion of the court, a suitable person to act as such”.<sup>445</sup>

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<sup>439</sup> MHA 2007, section 23(3); amending MHA 1983, section 29(1A).

<sup>440</sup> MHA 1983, section 29(3).

<sup>441</sup> MHA 2007, section 23(5)(b); amending MHA 1983, section 29(3)(e).

<sup>442</sup> MHA 2007, section 24(2); amending MHA 1983, section 30(1).

<sup>443</sup> MHA 2007, section 26, amending MHA 1983, section 26.

<sup>444</sup> ECHR, article 8.

<sup>445</sup> MHA 2007, section 23(3); amending MHA 1983, section 29(1A).



### 3.4.5 Supervised community treatment

The MHA 1983 contained certain provisions for compulsory treatment in the community including granting “leave to be absent”<sup>446</sup> for detained patients, subject to certain conditions,<sup>447</sup> and the responsible medical officer could recall the patient if needed.<sup>448</sup> Alternatively, section 25 of the 1983 Act (amended in 1996) outlined a mechanism for “after-care under supervision” which was subject to many conditions<sup>449</sup> and the process involved was extremely complex.<sup>450</sup>

The MHA 2007 repeals sections 25A-J of the MHA 1983 and introduces a new “supervised community treatment order” which can only be used when detained patients are leaving hospital; i.e. it cannot be used *de novo* in the community.<sup>451</sup> Under the MHA 2007, “the responsible clinician may by order in writing discharge a detained patient from hospital subject to his being liable to recall” under certain circumstances.<sup>452</sup> The agreement of “an approved mental health professional”<sup>453</sup> is needed and various criteria must be met before such an order is made.<sup>454</sup>

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<sup>446</sup> MHA 1983, section 17(1).

<sup>447</sup> MHA 1983, section 17(3).

<sup>448</sup> MHA 1983, section 17(4).

<sup>449</sup> MHA 1983, section 25A(4).

<sup>450</sup> MHA 1983, section 25A-J.

<sup>451</sup> MHA 2007, sections 32-36.

<sup>452</sup> MHA 2007, section 32(2); amending MHA 1983, section 17A(1).

<sup>453</sup> MHA 2007, section 32(2); amending MHA 1983, section 17A(4).

<sup>454</sup> The five criteria are: (a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment; (b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment; (c) subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital; (d) it is necessary that the responsible clinician should be able to exercise the

The order “shall specify conditions to which the patient is to be subject while the order remains in force” provided the responsible clinician and the approved mental health professional agree that such conditions are “necessary or appropriate for one or more of the following purposes”:

- (a) Ensuring that the patient receives medical treatment;
- (b) Preventing risk of harm to the patient’s health or safety;
- (c) Protecting other persons.<sup>455</sup>

Patients can be recalled to hospital if they require inpatient treatment, present a risk to themselves or others which can be addressed by recalling them to hospital, or fail to comply with conditions in the order.<sup>456</sup> If the patient is recalled, the community treatment order can be revoked by the responsible clinician, with the agreement of an approved mental health professional<sup>457</sup> and the patient is again detained in hospital.<sup>458</sup> If the community treatment order is not revoked, the patient can be treated as a detained patient in hospital for up to 72 hours and then released, but “remains subject to the community treatment order”.<sup>459</sup>

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power under section 17E(1) below to recall the patient to hospital; and (e) appropriate medical treatment is available for him (MHA 2007, section 32(2); amending MHA 1983, section 17A(5)).

<sup>455</sup> MHA 2007, section 32(2); amending MHA 1983, section 17B(2).

<sup>456</sup> MHA 2007, section 32(2); amending MHA 1983, section 17E.

<sup>457</sup> MHA 2007, section 32(2); amending MHA 1983, section 17F(4).

<sup>458</sup> MHA 2007, section 32(2); amending MHA 1983, section 17G(3).

<sup>459</sup> MHA 2007, section 32(2); amending MHA 1983, section 17F(7).

A community treatment order will remain in force for six months but can be extended for a further six months, then for a year, “and so on for periods of one year at a time”.<sup>460</sup> Within a two month period ending on the date of expiry of the order, the responsible clinician shall examine the patient and provide a report to “the managers of the responsible hospital” as to whether the conditions for renewal of the community treatment order are met.<sup>461</sup> If the community treatment order is not renewed, it expires either (a) six months after it was made; (b) when the patient is discharged “by the responsible clinician, by the managers of the responsible hospital, or by the nearest relative of the patient”<sup>462</sup> or by a tribunal;<sup>463</sup> (c) when the initial application for admission for treatment ceases to have effect;<sup>464</sup> or (d) when the order is revoked following recall to hospital.<sup>465</sup>

Regarding the provision for “leave of absence” in the MHA 1983,<sup>466</sup> the MHA 2007 states that “longer-term leave may not be granted to a patient unless the responsible clinician first considers whether the patient should be dealt with under section 17A instead” (i.e. community treatment order);<sup>467</sup> for this purpose “longer-term leave of absence” is defined as “a specified period of more than seven days”.<sup>468</sup>

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<sup>460</sup> MHA 2007, section 32(3); amending MHA 1983, section 20A(3).

<sup>461</sup> MHA 2007, section 32(3); amending MHA 1983, section 20A(4).

<sup>462</sup> MHA 2007, schedule 3, section 10(4); amending MHA 1983, section 23(2)(c).

<sup>463</sup> MHA 2007, schedule 3, section 20; amending MHA 1983; section 72.

<sup>464</sup> MHA 2007, section 32(3); amending MHA 1983; section 20B.

<sup>465</sup> MHA 2007, section 32(2); amending MHA 1983, section 17F(4).

<sup>466</sup> MHA 1983, section 17(1).

<sup>467</sup> MHA 2007, section 33(2); amending MHA 1983, section 17(2A).

<sup>468</sup> MHA 2007, section 33(2); amending MHA 1983, section 17(2B).

Under the MHA 2007, a patient over the age of 16 years on a community treatment order can be given treatment if:

- The patient has capacity and consents to treatment;
- A donee, deputy or Court of Protection consents on the patient's behalf;<sup>469</sup>
- Treatment is authorised in accordance with section 64D ("adult community patients lacking capacity")<sup>470</sup> or section 64G ("emergency treatment for patients lacking capacity or competence").<sup>471</sup>

Some of these reforms to "supervised community treatment" procedures<sup>472</sup> aroused significant concern amongst patients' groups, who feel they are excessively paternalistic and may lead to human rights abuses if used inappropriately or too widely, most notably through the imposition of involuntary treatment regimes on individuals well enough to live in the community.<sup>473</sup> On the day these changes came into effect, the Royal College of Psychiatrists and Department of Health moved swiftly to reassure the public "that

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<sup>469</sup> MHA 2007, section 35(1); amending MHA 1983, section 64C(2).

<sup>470</sup> Section 64D permits the administration of treatment to "adult community patients lacking capacity" once (a) reasonable steps have been taken to assess capacity; (b) it is established that the patient lacks capacity; (c) there is no reason to believe the patient objects; (d) treatment is given by, or under the direction of an approved clinician; and (e) it does not conflict with an advance directive or the decision of a donee, deputy or Court of Protection (MHA 2007, section 35(1); amending MHA 1983, section 64D).

<sup>471</sup> Section 64G permits "emergency treatment for patients lacking capacity or competence" once (a) the person giving treatment believes the patient lacks capacity or competence; (b) treatment is immediately necessary; and (c) if force must be used, the "the treatment needs to be given in order to prevent harm" and "the use of such force is a proportionate response to the likelihood of the patient's suffering harm, and to the seriousness of that harm" (MHA 2007, section 35(1); amending MHA 1983, section 64G).

<sup>472</sup> MHA 2007, sections 32-36.

<sup>473</sup> Butcher, J., "Controversial Mental Health Bill reaches the finishing line", *Lancet*, 2007, 370, 117-118.

clinicians will use their powers fairly and for the benefit of service users and their families”.<sup>474</sup>

The European Court of Human Rights has already accepted the general principle that conditions may be placed on discharge from psychiatric facilities in certain cases.<sup>475</sup>

There are still, however, specific human rights issues in relation to supervised community treatment, including the fact that such orders can be revoked by a “responsible clinician”<sup>476</sup> or, in the case of a recalled patient, by the “responsible clinician” once they have the agreement of an “approved mental health professional”,<sup>477</sup> and none of these individuals need be a medical doctor.

In addition, mental health tribunals do not have the power to vary the conditions of a community treatment order, even though it is conceivable that such conditions could, under certain circumstances, contravene ECHR rights.<sup>478</sup> As “public authorities”, tribunals have a duty to comply with ECHR rights under section 6(1) of the Human Rights Act 1998,<sup>479</sup> but have a defence if the tribunal is giving effect to an Act of Parliament, although the tribunal must, firstly, ensure that the legislation “cannot be read or given effect in a way which is compatible with the Convention rights”.<sup>480</sup> While

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<sup>474</sup> Bhugra, D., Appleby, L., “Mental illness, the law and rudeness”, *Guardian*, 2008, 3 November. The clinical usefulness of community treatment orders is far from established (Kisely et al, 2005; Lawton-Smith et al, 2008).

<sup>475</sup> *Johnson v UK* (1997) 27 EHRR 296; Bowen, 2007; pp. 91-92.

<sup>476</sup> MHA 2007, schedule 3, section 10(4); amending MHA 1983, section 23(2)(c); Bowen, 2007; p. 91.

<sup>477</sup> MHA 2007, section 32(2); amending MHA 1983, section 17F(4).

<sup>478</sup> ECHR, article 5(4); Bowen, 2007; p. 92.

<sup>479</sup> Human Rights Act 1998, section 6(1): “It is unlawful for a public authority to act in a way which is incompatible with a Convention right”.

<sup>480</sup> Human Rights Act 1998, section 6(2): “Subsection (1) does not apply to an act if - (a) as the result of one or more provisions of primary legislation, the authority could not have acted differently; or (b) in the

this affords the tribunal a degree of responsibility in reading or giving effect to legislation, the tribunal may still be unable to prevent a contravention of ECHR rights, and the relevant legislation would then be subject to challenge.<sup>481</sup>

These issues may not, however, represent violations of the ECHR in relation to supervised community treatment, because, notwithstanding the fact that the Tribunal cannot provide detailed guidance on which detained patients should be treated on community treatment orders and what the conditions on such orders should be, it still has the key power to revoke the patient's detention if it feels that is appropriate. In addition, the *Winterwerp* criteria indicate that objective medical expertise is one of the criteria for compulsory *confinement*,<sup>482</sup> and proposed amendments to the MHA 2007 which would have required the opinion of a medical doctor prior to *revoking* a community treatment order were explicitly rejected by the House of Commons during its consideration of the legislation.

### **3.4.6 Safeguards regarding electroconvulsive therapy**

Under the MHA 1983, a detained patient could receive electroconvulsive therapy (ECT) if:

- (a) he has consented to that treatment and either the responsible medical officer or a registered medical practitioner appointed for the purposes

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case of one or more provisions of, or made under, primary legislation which cannot be read or given effect in a way which is compatible with the Convention rights, the authority was acting so as to give effect to or enforce those provisions.”

<sup>481</sup> Human Rights Act 1998, sections 3 and 4.

<sup>482</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387.

of this Part of this Act by the Secretary of State has certified in writing that the patient is capable of understanding its nature, purpose and likely effects and has consented to it; or

- (b) a registered medical practitioner appointed as aforesaid (not being the responsible medical officer) has certified in writing that the patient is not capable of understanding the nature, purpose and likely effects of that treatment or has not consented to it but that, having regard to the likelihood of its alleviating or preventing a deterioration of his condition, the treatment should be given.<sup>483</sup>

Prior to making a certificate as outlined in section 58(b), “the registered medical practitioner concerned shall consult two other persons who have been professionally concerned with the patient’s medical treatment, and of those persons one shall be a nurse and the other shall be neither a nurse nor a registered medical practitioner”.<sup>484</sup>

The MHA 2007 introduces a number of further safeguards in relation to ECT for specific groups, including that detained patients who lack capacity, can only be administered ECT when a “second opinion appointed doctor”<sup>485</sup> certifies that the patient lacks capacity, ECT is an appropriate treatment, and (for an adult) the treatment does not conflict with a valid advance directive or “decision made by a donee or deputy or by the Court of Protection” (except in case of emergency).<sup>486</sup> Detained patients over the

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<sup>483</sup> MHA 1983, section 58(3); Department of Health and Social Security, *Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations*, London: Her Majesty’s Stationery Office, 1983; regulation 16.

<sup>484</sup> MHA 1983, section 58(4).

<sup>485</sup> MHA 1983, part 4.

<sup>486</sup> MHA 2007, section 27; amending MHA 1983, section 58A(5).

age of 18 years with capacity, can only be administered ECT when they consent and a “second opinion appointed doctor”<sup>487</sup> certifies that the patient possesses capacity (except in case of emergency).<sup>488</sup> The MHA 2007 also restricts the grounds upon which emergency ECT is permitted to circumstances in which “(a) it is immediately necessary to save the patient’s life; or (b) it is immediately necessary to prevent a serious deterioration of the patient’s condition and is not irreversible”.<sup>489</sup>

These amendments are consistent with the recommendations of the Richardson Committee which suggested that “certain forms of treatment [including ECT] should attract specific safeguards”<sup>490</sup> but also “heard argument to the effect that there may be occasions on which delay might endanger life and thus it would be unwise to remove ECT from the scope of the successor to section 62”.<sup>491</sup> The MHA 2007 balances the retention of emergency ECT in certain cases with this new restriction on the circumstances in which it can be administered,<sup>492</sup> reflecting a delicate balance between the autonomy and dignity of the patient, the paternalism inherent in involuntary treatment, and the right to medical care.<sup>493</sup>

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<sup>487</sup> MHA 1983, part 4.

<sup>488</sup> MHA 2007, section 27; amending MHA 1983, section 58A(2 and 3).

<sup>489</sup> MHA 2007, section 35(1); amending MHA 1983, section 64C(5) and (6).

<sup>490</sup> Expert Committee, 1999; p. 5.

<sup>491</sup> Expert Committee, 1999; p. 85.

<sup>492</sup> Hall and Ali, 2009; p. 229.

<sup>493</sup> UDHR, article 25(1)



### **3.4.7 Time-scales for the Mental Health Review Tribunal**

Under the MHA 1983 detained patients could apply to the Mental Health Review Tribunal following admission for assessment (within 14 days), admission for treatment (within six months) or being received into guardianship (within six months), amongst other circumstances.<sup>494</sup> The MHA 2007 alters some of these provisions to take account of various other changes in the legislation, including revised provisions for “supervised community treatment”.<sup>495</sup>

The MHA 2007 also requires that hospital managers refer cases to the Tribunal within six months of admission, for:

- (a) A patient who is admitted to a hospital in pursuance of an application for admission for assessment;
- (b) A patient who is admitted to a hospital in pursuance of an application for admission for treatment;
- (c) A community patient;
- (d) A patient whose community treatment order is revoked under section 17F above;
- (e) A patient who is transferred from guardianship to a hospital in pursuance of regulations made under section 19 above.<sup>496</sup>

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<sup>494</sup> MHA 1983, section 66.

<sup>495</sup> MHA 2007, sections 32-36.

<sup>496</sup> MHA 2007, section 37(3); amending MHA 1983, section 68(1).

Hospital managers shall also refer all such cases to the “Tribunal if a period of more than three years (or, if the patient has not attained the age of 18 years, one year) has elapsed since his case was last considered by such a tribunal, whether on his own application or otherwise”.<sup>497</sup>

The MHA 2007, therefore, includes automatic referral to the Tribunal for patients admitted for assessment, albeit after six months of detention;<sup>498</sup> such patients are generally detained for only 28 days, but this period may be extended if there is an application to displace a nearest relative<sup>499</sup> and during such an extended period there is no right of appeal to the Tribunal.<sup>500</sup> The inclusion of an automatic referral to the Tribunal after six months goes some of the way towards addressing the concerns articulated in *R (M) v Secretary of State for Health*,<sup>501</sup> although greater efficiency in processing requests to displace the “nearest relative”, as recommended by the House of Lords, would also help protect the ECHR right to respect for “private and family life”.<sup>502</sup>

Overall, the 2007 Act’s changes in relation to the Mental Health Review Tribunal appear likely to result in greater involvement in the Tribunal hearings for clinicians, which may add to workloads but also, possibly, result in greater emphasis on the “best”

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<sup>497</sup> MHA 2007, section 37(3); amending MHA 1983, section 68(6).

<sup>498</sup> MHA 2007, section 37, amending MHA 1983, section 2.

<sup>499</sup> MHA 1983, section 29(4).

<sup>500</sup> Bowen, 2007; p. 64. The House of Lords has found that this does not violate ECHR rights (*R (H) v Secretary of State for Health* [2005] UKHL 60, [2006] 1 AC 441).

<sup>501</sup> *R (M) v Secretary of State for Health* [2003] EWHC 1094 (Admin), [2003] 1 MHLR 88.

<sup>502</sup> ECHR, article 8.

rather than “medical” interests of the patient; i.e. greater emphasis on autonomy and dignity, as opposed to a clinically-constructed “right” to treatment.<sup>503</sup>

### 3.4.8 Advocacy

The MHA 2007 requires that the “appropriate national authority shall make such arrangements as it considers reasonable to enable persons (“independent mental health advocates”) to be available to help qualifying patients”.<sup>504</sup> Such help “should, so far as practicable, be provided by a person who is independent of any person who is professionally concerned with the patient’s medical treatment”<sup>505</sup> and can relate to a range of matters, including details of the MHA 2007,<sup>506</sup> medical treatment,<sup>507</sup> “rights which may be exercised under this Act by or in relation to” the patient,<sup>508</sup> and “help (by way of representation or otherwise) in exercising those rights”.<sup>509</sup>

A patient is a “qualifying patient”<sup>510</sup> for advocacy services if he or she is:

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<sup>503</sup> Sarkar, S.P., Adshead, G., “Black robes and white coats”, *British Journal of Psychiatry*, 2005, 186, 96-98. ECHR principles have been evoked in relation to treatment, but while rulings indicate that treatment, when provided, must be based on medical necessity and in the patient’s best interests (*R (PS) v Responsible Medical Officer* [2003] EWHC 2335 (Admin)), there is no automatic right to treatment (e.g. for an individual with untreatable personality disorder, detained on the basis of public protection) (*Hutchison Reid v UK* (2003) 37 EHRR 211).

<sup>504</sup> MHA 2007, section 30(2), amending MHA 1983, section 130A(1).

<sup>505</sup> MHA 2007, section 30(2), amending MHA 1983, section 130A(4).

<sup>506</sup> MHA 2007, section 30(2), amending MHA 1983, section 130B(1)(a)-(b).

<sup>507</sup> MHA 2007, section 30(2); amending MHA 1983, section 130B(1)(c)-(f).

<sup>508</sup> MHA 2007, section 30(2); amending MHA 1983, section 130B(2)(a).

<sup>509</sup> MHA 2007, section 30(2); amending MHA 1983, section 130B(2)(b).

<sup>510</sup> MHA 2007, section 30(2); amending MHA 1983, section 130A(1).

- (a) liable to be detained under this Act (otherwise than by virtue of section 4 or 5(2) or (4) above or section 135 or 136 below);<sup>511</sup>
- (b) subject to guardianship under this Act; or
- (c) a community patient.<sup>512</sup>

A patient is also a “qualifying patient” even if they do not fulfill these criteria but discuss “with a registered medical practitioner or approved clinician the possibility of being given a form of treatment to which section 57 above applies”.<sup>513</sup> Each “qualifying patient” is to be made aware of the advocacy services, by a “responsible person” who may be the hospital managers, responsible clinician, approved clinician, registered medical practitioner or responsible social services authority.<sup>514</sup>

While this strengthening of advocacy services should help with the promotion of dignity and autonomous exercise of patients’ capabilities, the new provisions do not specify the position of patients who lack capacity to make certain decisions (e.g. to consent to providing access to their records). This may present a significant problem because advocates can only access patients’ records (a) “where the patient has capacity or is competent to consent” and does consent, or (b) “in any other case, the production or

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<sup>511</sup> Section 4 concerns “admission for assessment in cases of emergency”; sections 5(2) and (4) concern making an “application in respect of patient already in hospital”; section 135 concerns a “warrant to search for and remove patients”; and section 136 concerns “mentally disordered persons found in public places”.

<sup>512</sup> MHA 2007, section 30(2); amending MHA 1983, section 130C(2).

<sup>513</sup> MHA 2007, section 30(2); amending MHA 1983, section 130C(3)(a). Section 57 of the MHA 1983 concerns “treatment requiring consent and a second opinion” including “(a) any surgical operation for destroying brain tissue or for destroying the functioning of brain tissue; and (b) such other forms of treatment as may be specified for the purposes of this section by regulations made by the Secretary of State”.

<sup>514</sup> MHA 2007, section 30(2); amending MHA 1983, section 130D(2).

inspection would not conflict with a decision made by a donee or deputy or the Court of Protection and the person holding the records” believes the records are relevant to the work of the advocate.<sup>515</sup>

Therefore, while patients capable of accessing advocacy services are likely to benefit from the enhanced provision of advocacy services under the new legislation, patients who are incapable of accessing and engaging with advocates (ironically, those most in need of advocacy) may experience difficulty engaging effectively. Notwithstanding this caveat, the enhanced emphasis on advocacy in the MHA 2007 is likely to assist in enhancing patient dignity and autonomy, by providing at least some patients with a stronger voice and facilitating exercise of specific capabilities.

### **3.5 Overall assessment**

The MHA 2007 makes a number of important changes which have the potential to advance the dignity and human rights of detained patients. Key changes include revising and simplifying the definition of “mental disorder” as “any disorder or disability of the mind”<sup>516</sup> (although it is a notably broad definition) and repealing the previous categorisations of mental disorder. The effects of these changes are not yet fully clear, however, and it is noteworthy that the explicit exclusions for “promiscuity or other immoral conduct, sexual deviancy”<sup>517</sup> are repealed.

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<sup>515</sup> MHA 2007, section 30(2); amending MHA 1983, section 130B(4).

<sup>516</sup> MHA 2007, section 1(2).

<sup>517</sup> MHA 2007, section 1(3).

The MHA 2007 replaces the “treatability test” of the MHA 1983 with a requirement that “appropriate medical treatment is available”,<sup>518</sup> although it is no longer necessary to demonstrate that treatment is “likely” to help, but rather that it has the “purpose” of helping, regardless of likely efficacy. In addition, widening the role of “responsible clinician”<sup>519</sup> may result in greater decision-making by individuals trained in settings which prioritise public safety over patient well-being; e.g. prisons (Section 3.4.2).<sup>520</sup>

More broadly, the MHA 2007 introduces a significant expansion of professional roles, potentially resulting in greater team-work and sharing of responsibility amongst various members of multi-disciplinary teams, although, again, it remains unclear whether renewal orders made out without the involvement of medical doctors will meet the ECHR requirement for objective medical evidence if liberty is lawfully to be denied on the grounds of “unsound mind”.<sup>521</sup> The MHA 2007 also permits a patient’s civil partner to be the “nearest relative” and permits the patient to apply to displace their “nearest relative” (which supports patient autonomy), although the court must be of the opinion that the patient’s nominee for “nearest relative” is “a suitable person to act as such”<sup>522</sup> (a notably paternalistic caveat).

Regarding treatment, the MHA 2007 revises and simplifies “supervised community treatment” procedures,<sup>523</sup> although the Tribunal’s power over such orders is still limited; they may be revoked without the opinion of medical doctors; and their clinical

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<sup>518</sup> MHA 2007, section 4(2)(b).

<sup>519</sup> MHA 2007, sections 9-17.

<sup>520</sup> Bowen, 2007; p. 55.

<sup>521</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387; Bowen, 2007: p. 134; ECHR, article 5(1).

<sup>522</sup> MHA 2007, section 23(3); amending MHA 1983, section 29(1A)

<sup>523</sup> MHA 2007, sections 32-36.

usefulness is not established. While treatment in the community as opposed to hospital is, at least in theory, supportive of patients' liberty, dignity and exercise of capabilities, the idea of compulsory treatment in the community is an inherently paternalistic one, and may be subject to misuse.

Regarding ECT, the MHA 2007 also introduces new safeguards for detained patients and further restricts the grounds on which emergency ECT can be administered, both of which are protective of patient's rights including their "right" to treatment.

Finally, the MHA 2007 introduces automatic referral to the Tribunal for patients admitted for assessment,<sup>524</sup> although referral will occur six months after admission on what was initially a 28-day order (this 28-day period may be extended if there is an application to displace a nearest relative). The legislation also requires that the "appropriate national authority" introduce a system of "independent mental health advocates"<sup>525</sup> for patients, a measure which has the potential to assist greatly with the protection of rights and exercise of capabilities, although not all patients will qualify for advocacy services.

Overall, the changes introduced by the MHA 2007 present a mixture of increased protections for certain human rights, specific measures which support patient dignity and capabilities, and other measures which are clearly paternalistic in tone and content. Notwithstanding these concerns, the legislation has strong overall potential to help advance rights, and, in particular, the effective use of advocacy could greatly enhance

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<sup>524</sup> MHA 1983, section 2.

<sup>525</sup> MHA 2007, section 30(2); amending MHA 1983, section 130A(1).

opportunity for patients to voice their views and exercise their capabilities in relation to care, and thus enhance their dignity.

The MHA 2007 was welcomed by many groups, most of whom recognized a broad need for reform.<sup>526</sup> The Royal College of Psychiatrists and Department of Health welcomed the Act warmly, stating that “the new legislation represents an important milestone in the reform of mental health care in England, backing up changes to services, led by frontline staff that have transformed community care”.<sup>527</sup>

The King’s Fund, an independent charity focusing on health policy and practice, noted that “the government has achieved much of what it set out to do” in amending the MHA 1983, although it had “failed to achieve the root-and-branch review of mental health legislation that it originally planned.”<sup>528</sup> Nonetheless, “the amended Act does, as it intended, break the link between compulsory treatment and hospital by extending compulsion to certain patients in the community” through new supervised community treatment orders (SCT):

In terms of protecting the public, SCT is unlikely to bring an end to the occasional high-profile homicide committed by people with a serious mental disorder, as many are committed by people who have not previously been in contact with services or had been assessed as low risk. However, SCT should lead to fewer and less violent incidents in specific cases as patients maintain treatment regimes they might otherwise ignore... The government

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<sup>526</sup> Brindle, D., “A new act, but mental health battles remain”, *Guardian*, 2007, 11 July.

<sup>527</sup> Bhugra & Appleby, 2008.

<sup>528</sup> King’s Fund, *Briefing: Mental Health Act 2007*, London: The King’s Fund, 2008; p. 7.



expects savings to be made from reduced bed usage as a result of SCT, but there is no guarantee these savings – if actually made – will be channeled into community mental health services. SCT also imposes extra costs on local authorities that will need to be found from within tight budgets.<sup>529</sup>

The King's Fund also highlighted the possibility of court challenges to the precise relevance of the Code of Practice, the requirement to ensure an “age-appropriate” setting in hospitals for children, and renewal of detention orders by responsible clinicians who are not doctors. Overall, it saw the legislation as striking a reasonable balance between autonomy and paternalism, although there was scant mention of the extent to which the MHA 2007 does or does not support patients' dignity or autonomous exercise of capabilities.

Mental Health Alliance was concerned about many of the same issues as the King's Fund, including the renewal of detention orders by responsible clinicians who are not doctors; they recommended that “at least two professional opinions should agree the detention, with those opinions coming from different disciplines, and at least one of them providing the ‘objective medical expertise’ required by human rights legislation”.<sup>530</sup> It is unclear whether or not the MHA 2007 meets relevant ECHR requirements as doctors are still required for initial detention orders but not renewal orders.

From the perspective of mental health social workers, it was especially notable that the MHA 2007 replaces the term “approved social worker” with “approved mental health

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<sup>529</sup> King's Fund, 2008; p. 7.

<sup>530</sup> Mental Health Alliance, 2006; p. 8.

professional”.<sup>531</sup> Rapaport and Manthorpe, writing in the *British Journal of Social Work*, argued that “research has identified a distinct difference between health and social work ethical approaches to the use of compulsion”; that “the feasibility of nurses promoting the social model is uncertain”; and that “it is not known how nurses’ competence will meet the demands of the role”.<sup>532</sup> They concluded that “the skills of nonsocial work professionals to promote the social model, to develop anti-oppressive practice and to identify care alternatives in making decisions will need to be evaluated.”<sup>533</sup>

More generally, the Mental Health Foundation, a mental health charity, expressed concern that the legislation increased the stigma associated with mental illness through its focus on risk of violence.<sup>534</sup> This is, possibly, the most far-reaching criticism of the MHA 2007 as it may help explain why certain issues such as human dignity and capabilities were not substantively addressed by the legislation: by focusing on public safety, the legislation dealt largely with involuntary detention and treatment, leading to a general emphasis on paternalism which would have been less prominent had the legislation engaged more deeply with other issues, especially those which affect voluntary patients (e.g. the issue of dignity for voluntary patients, who constitute the majority of mental health service-users).

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<sup>531</sup> MHA 2007, section 18.

<sup>532</sup> Rapaport, J., Manthorpe, J., “Family matters: Developments concerning the role of the nearest relative and social worker under mental health law in England and Wales”, *British Journal of Social Work*, 2008, 38, 1115-1131; p. 1126.

<sup>533</sup> Rapaport and Manthorpe, 2008; p. 1126.

<sup>534</sup> Batty, D., “Law ‘reinforced mental health stereotypes’” *Guardian*, 2008, 18 February.

Finally, both the Mental Health Alliance<sup>535</sup> and King's Fund noted that "in redefining mental disorder and removing the 'treatability' test, the new legislation allows clinicians to detain certain people who could avoid detention under the original 1983 Act".<sup>536</sup> Notwithstanding these concerns, many of the changes in the new legislation, especially in relation to advocacy and the definition of nearest relative, went at least some way to addressing the concerns of the Mental Health Foundation, Mental Health Alliance, King's Fund and others.

In the end, the precise extent to which these changes will advance or impede the protection of the human rights and dignity of detained patients in England is not yet clear. The impact of the MHA 2007 will depend critically on (a) the responses of mental health service-providers to the Act; (b) the attitude of the Courts in interpreting the Act in the context of the Human Rights Act 1998 and ECHR; and, increasingly, (c) legislative and policy developments at European level, including the Council of Europe, the EU, and their various member-states.<sup>537</sup> This European dimension, amongst other emergent themes, is explored in greater depth in Section 7.2.

In addition to looking at English legislation, however, this thesis focuses equally on another member-state of both the Council of Europe and EU: the Republic of Ireland. Recent changes in mental health legislation in Ireland are considered next.

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<sup>535</sup> Mental Health Alliance, 2006; p. 6.

<sup>536</sup> King's Fund, 2008; p. 7.

<sup>537</sup> Kelly, B.D., "The emerging mental health strategy of the European Union", *Health Policy*, 2008, 85, 60-70.

## Chapter 4

### Mental health legislation in Ireland

#### 4.1 Introduction

In Ireland, there was scant provision for individuals with mental illness throughout the seventeenth and eighteenth centuries.<sup>538</sup> The nineteenth century was, however, a time of intensive legislative activity resulting in the establishment of a large network of public asylums:<sup>539</sup> in 1851 there were 3,234 individuals in Irish asylums and by 1891 this had increased to 11,265.<sup>540</sup> This trend continued well into the twentieth century: by 1961, one in every 70 Irish people above the age of 24 was resident in a psychiatric hospital.<sup>541</sup> While there were similar problems with high committal rates in other countries, including France, England and the US,<sup>542</sup> Ireland's admission rates were especially high at their peak, and especially slow to decline.<sup>543</sup>

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<sup>538</sup> Psychiatrist, 1944; Robins, 1986; Kelly, B.D., "Mental illness in nineteenth century Ireland: a qualitative study of workhouse records", *Irish Journal of Medical Science*, 2004, 173, 53-55.

<sup>539</sup> Hallaran, 1810; Finnane, P., *Insanity and the Insane in Post-Famine Ireland*, London: Croon Helm, 1981.

<sup>540</sup> Inspectors of Lunatics, *The Forty-Second Report (With Appendices) of the Inspector of Lunatics (Ireland)*, Dublin: Thom & Co. for Her Majesty's Stationery Office, 1893.

<sup>541</sup> Lyons, 1985.

<sup>542</sup> Shorter, 1997; US Bureau of the Census, *Historical Statistics of the United States, Colonial Times to 1970, Bicentennial Edition, Part 2.*, Washington DC: GPO, 1975.

<sup>543</sup> Kelly, B.D., "Mental health law in Ireland, 1945 to 2001: Reformation and renewal?" *Medico-Legal Journal*, 2008; 76, 65-72.

Against this background, Ireland introduced a significant reform of mental health legislation in the form of the Mental Treatment Act 1945. This Act was to remain the cornerstone of Irish mental health law until the MHA 2001 was fully implemented in November 2006. This chapter examines key issues in Irish mental health law and human rights prior to the MHA 2001 (Section 4.2); outlines provisions of the MHA 2001 (Section 4.3); explores human rights implications of the MHA 2001 (Section 4.4); and concludes with an overall assessment of mental health law and human rights in Ireland today (Section 4.5).

## **4.2 Irish mental health law prior to the Mental Health Act 2001**

Ireland's Mental Treatment Act 1945 introduced several important reforms to mental health services. These included, most notably, the introduction of a voluntary admission status,<sup>544</sup> a reform which had already been implemented in Great Britain (1930) and Northern Ireland (1932).<sup>545</sup> Ireland's 1945 Act also introduced two new procedures for involuntary admission, one for "persons of unsound mind" and the other for "temporary chargeable patients". Both procedures required that a family member, relative or other person make an "application" for involuntary admission,<sup>546</sup> and that an "authorised medical officer" (e.g. general practitioner) examine the individual, who was then transported to the psychiatric hospital (by police, if necessary) where a detention order could be completed by a doctor, following psychiatric examination.

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<sup>544</sup> Mental Treatment Act, 1945, section 1.

<sup>545</sup> O'Neill, 2005; Kelly, B.D., "The Mental Treatment Act 1945 in Ireland: an historical enquiry", *History of Psychiatry*, 2008, 19, 47-67.

<sup>546</sup> Mental Treatment Act 1945, section 14, chapter 1.

The key difference between the “person of unsound mind” and “temporary chargeable patient” procedures was that the former resulted in detention and involuntary treatment for an indefinite period, while the latter resulted in detention and involuntary treatment for up to six months (although it could be extended if clinically indicated). Neither form of detention involved automatic review by tribunal, although any detention order could be revoked at any time by the treating psychiatrist.<sup>547</sup> If the patient wished to challenge his or her detention, he or she had to either write to the “Inspector of Mental Hospitals”<sup>548</sup> or selected other parties,<sup>549</sup> or instigate legal action in the courts under the Constitution of Ireland.<sup>550</sup> As a result, the “person of unsound mind” procedure resulted in indefinite, potentially life-long detention, without review, especially for individuals who lacked the mental capacity or financial resources to access the courts.

Even when a detained patient accessed legal representation in order to challenge their detention in the High Court, the 1945 Act, as amended by section 2(3) of the Public Authorities Judicial Proceedings Act 1954, stated:

No civil proceedings shall be instituted in respect of an act purporting to have been done in pursuance of this Act save by leave of the High Court and such leave shall not be granted unless the High Court is satisfied that there

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<sup>547</sup> Mental Treatment Act 1945, section 14, chapter 3.

<sup>548</sup> Mental Treatment Act 1945, section 18; the Inspector could look into the matter and report to the Minister for Health, who could then order the discharge of the patient.

<sup>549</sup> The patient had the right to have a letter forwarded, unopened, to the Minister for Health, President of the High Court, Registrar of Wards of Court, Health Board (i.e. local health authority), a Visiting Committee of a district mental hospital or the Inspector of Mental Hospitals (Mental Treatment Act 1945, section 266; Cooney, T., O'Neill, O., *Kritik 1: Psychiatric Detention: Civil Commitment in Ireland*, Delgany, Wicklow: Baikonur, 1996); p. 300.

<sup>550</sup> Constitution of Ireland, article 40.

are substantial grounds for contending that the person against whom the proceedings are to be brought acted in bad faith or without reasonable care.<sup>551</sup>

In 2008, after the Mental Treatment Act 1945 had been replaced by the MHA 2001, the Irish Supreme Court found that this section of the 1945 Act had been unconstitutional, as it restricted grounds for challenging detention to two specific grounds (acting in “bad faith” or proceeding “without reasonable care”).<sup>552</sup> The Supreme Court stated that this was a disproportionate restriction on the detained patient’s right to access the courts where a fundamental right, liberty, had been restricted, and was, thus, contrary to the Constitution of Ireland.<sup>553</sup>

Almost a decade earlier, in 1999, the Irish Law Society had already highlighted this problem, amongst several others, in a report titled *Mental Health: The Case for Reform*.<sup>554</sup> The Law Society reviewed case-law and international human rights legislation, and suggested that criteria for involuntary commitment be more clearly defined; a “least restrictive alternative” principle be introduced; a right to a minimum level of psychiatric service be introduced by statute; formal safeguards be extended to voluntary patients; and measures be introduced to enable the proposed “Mental Health Review Board” to review detention orders and order “planned discharge”.

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<sup>551</sup> Mental Treatment Act 1945, section 16, section 260(1); Spellman, J., “Section 260 of the Mental Treatment Act, 1945 Reviewed”, *Medico-Legal Journal of Ireland*, 1998, 4, 20-24.

<sup>552</sup> *Blehein v The Minister for Health and Children and others* [2008] IESC 40; Madden, E., “Section of Mental Health Act was unconstitutional”, *Irish Medical Times*, 2009, 30, 15.

<sup>553</sup> Constitution of Ireland, article 6.

<sup>554</sup> Law Reform Committee, *Mental Health: The Case for Reform*, Dublin: The Law Society, 1999.

Many of these proposals were consistent with the Irish government's 1995 White Paper which proposed a "new Mental Health Act" and openly acknowledged that the Mental Treatment Act 1945 did "not fully comply with this country's obligations under international law".<sup>555</sup>

The changes in Irish law that are required to ensure full compliance with our obligations under the European Convention...include a redefinition of the criteria for detention of mentally disordered persons, the introduction of procedures to review the decision to detain a person in a psychiatric hospital by a body independent of both the person who took the decision to detain and of the executive, an automatic review of long-term detention, and the introduction of greater safeguards for the protection of detained persons.<sup>556</sup>

For some decades prior to implementation of the MHA 2001, then, the process of reform in Ireland was largely driven by European and international influences, as evidenced by the Irish government's concern, in 1995, to "ensure full compliance with our obligations under the European Convention",<sup>557</sup> and the Law Society's explicit reliance on the ECHR and UN *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*<sup>558</sup> in their recommendations.<sup>559</sup> In 2000, this European dimension came even more urgently into focus when the lack of

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<sup>555</sup> Department of Health, 1995; p. 13.

<sup>556</sup> Department of Health, 1995; p. 15.

<sup>557</sup> Department of Health, 1995; p. 15.

<sup>558</sup> UN, 1991.

<sup>559</sup> Law Reform Committee, 1999.



automatic review of detention under the Mental Treatment Act 1945 formed the focus of a landmark case in the European Court of Human Rights.<sup>560</sup>

In this case, a detained patient pointed to the lack of an automatic, independent review of psychiatric detention in Ireland and, when the Irish Supreme Court stated this was not unconstitutional, the applicant took the case to the European Court of Human Rights, to argue that this breached his rights under the ECHR. A “friendly settlement” was reached in 2000, under which the Irish state noted its obligations under the ECHR and undertook to pay an agreed compensatory sum to the applicant. Most importantly, the Irish state noted that the applicant was the first individual to bring this important issue in front of the European Court of Human Rights and that the applicant’s claim had been initiated prior to the publication of the Mental Health Bill 1999, which formed a key part of Ireland’s defence.

The Mental Health Bill 1999 was actually the culmination of a lengthy process of reform, which had commenced long prior to this case,<sup>561</sup> but was pursued with considerably greater urgency after this case was instigated in the Irish courts in 1994 and later in the European Court of Human Rights.<sup>562</sup> As a result, this case reinforced the ECHR as the key driver of reform of mental health law in Ireland, and the Mental Health Bill 1999 led, in due course, to the MHA 2001. Human rights standards, as reflected in the ECHR, continued to dominate this reform process to the very end, as

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<sup>560</sup> *Croke v Smith* [1994] 3 IR 529; *Croke v Smith (No. 2)* [1998] 1 IR 101; *Croke v Ireland* (2000) ECHR 680.

<sup>561</sup> O’Neill, 2005.

<sup>562</sup> *Croke v Smith* [1994] 3 IR 529; Rutherford, A., “Detention in mental hospital after 6 month period without new order invalid”, *The Irish Times* 1994, 26 September; Department of Health, 1995; *Croke v Smith (No. 2)* [1998] 1 IR 101; Law Reform Committee, 1999.

concerns about the human rights of detained patients persisted even after the MHA 2001 had passed through the Oireachtas (Irish parliament) on 8 July 2001, and full implementation was awaited.<sup>563</sup> The MHA 2001 was finally, fully implemented on 1 November 2006.

Before exploring the MHA 2001 itself, it is worth noting that the issue of public safety was virtually absent from the debate leading to the new legislation in Ireland. This contrasts with the situation in England, where public safety was a key concept in the reform process (Section 3.3.1). This difference is probably attributable to the absence of any recent high-profile case of homicide involving a mentally ill individual in Ireland. Interestingly, the issues of human dignity and capabilities did not play an appreciable role in the reform process in *either* jurisdiction, possibly because both reform processes largely pre-dated the CRPD, which places particular emphasis on dignity.<sup>564</sup>

### **4.3 The Mental Health Act 2001**

The MHA 2001, which replaced the Mental Treatment Act 1945 in Ireland, is chiefly concerned with two aspects of psychiatric services: involuntary detention and mechanisms for assuring standards of care.<sup>565</sup> The four key parts of the Act concern:

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<sup>563</sup> Coulter, C., “Legal rights of mental health sufferers ignored”, *The Irish Times*, 2005, 1 November; Kelly, B.D., “Irish mental health law”, *Irish Psychiatrist*, 2006, 7, 29-30; Owens, J., “Mental health services crying out for reform”, *The Irish Times*, 2005, 21 November.

<sup>564</sup> CRPD, article 1.

<sup>565</sup> Kelly, B.D., “Viewpoint: The Mental Health Act 2001”, *Irish Medical Journal*, 2002, 95, 151-152; Kelly, B.D., “The Irish Mental Health Act 2001”, *Psychiatric Bulletin*, 2007, 31, 21-24; Kennedy, H., *The Annotated Mental Health Acts*, Dublin: Blackhall Publishing, 2007; Keys, M., *Annotated Legislation: Mental Health Act 2001*, Dublin: Round Hall, Sweet and Maxwell, 2002; Leahy, T., “Challenges with

- 4.3.1 Preliminary and general
- 4.3.2 Involuntary admission of persons to approved centres
- 4.3.3 Independent review of detention
- 4.3.4 Consent to treatment

#### **4.3.1 Preliminary and general**

The MHA 2001 defines “mental disorder” to include “mental illness, severe dementia or significant intellectual disability” where “there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons” or “the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission.”<sup>566</sup> It is also necessary that detention and treatment

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new mental health law”, *Forum*, 2007, 24, 14-15; Ryan, D., *The Mental Health Acts 2001-2009*, Dublin: Blackhall Publishing, 2010.

<sup>566</sup> MHA 2001, section 3(1). The phrase “serious likelihood” of harm has been interpreted by the High Court to represent a standard of proof of a high level of probability which is beyond the normal standard of proof in civil actions (i.e. more likely, or probable, to be true) but below the standard in criminal prosecution (i.e. beyond reasonable doubt); i.e. “proof to a standard of a high level of likelihood as distinct from simply being more likely to be true” (*MR v Cathy Byrne, administrator, and Dr. Fidelma Flynn, clinical director, Sligo Mental Health Services, Ballytivnan, Co. Sligo* [2007] IEHC 73; p. 16). In the same case, the meaning of the word “serious” in the phrase “immediate and serious harm” was interpreted as differing depending on whether the harm is directed at self or others: “Clearly, the infliction of any physical injury on another could only be regarded as ‘serious’ harm, while the infliction of a minor physical injury on the person themselves could be regarded as not ‘serious’” (p. 17).

“would be likely to benefit or alleviate the condition of that person to a material extent.”<sup>567</sup>

More specifically, “mental illness” is:

A state of mind of a person which affects the person’s thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons.<sup>568</sup>

“Severe dementia” is “a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression”.<sup>569</sup> “Significant intellectual disability” is “a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person”.<sup>570</sup>

These definitions accord moderately well with clinical definitions. For example, the WHO defines intellectual disability (“mental retardation”) as “a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, which contribute to the overall

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<sup>567</sup> MHA 2001, section 3(1).

<sup>568</sup> MHA 2001, section 3(2).

<sup>569</sup> MHA 2001, section 3(2).

<sup>570</sup> MHA 2001, section 3(2).

level of intelligence.”<sup>571</sup> The MHA 2001 echoes much of this wording, but adds a requirement for “abnormally aggressive or seriously irresponsible conduct.”<sup>572</sup> This reflects the fact that once an individual fulfils the definition of “significant intellectual disability”, a form of “mental disorder” under section 3 of the MHA 2001, that individual can be detained under the legislation. The MHA 2007 introduced a similar requirement in England, where individuals with learning disability “shall not be considered by reason of that disability” to be suffering from mental disorder “unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part”.<sup>573</sup>

Overall, the definitions in Ireland’s MHA 2001 are closer to those in England’s MHA 1983 than MHA 2007: England’s MHA 1983 defined “mental disorder” as “mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind”,<sup>574</sup> which is quite similar to Ireland’s MHA 2001. England’s MHA 2007, however, removed these four categories and re-defined “mental disorder” as “any disorder or disability of the mind”.<sup>575</sup> While these changes in England were in line with recommendations of the Richardson Committee<sup>576</sup> and Mental Health Act Commission,<sup>577</sup> they contrast with developments in Ireland, where the MHA 2001 introduced detailed definitions of mental disorder and various other terms for the first time.

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<sup>571</sup> WHO, *ICD-10 Guide for Mental Retardation*, Geneva: WHO, 1996.; p. 1.

<sup>572</sup> MHA 2001, section 3(2).

<sup>573</sup> MHA 2007, section 2(2).

<sup>574</sup> MHA 1983, section 1(2).

<sup>575</sup> MHA 2007, section 1(2).

<sup>576</sup> Expert Committee, 1999.

<sup>577</sup> Mental Health Act Commission, 2003; para. 7.31, pp. 85-86.

Moreover, an individual cannot be detained under Ireland's MHA 2001 solely on the grounds that he or she "is suffering from a personality disorder",<sup>578</sup> and while England's MHA 2007 removed the need for "abnormally aggressive or seriously irresponsible conduct" for a diagnosis of "psychopathic disorder",<sup>579</sup> detention can still occur when "it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment".<sup>580</sup>

#### **4.3.2 Involuntary admission of persons to approved centres**

Under Ireland's MHA 2001, an individual can be involuntarily admitted to an "approved centre" (i.e. registered psychiatric inpatient facility) on the grounds that the individual is suffering from a "mental disorder";<sup>581</sup> a person *cannot* be so admitted solely on the grounds that the person "(a) is suffering from a personality disorder, (b) is socially deviant, or (c) is addicted to drugs or intoxicants".<sup>582</sup> The Act does not provide a definition of "socially deviant."

An application for involuntary admission can be made by a spouse, relative, "authorized officer",<sup>583</sup> member of the Garda Síochána (police force) or, in circumstances where no one in these categories can be found, anyone else, subject to certain conditions.<sup>584</sup> In all

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<sup>578</sup> MHA 2001, section 8(2).

<sup>579</sup> MHA 1983, section 1(2).

<sup>580</sup> MHA 1983, section 3(2)(c).

<sup>581</sup> MHA 2001, section 8(1).

<sup>582</sup> MHA 2001, section 8(2).

<sup>583</sup> MHA 2001, section 9(8).

<sup>584</sup> MHA 2001, section 9(2).

cases, the applicant must have observed the individual within 48 hours of making the application.<sup>585</sup>

The next step involves examination of the individual by a registered medical practitioner (e.g. general practitioner).<sup>586</sup> Following this recommendation, the individual can be conveyed “to the approved centre” (i.e. psychiatric unit or hospital),<sup>587</sup> with the assistance of “staff of the approved centre”, if needed.<sup>588</sup> If “there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons”, the Garda Síochána can enter the person’s dwelling by force and ensure the removal of the person to the approved centre.<sup>589</sup>

At the approved centre, a consultant psychiatrist “shall, as soon as may be, carry out an examination of the person” and shall either (a) complete an “admission order” if “he or she is satisfied that the person is suffering from a mental disorder” or (b) refuse to make such an order.<sup>590</sup> The patient cannot be detained for more than 24 hours without such an examination taking place and such an order being made or refused. If an admission order is made it is authorizes “the reception, detention and treatment of the patient

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<sup>585</sup> MHA 2001, section 9(4).

<sup>586</sup> MHA 2001, sections 10(2) and 10(5).

<sup>587</sup> MHA 2001, section 13(1).

<sup>588</sup> MHA 2001, section 13(2). The Irish Health Service Executive (chief provider of public health services in Ireland) initially out-sourced the transport of patients to approved centres to a private company; however, following judicial review proceedings the High Court stated that, under the MHA 2001, removal of persons to approved centres must be performed by staff of the approved centre (*EF v The Clinical Director of St Ita’s Hospital* [2007] JR 816). An amendment to the MHA 2001 allowed approved centres to authorise other individuals (instead of staff) to remove persons to approved centres (Health (Miscellaneous Provisions) Act 2009; section 63).

<sup>589</sup> MHA 2001, section 13(3).

<sup>590</sup> MHA 2001, section 14(1).

concerned and shall remain in force for a period of 21 days”;<sup>591</sup> this period may be extended by a “renewal order” for a period of up to 3 months;<sup>592</sup> this may be further extended by a period of up to 6 months; and each further extension can be for a period of up to 12 months.<sup>593</sup>

Following the completion of an involuntary admission order, the consultant psychiatrist must inform the Mental Health Commission of the order and the Mental Health Commission shall then (a) refer the matter to a mental health tribunal; (b) assign a legal representative to the patient, “unless he or she proposes to engage one”; and (c) direct that an independent psychiatrist examine the patient, interview the patient’s consultant psychiatrist and review the patient’s records.<sup>594</sup> Within 21 days of an involuntary admission, a mental health tribunal shall review the detention of the patient (Section 4.3.3).

Regarding medical treatment, the MHA 2001 permits the clinical director to arrange for the transfer of a patient “detained in that centre for treatment to a hospital or other place

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<sup>591</sup> MHA 2001, section 15(1).

<sup>592</sup> MHA 2001, section 15(2). Each new period of detention commences on the expiry of the previous period, once the renewal order has been completed prior to the expiry of the previous order (*MD v Clinical Director of St Brendan’s Hospital & Anor* [2007] IEHC 183); see also: Madden, E., “Involuntary detention found admissible in the High Court”, *Irish Medical Times*, 2007, 28, 20.

<sup>593</sup> MHA 2001, section 15(3); renewal orders should be completed by the consultant psychiatrist responsible for the care and treatment of the patient; more than one consultant psychiatrist may meet that description (e.g. if a detained patient is under the care of a consultant forensic psychiatrist in the Central Mental Hospital but their catchment-area psychiatrist is also involved in their treatment) (*JB v The Director of the Central Mental Hospital and Dr. Ronan Hearne and the Mental Health Commission and the Mental Health Tribunal* [2007] IEHC 201). See also: *MM v Clinical Director Central Mental Hospital* [2008] IESC 31; Madden, E., “Supreme Court rules on Mental Health Act”, *Irish Medical Times*, 2008, 22, 26.

<sup>594</sup> MHA 2001, section 17(1).



and for his or her detention there for that purpose” and the “detention of a patient in a hospital or other place under this section shall be deemed for the purposes of this Act to be detention in the centre from which he or she was transferred”.<sup>595</sup>

Regarding voluntary patients, the MHA 2001 states that when a voluntary patient “indicates at any time that he or she wishes to leave the approved centre”, a staff member may, if “of opinion that the person is suffering from a mental disorder”, detain the person for up to 24 hours.<sup>596</sup> During this period, the consultant psychiatrist responsible for the care of the patient “shall either discharge the person or arrange for him or her to be examined by another consultant psychiatrist”,<sup>597</sup> and, if that second psychiatrist “is satisfied that the person is suffering from a mental disorder, he or she shall issue a certificate in writing” to that effect;<sup>598</sup> then, the consultant psychiatrist responsible for the care of the patient shall make a 21-day admission order<sup>599</sup> which will be subject to review by a mental health tribunal within 21 days.<sup>600</sup>

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<sup>595</sup> MHA 2001, section 22(1); the legislation states that such transfers must be arranged by the clinical director, but the High Court found that, in cases of medical emergency, it would be “manifestly absurd and contrary to the whole spirit and intention of the Act” (p. 7) to potentially jeopardise the health of a detained patient owing to the non-availability of the clinical director to personally “arrange” such transfer to a medical facility; other staff may do so under such circumstances (*Patrick McCreevy v The Medical Director of the Mater Misericordia Hospital in the City of Dublin, and the Clinical Director of St. Aloysius Ward Psychiatric Unit of the Mater Misericordia Hospital in the City of Dublin and the Health Service Executive and, by order, the Mental Health Tribunal* [2007] SS 1413).

<sup>596</sup> MHA 2001, section 23(1); the individual must express a desire to leave for this procedure to be invoked; other expressions of disagreement with treatment plans (e.g. declining medication) do not constitute grounds for detention under this section (*Q v St Patrick’s Hospital* [2006] O’Higgins J, *ex tempore*, 21 December 2006).

<sup>597</sup> MHA 2001, section 24(1).

<sup>598</sup> MHA 2001, section 24(2)(a).

<sup>599</sup> MHA 2001, section 24(3).

<sup>600</sup> MHA 2001, section 24(4).

### 4.3.3 Independent review of detention

The MHA 2001 makes provision for the appointment of a “Mental Health Commission” the principal functions of which is to appoint mental health tribunals “to determine such matter or matters as may be referred to it by the Commission”.<sup>601</sup> One of the chief functions of tribunals is to review involuntary detention orders. Each tribunal comprises three members, including one consultant psychiatrist, one barrister or solicitor (of not less than 7 years experience) and one other person.<sup>602</sup> Decisions are made by majority voting.<sup>603</sup>

The Commission directs that an independent psychiatrist examine each detained patient, interview the patient’s consultant psychiatrist and review the patient’s records. Then, within 21 days of an involuntary admission, a mental health tribunal reviews the detention and, “if satisfied that the patient is suffering from a mental disorder” and that appropriate procedure has been followed, shall affirm the order; if the tribunal is not so satisfied, the tribunal shall “revoke the order and direct that the patient be discharged from the approved centre concerned”.<sup>604</sup> Similarly for renewal orders, a tribunal must be held within 21 days of the making of the renewal order.<sup>605</sup> These changes are strongly protective of the patient’s right to liberty and support patient dignity by facilitating exercise of specific capabilities in appealing detention orders.

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<sup>601</sup> MHA 2001, section 48(1).

<sup>602</sup> MHA 2001, section 48(3).

<sup>603</sup> MHA 2001, section 48(4).

<sup>604</sup> MHA 2001, section 18(1).

<sup>605</sup> The 21 days commence on the date of the *making* of the renewal order, even if it does not come into effect on that day (i.e. if it has been made some days in advance of the expiry of the existing detention order) (*AMC v St Lukes Hospital, Clonmel* [2007] IEHC 65).

Grounds for appeal of tribunal decisions are, however, limited: the patient “may appeal to the Circuit Court against a decision of a tribunal to affirm an order made in respect of him or her on the grounds that he or she is not suffering from a mental disorder”;<sup>606</sup> i.e. there is no possibility of appeal to the Circuit Court on other grounds (e.g. procedural aberrations). Following an appeal in the Circuit Court, the patient may, if they wish, appeal to the High Court but not on grounds related to whether or not they suffer from a mental disorder; they may appeal to the High Court solely “on a point of law”.<sup>607</sup>

#### **4.3.4 Consent to treatment**

The MHA 2001 specifies that “the consent of a [detained] patient shall be required for treatment” except where the patient is incapable for providing consent and the treating psychiatrist believes it “is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering”.<sup>608</sup>

Psycho-surgery can only be carried out if the patient consents in writing and surgery is authorized by a tribunal.<sup>609</sup> ECT shall be administered only if either (a) the patient consents in writing,<sup>610</sup> or (b) if the patient is “unable or unwilling” to provide consent, the treatment is approved by the treating consultant psychiatrist and one other

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<sup>606</sup> MHA 2001, section 19(1); see also: Mills, S., “The Mental Health Act 2001”, *Irish Psychiatrist*, 2004, 5, 49-55.

<sup>607</sup> MHA 2001, section 19(16).

<sup>608</sup> MHA 2001, section 57(1).

<sup>609</sup> MHA 2001, section 58(1).

<sup>610</sup> MHA 2001, section 59(1)(a).

psychiatrist.<sup>611</sup> Similarly, if “medicine has been administered to a [detained] patient for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medication shall not be continued” unless either (a) the patient consents in writing, or (b) if the patient is “unable or unwilling” to provide consent, the treatment is approved by the treating consultant psychiatrist and one other psychiatrist.<sup>612</sup>

#### **4.4 Human rights implications**

The MHA 2001 introduced several important changes to Irish mental health law. The High Court recognises that these changes are important in terms of human rights:

These provisions are exacting and complex. They were designed, however, by the Oireachtas [Irish parliament] in order to replace the situation whereby it was potentially possible for a person to be certified and detained in a mental hospital and then forgotten. The need for periodic review and renewal, and the independent examination of these conditions is not a mere bureaucratic layer grafted on to the previous law for the treatment of those who are seriously ill and a danger to themselves and others: it is an essential component of the duty of society to maintain the balance between the

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<sup>611</sup> MHA 2001, section 59(1)(b).

<sup>612</sup> MHA 2001, section 60.

protection of its interests and the rights of those who are apparently mentally ill.<sup>613</sup>

Prior to the MHA 2001, myriad concerns were expressed about the Irish psychiatric service's apparent un-readiness for the legislation, including issues related to an apparent lack of resources,<sup>614</sup> the potential effects of tribunals on therapeutic relationships,<sup>615</sup> legal representation at tribunals for psychiatrists,<sup>616</sup> staffing of tribunals,<sup>617</sup> disagreements about indemnity<sup>618</sup> and rates of payment for psychiatrists at tribunals,<sup>619</sup> and unclearness about responsibility for harm to patients resulting from lack of resources for implementing the new legislation.<sup>620</sup> Psychiatrists expressed particular concern about the potential effects of adversarial tribunals on the therapeutic alliance, increased administrative activity, and potential for the legislation disproportionately to divert resources from voluntary to involuntary patient services.<sup>621</sup>

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<sup>613</sup> *D Han v The President of the Circuit Court and Doctor Malcolm Garland and Doctor Richard Blennerhassett and Doctor Conor Farren and Professor Patrick McKeon and the Mental Health Commission and the Mental Health Tribunal* [2008] IEHC 160; pp. 10-11.

<sup>614</sup> Barnes, J.-A., "Red-letter day for mental health?", *Irish Medical News*, 2006, 41, 4; Shannon, J., "Getting one's Act together", *Medicine Weekly*, 2006, 43, 20; Wrigley, M., "A State of unpreparedness", *Irish Medical Times*, 2006, 40, XI.

<sup>615</sup> Whelan, D., "Mental health tribunals", *Medico-Legal Journal of Ireland*, 2004, 10, 84-89; p. 87.

<sup>616</sup> McGuinness, I., "Tribunals to decide on legal representation", *Irish Medical Times*, 2006, 45, 1.

<sup>617</sup> O'Brien, C., "Reviews for mental patients in detention", *The Irish Times*, 2006, 1 November.

<sup>618</sup> McGuinness, I., "Consultants not to apply for mental health tribunal positions", *Irish Medical Times*, 2005, 10, 1.

<sup>619</sup> Vize, E., "Pay threat to psychiatrists over mental health tribunals", *Medicine Weekly*, 2005, 41, 1.

<sup>620</sup> Ó Cionnaith, F., "Consultants not responsible for harm under Act", *Medicine Weekly*, 2006, 43, 1.

<sup>621</sup> Ganter, K., Daly, I., Owens, J., "Implementing the Mental Health Act 2001", *Irish Journal of Psychological Medicine*, 2005, 22, 79-82; Kelly, B.D., Lenihan, F., "Attitudes towards the implementation of the Mental Health Act 2001", *Irish Journal of Psychological Medicine*, 2006, 23, 82-84.

In 2005, prior to full implementation of the Act, the Irish College of Psychiatrists stated that the absence of funding to implement the legislation in a timely fashion had serious implications in terms of human rights, for both future *and* current patients, whose mental health services might be curtailed in order to divert resources towards the implementation of the Act:

This is a human rights issue. People are entitled to the increased safeguards which are central to the Act – and it is imperative that people already attending should not have their services curtailed so that the Act can be implemented.<sup>622</sup>

Following considerable discussion, some additional resources were made available for mental health services, including extra consultant psychiatrist posts and additional funds,<sup>623</sup> and the final elements of the legislation (relating chiefly to tribunals) were implemented on 1 November 2006. In the first eleven months following full implementation, approximately 12% of involuntary admission and renewal orders examined by tribunals were revoked.<sup>624</sup> There is no systematic information available about the precise reasons for revocation (e.g. procedural aberrations, absence of mental disorder) because the Mental Health Commission does not record the reasons for decisions of mental health tribunals. The Commission has, however, outlined the cost

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<sup>622</sup> Ganter, K., “Funding for Mental Health Act is a human rights issue”, *Medicine Weekly*, 2005, 13, 26.

<sup>623</sup> Barnes, J.-A., “Mental health chief confident HSE will meet legal obligations”, *Irish Medical News*, 2006, 40, 24.

<sup>624</sup> McGuinness, I., “Tribunals revoke 12 per cent of detentions”, *Irish Medical Times*, 2007, 43, 3.

of tribunals: each tribunal costs a total of €3377 (£2901), including €1319 (£1133) for the patient's legal representative.<sup>625</sup>

Two years after full implementation, it was apparent that the MHA 2001 had brought both challenges and benefits to Irish mental health services.<sup>626</sup> Some of the challenges related to the role of general practitioners in involuntary admissions, timing of tribunals, conduct of some patients' legal representatives, availability of reports by independent psychiatrists prior to tribunals, and increased workloads reported by psychiatrists.<sup>627</sup> Notwithstanding these reported problems, 73% of psychiatrists reported that the legislation had resulted in greater protection for the rights of involuntary patients.<sup>628</sup>

The precise effects of the legislation in relation to human rights can be considered in relation to six specific areas:

#### 4.4.1 Mental health tribunals for patients currently detained

#### 4.4.2 Civil proceedings in the Circuit Court and High Court

#### 4.4.3 Mental health tribunals for discharged patients

#### 4.4.4 Capacity in relation to voluntary patients

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<sup>625</sup> Barnes, J.-A., "Mental health tribunals cost €2.56m", *Irish Medical News*, 2007, 22, 12.

<sup>626</sup> Kelly, B.D., "The Mental Health Act 2001", *Irish Medical News*, 2009, 20, 29; Ní Mhaoláin, Á., Kelly, B.D., "Ireland's Mental Health Act 2001", *Psychiatric Bulletin*, 2009, 33, 161-164.

<sup>627</sup> Lynch, P., "GPs in revolt over psychiatric admissions", *Irish Medical News*, 2007, 39, 1; McGuinness, I., "Litany of failures", *Irish Medical News*, 2007, 6, 1; O'Reilly, B., "Congratulations to IMT for raising the issues of mental health tribunals", *Irish Medical Times*, 2007, 14, 19; Baker, N., "Psychiatrists seek to readmit patients released by tribunals", *Irish Examiner*, 2009, 7 April; Jabbar, F., Kelly, B.D., Casey, P., "National survey of psychiatrists' responses to implementation of the Mental Health Act 2001 in Ireland", *Irish Journal of Medical Science*, 2010, 179, 291-294

<sup>628</sup> O'Donoghue, B., Moran, P., "Consultant psychiatrists' experiences and attitudes following the introduction of the Mental Health Act 2001", *Irish Journal of Psychological Medicine*, 2009, 26, 23-26.

#### 4.4.5 The Mental Health Act 2008

#### 4.4.6 Paternalism

##### **4.4.1 Mental health tribunals for patients currently detained**

The introduction of tribunals to review all detention orders brings Irish legislation into greater accordance with the ECHR which states that:

Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.<sup>629</sup>

In judgments to date, the European Court of Human Rights has found that delays of 55 days<sup>630</sup> and 24 days<sup>631</sup> are not sufficiently speedy, suggesting that a maximum delay of approximately two or three weeks is likely to be acceptable, in the absence of specific requests by the patient for deferral (e.g. in order to seek independent medical opinion).<sup>632</sup> In Ireland, the MHA 2001 requires that the Mental Health Commission arranges an independent medical examination prior to tribunal, and that tribunals are held within 21 days of the signing of an order.

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<sup>629</sup> ECHR, article 5(4).

<sup>630</sup> *E v Norway* (1990) 17 EHRR 30; in this case, E was transferred to a secure psychiatric setting on 21 July 1988; applied for a court hearing on 3 August 1988; and judgment was delivered on 27 September 1988.

<sup>631</sup> *LR v France* App no 33395/96 (ECHR, 27 June 2002).

<sup>632</sup> Bartlett et al, 2007; pp. 66-67.



In 2007, however, it emerged that the Commission tended to schedule tribunals for as late as possible in the 21 day period in order “to minimise costs”,<sup>633</sup> i.e. the tribunal was scheduled for day 20 or 21, in the hope that the psychiatrist would have revoked the detention order prior to that, thus removing the need for a tribunal at that time (although the individual could still request a tribunal at a later date). This practice was strongly criticised by the Department of Health and Children.<sup>634</sup> In 2008, the Mental Health Commission stated it was now “fully committed to arranging the mental health tribunal hearing as early as possible”.<sup>635</sup>

Before affirming an admission or renewal order, the mental health tribunal must be “satisfied that the patient is suffering from a mental disorder”<sup>636</sup> and appropriate procedures were followed in making the order. If there was a failure to follow procedures, the mental health tribunal can still affirm the order provided “the failure does not affect the substance of the order and does not constitute an injustice”.<sup>637</sup> This provision allows tribunals to overlook certain procedural anomalies but it is not clear to what extent such discretionary powers are used by tribunals as there is no systematic record of tribunal reasoning made public.

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<sup>633</sup> McGuinness, I., “Penny-pinching delays”, *Irish Medical Times*, 2007, 25, 1; Department of Health and Children, *Review of the Operation of the Mental Health Act 2001*, Dublin: Department of Health and Children, 2007; p. 24.

<sup>634</sup> Department of Health and Children, 2007; p.24.

<sup>635</sup> Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001*, Dublin: Mental Health Commission, 2008; p. 88.

<sup>636</sup> MHA 2001, section 18(1)(a).

<sup>637</sup> MHA 2001, section 18(1)(a)(ii).

There is more evidence available from the courts, which hear appeals. In *Z v Khattak and Anor*,<sup>638</sup> for example, there was a series of concerns regarding the procedures followed during an involuntary admission, including the following:

- (a) The police took the individual in question into custody under section 12 of the MHA 2001, which requires that, following such detention, a member of the police force “shall make an application forthwith in a form specified by the Commission to a registered medical practitioner for a recommendation”,<sup>639</sup> the police did not, however, make such an application, and, instead, an application was signed by the patient’s brother (under section 9).<sup>640</sup>
- (b) The subsequent “examination” carried out by a general practitioner comprised a “chat”<sup>641</sup> of ten minutes duration during which both parties smoked cigarettes at the rear of a police station; in the High Court, the general practitioner stated that he was not familiar with the definition of “examination” in the MHA 2001 and “was not even aware of what a mental state examination might entail”.<sup>642</sup>
- (c) A “delay of seven and a half hours” occurred between the arrival of the individual in question at the approved centre and the examination by the consultant psychiatrist; the patient submitted to the High Court that this did not accord with the requirement that “a consultant psychiatrist on the staff of the approved centre shall, as soon as may be, carry out an examination”,<sup>643</sup> although

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<sup>638</sup> *Z v Khattak and Anor* [2008] IEHC 262.

<sup>639</sup> MHA 2001, section 12(2).

<sup>640</sup> MHA 2001, section 9(1).

<sup>641</sup> *Z v Khattak and Anor* [2008] IEHC 262; p. 4.

<sup>642</sup> *Z v Khattak and Anor* [2008] IEHC 262; p. 4.

<sup>643</sup> MHA 2001, section 14(1).

under the Act the individual can be detained at the approved centre for up to 24 hours for the purpose of such an examination.<sup>644</sup>

- (d) The detention order, when completed, was not sent to the Mental Health Commission within the 24 hour time-limit required by the Act;<sup>645</sup> the order was faxed approximately 45 hours after completion.

Having considered the matter in some detail, the High Court (a) stated “that even though a somewhat unusual sequence of events occurred by the adoption of the s. 9 procedure instead of continuing the procedures under s. 12, there was nothing impermissible in what was done”;<sup>646</sup> (b) expressed “a certain disquiet” about the manner of the general practitioner’s “examination” but “this complaint does not invalidate the applicant’s detention”;<sup>647</sup> (c) stated the Act did not require the consultant psychiatrist “should immediately drop whatever he was doing...and attend immediately or forthwith”;<sup>648</sup> provided the examination was performed within 24 hours; and (d) in relation to the failure to send the detention order to the Mental Health Commission within 24 hours, stated that “while there has been a breach of a technical requirement in this regard, it has not affected any right of the applicant in any fundamental way or at all”.<sup>649</sup>

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<sup>644</sup> MHA 2001, section 14(2).

<sup>645</sup> MHA 2001, section 16(1).

<sup>646</sup> *Z v Khattak and Anor* [2008] IEHC 262; p. 7.

<sup>647</sup> *Z v Khattak and Anor* [2008] IEHC 262; p. 8; the Mental Health Subcommittee of the Criminal Law Committee of the (Irish) Law Society subsequently noted that the judge had “endorsed, less than overwhelmingly,” this mental state examination (Mental Health Subcommittee, “Advising a mentally disordered client”, *Law Society Gazette*, 2009, 103, 44-45; p.44).

<sup>648</sup> *Z v Khattak and Anor* [2008] IEHC 262; pp. 8-9.

<sup>649</sup> *Z v Khattak and Anor* [2008] IEHC 262; p. 9.

Evidence from the High Court, including this case, clearly indicates a willingness at that level to overlook “technical” concerns (such as failure to submit forms to the Commission within time-limits), but, regrettably, there is no mechanism to assess similar precedents at the level of tribunals, which are held “in private”.<sup>650</sup>

#### **4.4.2 Civil proceedings in the Circuit Court and High Court**

Under the MHA 2001, detained patients have automatic access to mental health tribunals, in which the burden of proof lies on the detaining authority to demonstrate the patient has mental disorder and is lawfully detained.<sup>651</sup> The patient can appeal tribunal decisions to the Circuit Court although only on the grounds of not having mental disorder.<sup>652</sup> In the Circuit Court, however, the burden of proof lies on the patient:

On appeal to it under subsection (1), the Circuit Court shall (a) unless it is shown by the patient to the satisfaction of the Court that he or she is not suffering from a mental disorder, by order affirm the order, or (b) if it is so shown as aforesaid, by order revoke the order.<sup>653</sup>

If the detained patient wishes to appeal the decision of the Circuit Court to the High Court, they can only make such an appeal on a point of law, and *not* in relation to the

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<sup>650</sup> MHA 2001, section 49(9).

<sup>651</sup> MHA 2001, section 18.

<sup>652</sup> MHA 2001, section 19(1).

<sup>653</sup> MHA 2001, section 19(4).

Circuit Court's decision regarding whether or not they have mental disorder.<sup>654</sup> The MHA 2001 also states:

No civil proceedings shall be instituted in respect of an act purporting to have been done in pursuance of this Act save by leave of the High Court and such leave shall not be refused unless the High Court is satisfied: (a) that the proceedings are frivolous or vexatious, or (b) that there are no reasonable grounds for contending that the person against whom the proceedings are brought acted in bad faith or without reasonable care.<sup>655</sup>

Compared to the 1945 Act, the MHA 2001 has reversed the onus of proof for initiating High Court proceedings: under the MHA 2001, the *detaining authority* must demonstrate that “there are no reasonable grounds for contending that” the detaining authority “acted in bad faith or without reasonable care”<sup>656</sup>, while under the 1945 Act, the *patient* had to demonstrate to the High Court that there were “substantial grounds for contending” that the detaining authority “acted in bad faith or without reasonable care”.<sup>657</sup>

Overall, the MHA 2001 broadens and clarifies avenues of legal redress for individuals who object to their detention in psychiatric facilities.<sup>658</sup> In a Circuit Court appeal, however, the burden of proof still lies with the patient to demonstrate that he or she does

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<sup>654</sup> MHA 2001, section 19(16): “No appeal shall lie against an order of the Circuit Court under this section other than an appeal on a point of law to the High Court”.

<sup>655</sup> MHA 2001, section 73(1).

<sup>656</sup> MHA 2001, section 73(1).

<sup>657</sup> Mental Treatment Act 1945, section 290(1).

<sup>658</sup> Ryan, 2010; pp. 96-98.

not have mental disorder.<sup>659</sup> The European Court of Human Rights has previously ruled that section 64 of the Mental Health (Scotland) Act 1984, which placed the burden of proof on the patient in an appeal against detention, was incompatible with the ECHR.<sup>660</sup> In 2007, a detained patient in Ireland instigated judicial proceedings in the High Court arguing that the fact that the burden of proof lies with the patient in Circuit Court appeals was incompatible with the ECHR.<sup>661</sup> As required under Ireland's European Convention on Human Rights Act 2003,<sup>662</sup> the High Court took account of relevant European case-law, including, most notably, *Hutchison Reid v UK*.<sup>663</sup> The High Court concluded that the burden of proof must not lie with the patient in a first instance review of detention (i.e. mental health tribunal) but that this did not apply to courts of further appeal (i.e. Circuit Court).<sup>664</sup>

Notwithstanding this judgment, the *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* recommends that the MHA 2001 should be revised so that the onus of proof does not fall on the patient in the Circuit Court.<sup>665</sup>

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<sup>659</sup> Shannon, J, "Mental Health Act is in breach of human rights", *Medicine Weekly*, 2006, 45, 1; Whelan, D., "Legacy of unresolved legal issues on mental health", *The Irish Times*, 2008, 4 November.

<sup>660</sup> ECHR, article 5(4); see: *Hutchison Reid v UK* (2003) 37 EHRR 211.

<sup>661</sup> *TS v Mental Health Tribunal, Ireland, The Attorney General, The Minister for Health and Children, The Mental Health Commission, Bola Oluwole and Ciaran Power* [2007] JR 1562.

<sup>662</sup> European Convention on Human Rights Act 2003, section 4.

<sup>663</sup> *Hutchison Reid v UK* (2003) 37 EHRR 211.

<sup>664</sup> *TS v Mental Health Tribunal, Ireland, The Attorney General, The Minister for Health and Children, The Mental Health Commission, Bola Oluwole and Ciaran Power* [2007] JR 1562; p.11. This is also the position held by the Department of Health and Children (2007; p. 16).

<sup>665</sup> Steering Group on the Review of the Mental Health Act 2001, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001*. Dublin: Department of Health, 2012; p. 29.

#### 4.4.3 Mental health tribunals for discharged patients

If a detained patient has their detention order revoked by the treating psychiatrist prior to mental health tribunal, the tribunal is cancelled and a tribunal “shall not be held unless the patient indicates by notice in writing addressed to the Commission within 14 days of his or her discharge that he or she wishes such a review to be held”.<sup>666</sup> If the individual requests such a tribunal, it shall be held in accordance with usual tribunal procedures for patients who are currently detained but “with any necessary modifications”.<sup>667</sup>

The specific purposes of tribunals are to determine whether or not (a) correct procedure was followed in instigating the detention and (b) “the patient is suffering from a mental disorder”.<sup>668</sup> If the tribunal occurs following discharge, the procedural question (a) can be examined just as it is for a patient who is still detained at the time of the tribunal (through examining documents, witnesses, etc.). The clinical question (b), however, is still phrased in the present tense, suggesting that the tribunal must determine whether or not “the patient is suffering from a mental disorder” *on the day of the tribunal*, even though the individual in question is no longer a “patient” within the meaning of the Act<sup>669</sup> and it is likely that no parties will argue that the individual still has a mental disorder, because the individual has already been discharged.<sup>670</sup>

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<sup>666</sup> MHA 2001, section 28(5).

<sup>667</sup> MHA 2001, section 28(5).

<sup>668</sup> MHA 2001, section 18(1)(a); *T O’D. v Harry Kennedy and Others* [2007] IEHC 129.

<sup>669</sup> MHA 2001, section (2), defines “patient” as an individual *detained* under the Act.

<sup>670</sup> Eldergill, A., “The best is the enemy of the good”, *Journal of Mental Health Law*, 2008, 5, 21-37; p. 37.

The High Court has placed considerable emphasis on the use of the present tense in the phrase “the patient is suffering from a mental disorder”.<sup>671</sup> When a patient who is discharged prior to tribunal requests and has a tribunal, and then wishes to appeal to the Circuit Court, the High Court has ruled that there is no statutory justification for such an appeal to be heard, because the only ground for such appeal is that the patient “*is not suffering from a mental disorder*” (my italics).<sup>672</sup> In the case of the already-discharged patient, the issue of whether or not the individual had a mental disorder at time of detention is an *historical* one and therefore does not represent grounds for appeal to the Circuit Court, which are “that he or she *is not suffering from a mental disorder*” (my italics).<sup>673</sup> On this basis, while a patient discharged prior to tribunal can later have a tribunal, he or she cannot appeal its decision to the Circuit Court.

#### **4.4.4 Capacity in relation to voluntary patients**

The MHA 2001 defines “voluntary patient” as “a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order”.<sup>674</sup> Throughout the remainder of the Act, the term “patient” is used to mean a patient detained in accordance with the Act<sup>675</sup> and *not* a voluntary patient. This definition of “voluntary patient” is a broad one and does not make any reference to capacity and can,

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<sup>671</sup> MHA 2001, section 18(1)(a); *D Han v The President of the Circuit Court and Doctor Malcolm Garland and Doctor Richard Blennerhassett and Doctor Conor Farren and Professor Patrick McKeon and the Mental Health Commission and the Mental Health Tribunal* [2008] IEHC 160.

<sup>672</sup> MHA 2001, section 19(1).

<sup>673</sup> MHA 2001, section 19(1).

<sup>674</sup> MHA 2001, section 2(1).

<sup>675</sup> MHA 2001, section 2(1).



therefore, include individuals who are not detained but lack capacity (e.g. a patient admitted voluntarily in the first instance who loses capacity during their admission).

The High Court has supported this highly paternalistic definition of voluntary patient, stating it “was cast in the wide terms used in order to provide for the variety of circumstances wherein a person is in an approved centre receiving care and treatment, but not subject to an admission order or a renewal order, including...where a detention pursuant to an admission order or a renewal order breaks down, but where the patient is suffering from a mental disorder and receiving care and treatment”.<sup>676</sup> This position was upheld by the Supreme Court.<sup>677</sup> As a result, while the MHA 2001 explicitly outlines the requirements if involuntary patients are to be regarded as having capacity,<sup>678</sup> it does not even require that voluntary patients *possess* capacity in order to become voluntary patients in the first instance.

The *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* emphasises the need for supported decision-making structures for voluntary psychiatric inpatients with fluctuating capacity, and suggests relevant measures be included in proposed mental capacity legislation, but does not provide specific proposals to amend the definition of “voluntary patient”.<sup>679</sup> As a result, the current situation is that, in the absence of dedicated capacity legislation, individuals without capacity may be *de facto*

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<sup>676</sup> *EH v Clinical Director of St. Vincent's Hospital and Ors* [2009] IEHC 69; p. 7.

<sup>677</sup> *EH v St. Vincent's Hospital and Ors* [2009] IESC 46; Shannon, J, “Mental Health Act is in breach of human rights”, *Medicine Weekly*, 2006, 45, 1; Madden, E., “Supreme Court critical of case taken against St Vincent's Hospital”, *Irish Medical Times*, 2009, 28, 18.

<sup>678</sup> MHA 2001, section 56: “The consultant psychiatrist responsible for the care and treatment of the [detained] patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment”.

<sup>679</sup> Steering Group on the Review of the Mental Health Act 2001, 2012; p. 22.

deprived of their liberty without the protections of effective capacity or mental health legislation,<sup>680</sup> similar to the situation outlined in *Bournewood* (which was incompatible with the ECHR).<sup>681</sup> The human rights implications of this highly paternalistic situation are further explored in Section 5.3.3.2.

#### **4.4.5 The Mental Health Act 2008**

The MHA 2008 was a piece of emergency legislation enacted in response to a specific problem that emerged under the MHA 2001. In October 2008, an involuntary patient (“SM”) engaged in judicial review proceedings in the High Court to appeal the decision of a tribunal to affirm a 12-month renewal order. According to SM *and* her psychiatrist, SM’s detention was largely attributable to a lack of appropriate hostel accommodation in which SM could be treated in a less restrictive environment.<sup>682</sup> The section of the MHA 2001 governing 12-month renewal orders reads as follows:

The period referred to in subsection (1) may be further extended by order made by the consultant psychiatrist concerned for a period not exceeding 6 months beginning on the expiration of the renewal order made by the psychiatrist under subsection (2) and thereafter may be further extended by

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<sup>680</sup> Eldergill, 2008; p. 26.

<sup>681</sup> Eastman & Peay, 1998; Morris, 1999; *HL v UK (Bournewood)* (2004) 40 EHRR 761.

<sup>682</sup> Cummings, E., O’Conor, O., “The SM Judgment and The Mental Health Act 2008”, *Irish Medical Journal*, 2009, 7, 234; *SM v The Mental Health Commissioner, The Mental Health Tribunal, The Clinical Director of St Patrick’s Hospital, Dublin, Attorney General and the Human Rights Commission* [2008] JR 749.

order made by the psychiatrist for periods each of which does not exceed 12 months.<sup>683</sup>

During initial submissions, the judge raised an issue regarding the duration of SM's renewal order.<sup>684</sup> Specifically, the judge pointed out that the renewal form designed by the Mental Health Commission used a "tick box" system which did not permit the consultant psychiatrist to make a renewal order for any specified period *less than* 12 months, but only for "a period not exceeding" 12 months; i.e. the renewal order could only be made out for 12 months in the first instance, although it could subsequently be revoked before 12 months had elapsed. This, in the view of the judge, appeared inconsistent with the MHA 2001 which stated that the renewal order "may be further extended by order made by the psychiatrist for periods each of which does not exceed 12 months".<sup>685</sup>

Once the judge made these remarks, SM successfully applied to amend her proceedings to incorporate the judge's observations.<sup>686</sup> Having listened to arguments, the judge, on 17 October 2008, reserved his decision, which he did not deliver until two weeks later, on 31 October 2008.<sup>687</sup> It is of note that the Attorney General and Human Rights Commission were notice parties to these proceedings and, during the two-week period

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<sup>683</sup> MHA 2001, section 15(3).

<sup>684</sup> Cummings & O'Connor, 2009.

<sup>685</sup> MHA 2001, section 15(3); Carolan, M., "Psychiatric patient takes case against involuntary detention in hospital", *The Irish Times*, 2008, 16 October.

<sup>686</sup> Coulter, C., "Government and judge combine to clear up loophole", *The Irish Times*, 2008, 1 November.

<sup>687</sup> Carolan, M., "Woman's hospital detention ruled unlawful by court", *The Irish Times*, 2008, 1 November.

between the judge reserving and delivering his decision, a piece of emergency legislation was passed by the Oireachtas (parliament), entitled the MHA 2008.<sup>688</sup>

The MHA 2008 stated that any renewal orders that might be deemed to be without a basis in law under the MHA 2001 for the reason suggested by the judge would be deemed lawful under the MHA 2008 and would be deemed (retrospectively) to have been lawful all along.<sup>689</sup> Such renewal orders would remain in force until:

(a) the expiration of 5 working days immediately following the passing of this Act, (b) a replacement renewal order is made to replace the unexpired renewal order, or (c) the expiration of the last day of the maximum period concerned specified in section 15(2) or (3) of the Act of 2001 by which it extended or further extended the period referred to in section 15(1) of that Act, whichever occurs first.<sup>690</sup>

On this basis, even if the judge were to rule that SM's renewal order was without legal basis under the MHA 2001, all other patients detained on such orders would remain legally detained for five working days under the MHA 2008, during which time the detaining authority could instigate a replacement renewal order or discharge the patient. On 31 October 2008, the day after the MHA 2008 was hurriedly signed into law, the judge duly ruled that SM's detention was without legal basis for the reason he had

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<sup>688</sup> Collins, S., "Emergency mental health law rushed through Dáil", *The Irish Times*, 2008, 31 October.

<sup>689</sup> MHA 2008, section 3(1).

<sup>690</sup> MHA 2008, section 3(2).

suggested at the outset.<sup>691</sup> Some hours earlier, however, the MHA 2008 had become law and, over the subsequent five working days, an estimated 209 patients who were detained on pre-existing (flawed) renewal orders became the subject of *replacement* renewal orders,<sup>692</sup> which permitted the consultant psychiatrist to specify a precise period of detention and were, thus, consistent with the MHA 2001.<sup>693</sup>

The only exception to the provisions of the MHA 2008 were individuals who had already instigated proceedings in respect of this matter prior to the enactment of the MHA 2008; i.e. SM.<sup>694</sup> Even in the case of SM, however, the judge did not order her immediate release; owing to the fact that SM was clearly mentally ill and in need of treatment, the judge placed a stay of four weeks on his order for her release, so as to allow appropriate arrangements to be made.<sup>695</sup> This decision was not without precedent: in February 2007, the High Court ruled that a particular detention was unlawful but noted no parties contested the fact that the individual in question had mental disorder; thus, in order to protect the individual's welfare, the High Court ordered the applicant be released seven hours after the Court's order was made, so as to facilitate immediate re-admission under the MHA 2001.<sup>696</sup>

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<sup>691</sup> *SM v The Mental Health Commissioner, The Mental Health Tribunal, The Clinical Director of St Patrick's Hospital, Dublin, Attorney General and the Human Rights Commission* [2008] JR 749.

<sup>692</sup> Cummings & O'Connor, 2009.

<sup>693</sup> MHA 2001, section 15.

<sup>694</sup> MHA 2008, section 7(2).

<sup>695</sup> Carolan, M., "Woman's hospital detention ruled unlawful by court", *The Irish Times*, 2008, 1 November.

<sup>696</sup> *JH v Vincent Russell, Clinical Director of Cavan General Hospital* [2007] unreported High Court judgment; Nolan, N., "Case law on the MHA 2001: part 1", *Irish Psychiatrist*, 2008, 3, 176-182; p. 177.

In the case of the MHA 2008, the legislation resulted in the continued detention of approximately 209 patients for up to five working days; the completion of approximately 209 replacement renewal orders during those five working days; and the subsequent examination of these 209 replacement renewal orders by 209 mental health tribunals, within 21 days. The resultant cost of the MHA 2008 was estimated at €993,377 (£853,329), excluding the costs of the judicial review process itself and the indirect costs of tribunals, which amount to double the direct costs.<sup>697</sup> If that sum of €993,377 (£853,329) had been spent providing hostel accommodation for SM, the lack of which had formed the original, hastily-abandoned focus of her proceedings, SM could have been accommodated in an appropriate hostel for 370 years.<sup>698</sup>

Overall, the MHA 2008 was an emergency measure clearly intended pre-emptively to address a likely High Court ruling which might have resulted in the immediate release of 209 detained patients. Despite the MHA 2008's effectiveness in preventing the release of 209 mentally-ill individuals owing to a poorly-worded form, the initial substantive issue in this case (an alleged deficiency in resources) remained unaddressed and, paradoxically, the entire episode commanded a substantial opportunity cost in terms of diversion of State resources from the provision of care to the resolution of "teething problems" with the MHA 2001.<sup>699</sup>

The MHA 2008, and the manner of its implementation, also raises the issue of paternalism. When delivering judgment on the SM case, on the day after the MHA

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<sup>697</sup> Cummings & O'Connor, 2009; Blumenthal, S., Wessely, S., "The cost of Mental Health Review Tribunals", *Psychiatric Bulletin*, 1994, 18, 274-276.

<sup>698</sup> Cummings & O'Connor, 2009.

<sup>699</sup> Whelan, 2008.

2008 had been rushed through parliament, the judge stated he had only learned of the emergency legislation in the newspapers.<sup>700</sup> The neatness of the sequence of events, however, as the judge reserved his decision for two weeks during which emergency legislation was enacted in accurate anticipation of his judgment, resulted in a perception that, in the words of one newspaper, “government and judge combine to clear up loophole”.<sup>701</sup> This understandable interpretation of the sequence of events may, on one hand, reflect the wisdom of having the Attorney General as a notice party to the proceedings but may also, on the other hand, reflect the persistence of an excessively paternalistic approach to the mentally ill.

#### **4.4.6 Paternalism**

While the MHA 2001 opened up the possibility of greater observance of human rights and personal dignity, interpretation of the Act by Irish Courts, and the enactment of the MHA 2008, demonstrate substantial evidence of a paternalistic approach to the mentally ill, similar to that in evidence under the Mental Treatment Act 1945.<sup>702</sup> The High Court made this explicit:

In my opinion having regard to the nature and purpose of the Act of 2001 as expressed in its preamble and indeed throughout its provisions, it is appropriate that it is regarded in the same way as the Mental Treatment Act

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<sup>700</sup> Carolan, M., “Woman’s hospital detention ruled unlawful by court”, *The Irish Times*, 2008, 1 November.

<sup>701</sup> Coulter, 2008.

<sup>702</sup> Craven, C., “Signs of paternalist approach to the mentally ill persist”, *The Irish Times*, 2009, 27 July.

of 1945, as of a paternal character, clearly intended for the care and custody of persons suffering from mental disorder.<sup>703</sup>

The Supreme Court agrees that interpretation of the MHA 2001 “must be informed by the overall scheme and paternalistic intent of the legislation”,<sup>704</sup> as exemplified by the Act’s requirement that the “best interests of the person shall be the principal consideration with due regard being given to the interests of other persons”.<sup>705</sup> The High Court has stated that this section “infuses the entire of the legislation with an interpretative purpose”.<sup>706</sup>

Several cases in the High and Supreme Courts have supported a paternalist approach, especially when the paternalist actions are presented as taken in the best interest of the patient.<sup>707</sup> In *FW v Dept. of Psychiatry James Connolly Memorial Hospital*, a consultant psychiatrist realised that a specific patient (FW) was unlawfully detained, when it emerged that FW had issued proceedings against her husband, the applicant, under the Domestic Violence Act 1996.<sup>708</sup> The psychiatrist immediately advised the patient she was free to go but when the patient, some time later, chose to leave, staff of

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<sup>703</sup> *MR v Cathy Byrne, administrator, and Dr. Fidelma Flynn, clinical director, Sligo Mental Health Services, Ballytivnan, Co. Sligo* [2007] IEHC 73; p. 14.

<sup>704</sup> *EH v St. Vincent’s Hospital and Ors* [2009] IESC 46; p. 12.

<sup>705</sup> MHA 2001, section 4(1).

<sup>706</sup> *T O’D. v Harry Kennedy and Others* [2007] IEHC 129; p. 21.

<sup>707</sup> Craven, 2009; *PL v Clinical Director of St. Patricks University Hospital and Dr. Séamus Ó Ceallaigh* [2012] IEHC 15.

<sup>708</sup> *FW v Dept. of Psychiatry James Connolly Memorial Hospital* [2008] IEHC 283. While a spouse can make an application for involuntary admission, the term “spouse”, for this purpose, does not include a person “in respect of whom an application or order has been made under the Domestic Violence Act, 1996” (MHA 2001; section 9(8)). See also: Madden, E., “Judge commends action of hospital staff in detention”, *Irish Medical Times*, 2008, 37, 28.



the hospital had speedily arranged that members of the police force (Gardaí) were present at the door of the hospital to take her into custody and commence new involuntary detention proceedings at once.

The patient challenged her detention in the High Court on the grounds that she had “never been released in reality from an admitted unlawful detention”.<sup>709</sup> The High Court noted that the actions of the hospital were motivated by concern for the patient:

I consider the action of Dr. Benbow and her staff to be highly creditable in the circumstances. Dealing with a very difficult situation, their predominant interest was the care and safety of the applicant. Their action ensured as best they could that when the applicant did leave their care, she did not depart into the night with no arrangements to ensure her safety and well-being. The actions of Dr. Benbow and her staff and those of the Gardaí at Blanchardstown Garda Station may well have prevented a tragic outcome to the day's event.<sup>710</sup>

Notwithstanding this paternalistic interpretation of the legislation in this and several other judgments,<sup>711</sup> there are still limits on the extent to which the legislation, even when interpreted paternalistically, permits the High Court or tribunals to overlook non-compliance with the precise requirements of the Act, according to the High Court:

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<sup>709</sup> *FW v Dept. of Psychiatry James Connolly Memorial Hospital* [2008] IEHC 283; p. 2.

<sup>710</sup> *FW v Dept. of Psychiatry James Connolly Memorial Hospital* [2008] IEHC 283; p. 3.

<sup>711</sup> See, for example, *EH v St. Vincent's Hospital and Ors* [2009] IESC 46; *MR v Cathy Byrne, administrator, and Dr. Fidelma Flynn, clinical director, Sligo Mental Health Services, Ballytivnan, Co. Sligo* [2007] IEHC 73; *T O'D. v Harry Kennedy and Others* [2007] IEHC 129.

It is to be borne in mind that s. 4 requires that where decisions are made under the Act concerning the care and treatment of person, the best interest of the person is to be the principle consideration. This requirement applies to Mental Health Tribunals who must consider the validity or otherwise of Renewal Order or Admission Orders. In my opinion the best interests of a person suffering from a mental disorder are secured by a faithful observance of and compliance with the statutory safeguards put into the 2001 Act, by the Oireachtas. That together with the restriction in s. 18(1)(a)(ii) mean that only those failures of compliance which are of an insubstantial nature and do not cause injustice can be excused by a Mental Health Tribunal.<sup>712</sup>

Regrettably, it is not possible to establish the extent to which tribunals overlook such aberrations “of an insubstantial nature” or, indeed, act in a paternalistic fashion, owing to the fact that the Mental Health Commission does not collect data on reasons underlying decisions by tribunals. At least some tribunal chairpersons, however, agree with the Courts that the legislation requires a paternalistic approach, and recommend that tribunals should be inquisitorial rather than adversarial in nature:

As regards the hearing, in my view, given the paternalistic nature of the act and in order not to undermine the doctor/patient relationship, it should be inquisitorial rather than adversarial. However, the act is silent on this.<sup>713</sup>

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<sup>712</sup> *WQ v Mental Health Commission* [2007] IEHC 154; see also: *Q v St Patrick’s Hospital* [2006] O’Higgins J, *ex tempore*, 21 December 2006.

<sup>713</sup> Lee, G., “Far from the madding crowd”, *Law Society Gazette*, 2008, 6, 40-43.

Notwithstanding such views, there is now significant evidence that at least some tribunals are adversarial in nature and have significantly negative effects on the doctor-patient relationship.<sup>714</sup> This is, broadly, inconsistent with the intention of the legislators that the “best interests of the person shall be the principal consideration” in all decisions made under the Act<sup>715</sup> and with the generally paternalistic interpretations of the High and Supreme Courts.<sup>716</sup>

The issue of paternalism is a complex one in Irish law, and although Whelan points to an international move away from “benign paternalism” towards autonomy (in, for example, the CRPD), he notes that “the Irish courts have not yet engaged with these debates”.<sup>717</sup> Kennedy, an Irish professor of forensic psychiatry, argues that criticism of alleged paternalism “arises from a mistaken translation of the legal Latin term *parens patriae*, the common law principle that the State (*patriae*), has parental (*parens*) obligations to care for the vulnerable amongst its citizens”,<sup>718</sup> as enshrined in the Constitution. He continues:

Far from being a patriarchal instrument of oppression, *parens patriae* (the paternalistic interpretation of legislation regarding the vulnerable and incapacitated) is a means for the judiciary to hold the executive to some limited welfare obligations towards vulnerable citizens, in the absence of a comprehensive health and welfare system for all.

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<sup>714</sup> Jabbar et al, 2010; Department of Health and Children, 2007; p. 24.

<sup>715</sup> MHA 2001, section 4(1).

<sup>716</sup> Craven, 2009.

<sup>717</sup> Whelan, 2009; p. 28.

<sup>718</sup> Kennedy, H., “‘Libertarian’ groupthink not helping mentally ill”, *The Irish Times*, 2012, 12 September.

Notwithstanding these arguments, the *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* in 2012 stated that “paternalism is incompatible with such a rights-based approach and accordingly the Act should be refocused away from ‘best interests’ in order to enhance patient autonomy”.<sup>719</sup> The *Interim Report* did not, however, present specific suggestions for legislative revision to this effect.

#### **4.5 Overall assessment**

The MHA 2001 introduced many important changes, most notably in relation to involuntary admission procedures and independent reviews of involuntary detention orders. A majority of stake-holders in mental health services (service-users, service-providers and others) believe the MHA 2001 has helped protect human rights.<sup>720</sup> More specifically, the Act has resulted in the removal of indefinite detention orders that existed under the Mental Treatment Act 1945; new involuntary admission procedures; automatic, independent review of detention orders by tribunals; free legal representation and independent psychiatric opinions for patients prior to tribunals; and establishment of the Mental Health Commission to oversee implementation of the Act and standards of care. Many of these changes promote human rights, enhance dignity, and advance patients’ autonomous exercise of capabilities, especially in relation to appealing against involuntary detention orders.

The implementation of the MHA 2001, and its subsequent case-law have, however, raised a series of human rights issues, some of which stem from the absence of

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<sup>719</sup> Steering Group on the Review of the Mental Health Act 2001, 2012; p. 11.

<sup>720</sup> Mental Health Commission, 2008; p. 69; O’Donoghue and Moran, 2009; p. 24.

systematic data-collection about decisions of mental health tribunals, leading to uncertainty about reasons for revocations (e.g. procedural aberrations, absence of mental disorder); unclarity the extent to which procedural aberrations are overlooked by tribunals; and an absence of cumulative tribunal “case-law” to guide tribunal decisions. There are also restrictions on the acceptable grounds for civil proceedings in the Circuit and High Courts, and the burden of proof lies with the patient in the Circuit Court.

Other human rights concerns stem from unclarity about the precise matters at issue in tribunals for discharged patients and the legal definition of voluntary patient, which does not include a requirement for capacity. The hurried enactment of the MHA 2008, which stemmed from a poorly-worded statutory form, raised a number of specific issues including the *retrospective* declaration that detentions based on flawed forms had been lawful all along and would remain so for five days. Finally, there is evidence of paternalism in the implementation and interpretation of the MHA 2001 by psychiatric services and Courts, raising the issue of the balance between individual autonomy and exercise of capabilities on the one hand and the obligation on the State to protect the vulnerable on the other.

Overall, measures introduced in the MHA 2001 hold strong potential to protect specific rights (e.g. the right to liberty), enhance patient dignity, and promote the exercise of specific capabilities (e.g. challenging involuntary detention). As in England, however, these potential benefits are accompanied by significant limitations and caveats. Critically, there is evidence of arguably excessive emphasis on paternalism and welfare-based concerns in the implementation and interpretation of the MHA 2001, and it is not

yet clear whether or not this trend is proportionate to the strong paternalistic and welfare-based concerns outlined in the Irish Constitution.

In resource terms, there are also significant opportunity costs associated with the legislation, including increased workloads for medical staff and decreased time spent with patients, owing to increased administrative activities and attendance at court proceedings.<sup>721</sup> As a result, while there is significant agreement that the Act has enhanced protections of the right to liberty for detained individuals,<sup>722</sup> there is little evidence that it has enhanced the quality of psychiatric services, and some evidence that the resource and opportunity costs of the legislation may have even eroded what one psychiatrist has termed “the right to treatment”.<sup>723</sup> This has significant implications in terms of effective treatment of mental illness which would support patient dignity, and limits the extent to which the MHA 2001 supports patients in the autonomous exercise of their capabilities.

When questioned in Dáil Éireann (parliament) in 2005 about resource problems as the Act was being rolled out (2001-2006), the government Minister with responsibility for mental health responded that “a constant reiteration and repetition of the problems in the mental health service is becoming a bit tiresome”.<sup>724</sup> “Tiresome” as these issues may be, they are likely to come into increasing focus in future years owing not only to pressure

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<sup>721</sup> Baker, 2009; Jabbar et al, 2010, 179, 291-294; McGuinness, I., “More court appeals”, *Irish Medical Times*, 2007, 24, 3.

<sup>722</sup> O’Donoghue & Moran, 2009; p. 24.

<sup>723</sup> Fitzsimons, K., “Right to treatment should not be forgotten in psychiatry”, *Irish Medical News*, 2007, 45, 4; Jabbar et al, 2010; O’Donoghue & Moran, 2009.

<sup>724</sup> O’Malley, T. (Minister of State at the Department of Health and Children), “Mental Health Services”, *Dáil Éireann Debate*, 2005 (10 February), 597, 4.

resulting from delays implementing Ireland's 2006 mental health policy, *A Vision for Change*,<sup>725</sup> but also international pressure resulting from Ireland's public commitment to the WHO's *Mental Health Declaration for Europe*<sup>726</sup> and *Mental Health Action Plan for Europe*,<sup>727</sup> both of which emphasise the importance of adequate resourcing of mental health services.<sup>728</sup>

Moreover, in addition to these general statements of mental health policy, the WHO has made specific and robust recommendations in relation to mental health law in individual states,<sup>729</sup> placing particular emphasis on human rights.<sup>730</sup> The complex, critical relationship between human rights and mental health legislation is considered next.

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<sup>725</sup> Expert Group on Mental Health Policy, *A Vision for Change*, Dublin: The Stationery Office, 2006; Guruswamy, S., Kelly, B.D., "A change of vision? Mental health policy", *Irish Medical Journal*, 2006, 99: 164–166.

<sup>726</sup> WHO Ministerial Conference on Mental Health, *Mental Health Declaration for Europe*, Helsinki: WHO, 2005.

<sup>727</sup> WHO Ministerial Conference on Mental Health, *Mental Health Action Declaration for Europe*, Helsinki: WHO, 2005.

<sup>728</sup> Mudiwa, L., "Ireland signs WHO declaration on mental health", *Medicine Weekly*, 2005, 3, 18.

<sup>729</sup> WHO, *Mental Health Law: Ten Basic Principles*, Geneva: WHO, 1996.

<sup>730</sup> WHO, 2005.

## Chapter 5

### Human rights and mental health law

#### 5.1 Introduction

Over the previous three decades, human rights had emerged as an important element in the legislative background against which new mental health legislation was introduced in England (MHA 2007) and Ireland (MHA 2001). Against this background, it is reasonable and timely to examine the international human rights standards with which national mental health legislation should, in theory, comply, and the extent to which the MHAs 2007 and 2001 meet these standards.

#### 5.2 International human rights standards for national mental health legislation

A human rights approach to mental health legislation is strongly supported and informed by the UN which, in 1991, adopted *Resolution 46/119, Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*.<sup>731</sup> Key rights include rights to the best mental health care available and to be treated with humanity and respect. All people with mental illnesses have the right to live, work and receive treatment in the community, as far as possible. Mental health facilities shall be appropriately resourced and an impartial review body shall, in consultation with mental health practitioners, review the cases of involuntary patients

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<sup>731</sup> UN, 1991.



The WHO, as the directing and coordinating authority for health within the UN system, developed this approach further by publishing “ten basic principles” based on “a comparative analysis of mental health laws in a selection of 45 countries worldwide”,<sup>732</sup> as well as the UN *Principles*. The WHO’s “ten basic principles” state that “everyone in need should have access to basic mental health care” and “everyone should benefit from the best possible measures to promote their mental well-being”. Mental health care should be provided in the “least restrictive” fashion possible and, for decisions affecting integrity (treatment) and/or liberty (hospitalization) with a long-lasting impact, there should be an automatic periodical review mechanism.

These principles were underscored by the WHO’s *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders*, which noted that “international instruments supporting even the most basic rights of persons with mental disorders have been very long in coming”,<sup>733</sup> and provided much-needed detail on the implementation of the WHO’s “ten basic principles” at national level. At global policy level, these rights-based considerations were underscored in 2001 when the WHO devoted its World Health Report to *Mental Health: New Understanding, New Hope*.<sup>734</sup>

Throughout these rights-based publications from the UN and WHO, the division between law and policy is not always clear, and the extent to which legislation, as opposed to policy, should govern some of these issues not always apparent. Other

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<sup>732</sup> Division of Mental Health and Prevention of Substance Abuse (WHO), *Mental Health Care Law: Ten Basic Principles*, Geneva: WHO, 1996; p. 7.

<sup>733</sup> Division of Mental Health and Prevention of Substance Abuse (WHO), *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders*, Geneva: WHO, 1996; p. 11.

<sup>734</sup> WHO, *Mental Health: New Understanding, New Hope*, Geneva: WHO, 2001.

issues related to these publications centre on the WHO's acceptance of involuntary committal in the first instance, something to which the World Network of Survivors and Users of Psychiatry objects on principle.<sup>735</sup>

Some of these issues were clarified somewhat in 2005 in the WHO *Resource Book on Mental Health, Human Rights and Legislation*<sup>736</sup> which presents a detailed statement of human rights issues which, according to the WHO, need to be addressed in national mental health legislation. More specifically, the Resource Book includes a detailed "Checklist on Mental Health Legislation" based, in large part, on previous UN and WHO publications:

This checklist is a companion to the WHO *Resource Book on Mental Health, Human Rights and Legislation*. Its objectives are to: a) assist countries in reviewing the comprehensiveness and adequacy of existing mental health legislation; and b) help them in the process of drafting new law. This checklist can help countries assess whether key components are included in legislation, and ensure that the broad recommendations contained in the Resource Book are carefully examined and considered.<sup>737</sup>

The checklist, although lengthy, detailed and explicitly informed by the UDHR, is not a set of absolute rules, and is not legally binding. There are no sanctions for states which fail to accord with its standards and, unlike the UN *International Covenant on Civil and*

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<sup>735</sup> Perlin, M.L., Kanter, A.S., Treuthart, M.P., Szeli, E., Gledhill, K., *International Human Rights and Comparative Mental Disability Law*, Durham, NC: Carolina Academic Press, 2006; pp. 891-894.

<sup>736</sup> WHO, 2005.

<sup>737</sup> WHO, 2005; p. 120.

*Political Rights*, the UN Human Rights Committee does not review Member States' reports on their compliance with it.

The WHO checklist is, rather, designed to work by influencing Member States as they redraft and implement national mental health laws. Given the checklist's close links with the UDHR and WHO documents outlining the rights of the mentally ill, the authors make the assumption that the checklist standards will be accepted by the international community and deemed worth reflecting in national mental health law. It is still arguable, however, that some of the issues which the WHO suggests should be covered by mental health legislation should be covered by public health or social policy instead. Indeed, the WHO explicitly states that some countries may address some or all of these mental health issues in general legislation (e.g. equality legislation), other forms of (not legally-binding) regulation, or mental health policy, rather than specific mental health legislation.<sup>738</sup>

The history of psychiatry, however, supports the unique importance of dedicated mental health legislation, rather than general law or non-binding regulation, for protecting the rights of the mentally-ill: while there were substantial advances in the articulation of human rights standards for the general population throughout the early twentieth century,<sup>739</sup> the plight of the mentally ill remained bleak until much later in most jurisdictions,<sup>740</sup> suggesting a need for specific and dedicated measures to protect their rights.<sup>741</sup> The WHO acknowledges the centrality of law in this process when it presents

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<sup>738</sup> WHO, 2005; p. 120.

<sup>739</sup> Hunt, 2007.

<sup>740</sup> Robins, 1986; Shorter, 1997; Torrey & Miller, 2001; Walsh & Daly, 2004.

<sup>741</sup> Gostin et al, 2010.

its final checklist in the Resource Book as a “Checklist for Mental Health *Legislation*” (my italics).

This is one of the key reasons why the WHO checklist forms the focus of this thesis: the WHO checklist is the most detailed and comprehensive human rights-based framework developed to date for the analysis of national mental health legislation. There are no other comparable statements of standards to which national mental health legislation might reasonably be expected to adhere, and so the WHO checklist provides the only comprehensive, coherent and relevant framework for this kind of analysis.<sup>742</sup>

In addition, WHO guidelines have been previously used, to good effect, to inform analysis of mental health legislation in diverse Commonwealth jurisdictions (not including Ireland, which is not part of the Commonwealth).<sup>743</sup> However, the full, detailed, comprehensive WHO checklist used in the present study has not previously been applied to the new legislation in England and Ireland. The analysis of Commonwealth countries, however, which used various WHO guidelines in combination with other sources to develop the authors’ own analytic framework, did highlight one of the key general strengths of the WHO approach to this topic, which is its close reliance on the UDHR to inform its principles and statements of rights.<sup>744</sup> This reliance on the UDHR adds to the relevance of the WHO guidelines, increasing both their usefulness and likely acceptability in diverse countries around the world.

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<sup>742</sup> WHO, 2005; pp. 8-17.

<sup>743</sup> Fistein, E.C., Holland, A.J., Clare, I.C.H., Gunn, M.J., “A comparison of Mental health legislation from diverse Commonwealth jurisdictions”, *International Journal of Law and Psychiatry*, 2009, 32, 147-155.

<sup>744</sup> Fistein et al, 2009, p. 149.

This is also a key strength of the WHO checklist as used in the present analysis: the contents of the checklist are based on both a widely-accepted general statement of rights (UDHR) *and* the literature's most comprehensive documents focussing on the rights of the mentally ill, including the UN *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*,<sup>745</sup> the WHO's *Mental Health Care Law: Ten Basic Principles*,<sup>746</sup> the WHO's *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders*,<sup>747</sup> and the WHO's World Health Report on *Mental Health: New Understanding, New Hope*.<sup>748</sup> As a result, the WHO checklist reflects *both* general human rights standards *and* human rights issues of particular relevance to the mentally ill. Finally, both England and Ireland are members of the UN and WHO, so it is reasonable to compare their national legislation with these standards.

The WHO checklist is not, however, perfect, and shares one of the key limitations of most WHO guidance documents: it is based largely on expert opinion and international consensus, rather than empirical evidence.<sup>749</sup> That is, the WHO checklist is not based on research field-work amongst the mentally-ill to determine precisely which rights are most commonly infringed, and what steps might be best taken to improve matters. The checklist is, however, based on widely-accepted human rights standards (e.g. UDHR) and, as a result, achieves certain legitimacy. This issue of empirical evidence is still an important one, however, and is further explored in Section 8.4.1 of this thesis which

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<sup>745</sup> UN, 1991.

<sup>746</sup> Division of Mental Health and Prevention of Substance Abuse (WHO), *Mental Health Care Law: Ten Basic Principles*, Geneva: WHO, 1996.

<sup>747</sup> Division of Mental Health and Prevention of Substance Abuse (WHO), *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders*, Geneva: WHO, 1996.

<sup>748</sup> WHO, *Mental Health: New Understanding, New Hope*, Geneva: WHO, 2001.

<sup>749</sup> Hill, S., Pang, T., "Leading by example", *Lancet*, 2007, 369, 1842-1844; Oxman, A.D., "Use of evidence in WHO recommendations", *Lancet*, 2007, 369, 1883-1889.

focuses on the potential usefulness of a “realization-focused understanding of justice” (based on the *real-life outcomes* of measures intended to protect rights) as opposed to “an arrangement-focused view of justice” (based on verifying that current legislation and other arrangements *appear likely to* promote human rights).<sup>750</sup>

The second key limitation of the WHO checklist stems from the fact that, despite being a “Checklist for Mental Health *Legislation*” (my italics), the WHO states that certain rights may be better advanced through public mental health or social policy rather than dedicated mental health legislation.<sup>751</sup> The analysis presented in this thesis (arguably) illustrates this limitation by identifying economic and social rights as a key area in which national mental health legislation of both England and Ireland fails significantly to accord with WHO standards (Section 5.3.3.5). Nonetheless, the border-line between law and policy remains an important issue and is explored in greater depth in Chapters 7 and 8.

### **5.3 To what extent does national mental health legislation comply with international human rights standards?**

The WHO checklist comprises 175 individual standards, grouped into 27 categories (A-AZ). This thesis focuses on civil rather than criminal detention, so nine standards which relate solely to mentally ill offenders (E4, T1-6) are omitted. Table 1 lists the remaining 166 WHO standards and summarises the extent to which mental health

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<sup>750</sup> Sen, A., *The Idea of Justice*, London: Allen Lane, 2009; p. 10.

<sup>751</sup> WHO, 2005.

legislation in England and Ireland meet them; further detail is provided in the text (below).<sup>752</sup>

Overall, legislation in England meets 92 (55.4%) of the 166 standards set out by the WHO, while legislation in Ireland meets 81 standards (48.8%). Thematically, there are identifiable areas of high (Section 5.3.1), medium (Section 5.3.2) and low compliance (Section 5.3.3) in both jurisdictions.<sup>753</sup> These are discussed in the following three sections, with the appropriate WHO standards indicated in parentheses following each point; e.g. (B1). These same letters are used in Table 1 to label each WHO standard.

### **5.3.1 Areas of high compliance with human rights standards**

#### **5.3.1.1 Definition and determination of mental disorder**

Legislation in England and Ireland includes “clear definition[s] of mental disorder/mental illness” as required by the WHO (B1),<sup>754</sup> although in neither jurisdiction is it evident why these particular definitions were chosen (B2). Legislation in England<sup>755</sup> and Ireland<sup>756</sup> also meets WHO criteria in relation to “determinations of mental disorder” (N), emphasising medical involvement in diagnosis.

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<sup>752</sup> The WHO Resource Book recommends that ratings for each criterion should be detailed rather than binary, so while Table 1 in this thesis supplies ratings for each criterion in a “yes” or “no” fashion, this Table is supplemented by the text of Chapters 5 and 6, which examine criteria in greater detail.

<sup>753</sup> Kelly B.D., “Mental health legislation and human rights in England, Wales and the Republic of Ireland”, *International Journal of Law and Psychiatry*, 2011, 34, 439-454.

<sup>754</sup> England: B1: MHA 2007; section 1(2); B3, B4, B5: MHA 2007, sections 1 and 2. Ireland: B1: MHA 2001, sections 3(1) and (2); B3, B4, B5: MHA 2001; sections 3(1), 3(2) and 8(2).

<sup>755</sup> MHA 1983, sections 2, 3, 7, 12(2); MHA 2007, sections 1(2). section 9(4)(b); amending MHA 1983, section 20(5A).

### 5.3.1.2 Involuntary admission and treatment

Legislation in England meets most criteria regarding involuntary admission,<sup>757</sup> apart from requirements for provision of information (I7)<sup>758</sup> and “periodic reviews” of long-term *voluntary* admissions (I9). Most criteria are met in Ireland, too,<sup>759</sup> apart from provision of information (I7)<sup>760</sup> and reviews of long-term *voluntary* admissions (I9).

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<sup>756</sup> MHA 2001, part 2, section 2(1).

<sup>757</sup> I1a: MHA 1983, part II; MHA 2007, sections 1-3. I1b: MHA 1983, section 2(2)(b); MHA 1983, section 2(2)(c); MHA 1983, section 4. I1c: Under sections 3, 37, 45A and 47 (MHAs 1983 and 2007); MHA 2007 section 4; amending MHA 1983, sections 3(2)(b); 3(4)(b); 37(2)(a)(i); 45A(2)(c); 47(1); MHA 2007, section 4(4); amending MHA 1983, section 20(4); MHA 2007, section 5(8); amending MHA 1983, section 72(1)(b)(ii). [This criterion does not, apply to those detained under sections 2 (“admission for assessment”), 35 (“remand to hospital for report on accused’s mental condition”), 135 (“warrant to search for and remove patients”) or 136 (“mentally disordered persons found in public places”).] I2: MHA 1983, section 2, 3, 7, 12(2); MHA 2007, section 9(4)(b); amending MHA 1983, section 20(5A). I3: The work of the Care Quality Commission in investigating the treatment and care of patients detained under the MHA 1983, community patients and those subject to guardianship, and their role in protecting such patients, is expressly recognised in MHA 1983 (sections 120-120(D)), with “the regulatory authority” in relation to England being expressly recognised as the Care Quality Commission in MHA 1983 (section 145(1)) (amendments introduced by the Health and Social Care Act 2008) (section 1(2)). I4: MHA 2007, section 8; amending MHA 1983, section 118(2B)(c). I5, I6 and I8: MHA 1983 (section 66) as amended by the MHA 2007 (chapter 5). I10: MHA 1983; section 16(2).

<sup>758</sup> If an application for involuntary admission or guardianship is made by the approved social worker, “that social worker shall take such steps as are practicable to inform the person (if any) appearing to be the nearest relative of the patient” (MHA 1983; section 11(3)). The approved social worker should try (as far as is practicable) to consult such a relative before making the application and, if the relative objects, the social worker shall not make the application (MHA 1983, section 11(4)). There is no requirement the patient be informed.

<sup>759</sup> I1a: MHA 2001, sections 3 and 8(1); I1b: MHA 2001, section 3(1)(a) and (b)(i). I1c: MHA 2001, section 3(1)(b)(ii). I2: MHA 2001, part 2. I3: MHA 2001, sections 50 and 63(1). I4: MHA 2001, section 4(1). I5 and I6: MHA 2001, part 3, sections 18(2) and (4). I8: MHA 2001, part 3. I10: MHA 2001, sections 8(1) and 28(1).

<sup>760</sup> The MHA 2001 requires that patients (but *not* “families and legal representatives”) be informed of the legal basis of detention, right to appeal and various other matters (MHA 2001, section 16).



Specific standards in relation to “police responsibilities” are met by legislation in England<sup>761</sup> and Ireland.<sup>762</sup>

Legislation in England<sup>763</sup> and Ireland<sup>764</sup> meets most WHO requirements regarding involuntary *treatment* (J) too, apart from the requirement that a second practitioner agree the treatment plan (J3): the MHAs 1983 and 2007 (England) require two “medical recommendations” to support applications for detention for “assessment”,<sup>765</sup> “treatment”<sup>766</sup> or guardianship,<sup>767</sup> and the MHA 2001 (Ireland) has a similar requirement for involuntary admission,<sup>768</sup> but neither jurisdiction requires endorsement

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<sup>761</sup> S1 and 2: MHA 1983, as amended by the MHA 2007, sections 135 and 136. S3: Part III. S4 and 5: MHA 1983, as amended by the MHA 2007, sections 137 and 138.

<sup>762</sup> S1 and 2: MHA 2001, sections 12 and 13. S3: Criminal Law (Insanity) Act 2006. Kennedy, 2007. S4: MHA 2001, section 13. S5: MHA 2001, section 27(1).

<sup>763</sup> J1a: MHA 1983, as amended by the MHA 2007, part II. J1b and c: MHA 1983, as amended by MHA 2007, sets out such requirements for involuntary admission for assessment (section 2(2)(b)), admission for treatment (section 2(2)(c)), or emergency admission (section 4). J2: MHA 2007, section 9(9); amending MHA 1983, section 34(1); MHA 2007, section 12(7)(a); amending MHA 1983, section 64(1); MHA 2007, section 10; amending MHA 1983, section 34(1). J4: MHA 1983, as amended by MHA 2007, part V [mental health tribunals review involuntary admission and, by implication, involuntary treatment]. J5: MHA 1983, as amended by MHA 2007, section 20. J6 and 7: MHA 1983, section 66, as amended by MHA 2007, chapter 5.

<sup>764</sup> J1a: MHA 2001, part 2. J1b and c: MHA 2001 permits involuntary admission and, therefore, treatment, only if there is “serious likelihood” of “immediate and serious harm” (section 3(1)(a)) or “failure to admit the person to an approved centre would be likely to lead to a serious deterioration” (section 3(1)(b)(i)). J2: MHA 2001, sections 2(1) and 15(2). J4: MHA 2001, part 3 [mental health tribunals review involuntary admission and, by implication, involuntary treatment]. J5: MHA 2001, section 15. J6 and 7: MHA 2001, part 3.

<sup>765</sup> MHA 1983, section 2.

<sup>766</sup> MHA 1983, section 3.

<sup>767</sup> MHA 1983, section 7.

<sup>768</sup> MHA 2001, part 2.

of *treatment* plans, although certain treatments attract additional safeguards (e.g. ECT).<sup>769</sup>

Both jurisdictions provide for involuntary community treatment (L1): in England, individuals undergoing supervised community treatment enjoy “all the criteria and safeguards required for involuntary inpatient treatment” (L2),<sup>770</sup> while in Ireland a detained patient may be given leave “subject to such conditions as [the consultant psychiatrist] considers appropriate”<sup>771</sup> (e.g. taking medication) and retains access to tribunals.<sup>772</sup>

### **5.3.1.3 Offences and penalties**

Both jurisdictions are compliant with WHO requirements regarding “offences and penalties” (AZ).<sup>773</sup> The MHA 2001 (Ireland) outlines offences in connection with many matters relating to involuntary admissions,<sup>774</sup> obstructing inspectors,<sup>775</sup> approved centres<sup>776</sup> and rules governing seclusion and restraint.<sup>777</sup> The legislation also outlines *sanctions* for violations related to involuntary admissions<sup>778</sup> and rules governing

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<sup>769</sup> England: MHA 2007, section 27; Ireland: MHA 2001, section 59.

<sup>770</sup> MHA 2007, sections 32-36.

<sup>771</sup> MHA 2001, section 26.

<sup>772</sup> Kelly, B.D., “Community treatment orders under the Mental Health Act 2007 in England and Wales”, *Medico-Legal Journal of Ireland*, 2009, 15, 43-48.

<sup>773</sup> England: AZ1: MHA 2007, as amended by MHA 2007, part IX. AZ2: MHA 1983, section 127.

<sup>774</sup> MHA 2001, section 32.

<sup>775</sup> MHA 2001, section 53.

<sup>776</sup> MHA 2001, section 68.

<sup>777</sup> MHA 2001, section 69(3).

<sup>778</sup> MHA 2001, section 32.

seclusion and restraint (AZ2),<sup>779</sup> and provides specific guidance if such offences are committed by an individual or “body corporate”.<sup>780</sup>

### **5.3.2 Areas of medium compliance with human rights standards**

#### **5.3.2.1 Competence, capacity and consent**

Legislation in England meets some but not all WHO requirements in relation to “competence, capacity and guardianship” (F);<sup>781</sup> it does not meet requirements for “periodic reviews of decisions” (F4) and “systematic review of the need for a guardian” (F7); although an appeal mechanism exists, it is neither systematic nor automatic.<sup>782</sup> The situation in Ireland is similarly mixed: Ireland’s “Ward of Court” system (F1) does not “define ‘competence’ and ‘capacity’” (F2);<sup>783</sup> is un-responsive to changes in

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<sup>779</sup> MHA 2001, section 69(3).

<sup>780</sup> MHA 2001, section 74.

<sup>781</sup> F1: MCA 2005, as amended by MHA 2007; MHA 1983, as amended by MHA 2007, sections 7-10; Department of Health, *Code of Practice: Mental Health Act 1983*, London: The Stationery Office, 2008; p. 256; F2: MCA 2005, as amended by MHA 2007, sections 2(1) [“criteria”]; 5, 24-26 [“treatment decisions”]; and 9-23 [“selection of a substitute decision-maker, making financial decisions”]; F3: MCA 2005, as amended by MHA 2007, sections 2(1), 9-29; F5: MHA 1983, as amended by MHA 2007, sections 7-10; Department of Health, 2008; chapters 26 and 28; MCA 2005, as amended by MHA 2007, sections 9-29; F6: MCA 2005, as amended by MHA 2007, sections 19(8) and 20(1); F8: MCA 2005, as amended by MHA 2007, section 53.

<sup>782</sup> MCA 2005, as amended by the MHA 2007, section 53; Department for Constitutional Affairs, *The Mental Capacity Act Code of Practice*, London: The Stationery Office, 2007; p. 197. Patients under “guardianship” under the MHA 1983, as amended by MHA 2007, have access to mental health tribunals (section 66(1)(c)).

<sup>783</sup> Lunacy Regulations (Ireland) Act 1871; Leonard, P., and McLaughlin, M., “Capacity legislation for Ireland: filling the legislative gaps”, *Irish Journal of Psychological Medicine*, 2009, 26, 165-168.

capacity;<sup>784</sup> makes unwieldy provisions for appointing decision-makers (F3);<sup>785</sup> and permits appeals in front of a High Court judge, but there is no right to a jury and insufficient provision for *periodic* reviews (F4).<sup>786</sup> The law lays down procedures for the appointment of a guardian (F5) although the initial consequences are notably profound, as the Court gains jurisdiction over *all matters* in relation to the “person and estate”,<sup>787</sup> although it may later specify areas in which a “personal guardian” may “take decisions on behalf of a patient” (F6).<sup>788</sup>

Irish law does not, however, make sufficient “provision for a systematic review of the need for a guardian” (F7) although there is (limited) possibility of appeal (F8).<sup>789</sup> It is hoped these deficits will be addressed in new legislation in the coming years.<sup>790</sup> Notwithstanding these deficits, legislation in England<sup>791</sup> and Ireland<sup>792</sup> meet WHO criteria in relation to “proxy consent for treatment” (K).

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<sup>784</sup> Law Reform Commission, *Vulnerable Adults and the Law (LRC 83-2006)*, Dublin: Law Reform Commission, 2006.

<sup>785</sup> Lunacy Regulations (Ireland) Act 1871, section 6; Court Service, *Office of Wards of Court*, Dublin: The Courts Information Service, 2003; p. 4-6; Law Reform Commission, 2006.

<sup>786</sup> Court Service, 2003; p. 6.

<sup>787</sup> Lunacy Regulations (Ireland) Act 1871, section 103; Law Reform Commission, 2006; p. 29.

<sup>788</sup> Lunacy Regulations (Ireland) Act 1871, section 103; Court Service, 2003; pp. 7-11.

<sup>789</sup> Court Service, 2003; p. 6.

<sup>790</sup> The Mental Capacity and Guardianship Bill 2008 indicated intent to legislate in this area (Leonard & McLaughlin, 2009; p. 165). In March 2012, the Joint Committee on Justice, Defence and Equality published a *Report on Hearings in relation to the Scheme of the Mental Capacity Bill* but legislation is not yet in place (Joint Committee on Justice, Defence and Equality, *Report on Hearings in relation to the Scheme of the Mental Capacity Bill*, Dublin: Houses of the Oireachtas, 2012).

<sup>791</sup> K1: MCA 2005, as amended by the MHA 2007, sections 9-29; MHA 1983, as amended by the MHA 2007, sections 7-10; Department of Health, 2008; chapters 26 and 28. K2: MCA 2005, as amended by the MHA 2007, section 53; MHA 1983, as amended by the MHA 2007, section 66(1)(c). K3: MCA 1983, as amended by the MHA 2007, sections 24-26.

### 5.3.2.2 Oversight and review

Legislation in England meets some but not all WHO requirements in relation to “oversight and review” (R). Mental health review tribunals assess involuntary admissions (R1a(i))<sup>793</sup> and community treatment orders (R1);<sup>794</sup> entertain appeals (R1a(ii));<sup>795</sup> and review the cases of involuntary but *not* “long-term voluntary patients” (R1a(iii)). Legislation affirms the importance of the Mental Health Act Commission, now replaced by the Care Quality Commission,<sup>796</sup> with similar regulatory functions (R1a(iv)).<sup>797</sup> Legislation also regulates psychosurgery<sup>798</sup> and ECT (R1a(v)),<sup>799</sup> and tribunals are appropriately structured by law.<sup>800</sup> The Care Quality Commission regularly inspects facilities (R2a(i));<sup>801</sup> maintains appropriate statistics (R2a(iii));<sup>802</sup> publishes findings regularly (R2a(vi));<sup>803</sup> makes recommendations appropriately (R2a(v)); is appropriately structured (R2b);<sup>804</sup> and has clear authority (R2c).<sup>805</sup> It does not “provide

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<sup>792</sup> K1: Lunacy Regulations (Ireland) Act 1871; Court Service, 2003; p. 4-6; Law Reform Commission, 2006. K2: Court Service, 2003; p. 6. K3: Powers of Attorney Act 1996, section 2(1); Court Service, 2003; p. 6; Law Reform Commission, 2006; pp. 99-112.

<sup>793</sup> MHA 1983, as amended by the MHA 2007, part V.

<sup>794</sup> MHA 2007, section 37(3); amending MHA 1983, section 68(1).

<sup>795</sup> MHA 1983, as amended by the MHA 2007, section 66.

<sup>796</sup> Health and Social Care Act 2008, section 1(2).

<sup>797</sup> Health and Social Care Act 2008, section 2(2)(c).

<sup>798</sup> MHA 1983, as amended by the MHA 2007, section 57(1)(a).

<sup>799</sup> MHA 1983, as amended by the MHA 2007, section 58.

<sup>800</sup> R1b: MHA 1983, as amended by the MHA 2007, schedule 2, section 4. R1c: Decisions can be appealed to the High Court, commonly by way of judicial review (Fennell, 2007; pp. 225-227.).

<sup>801</sup> Health and Social Care Act 2008, sections 60, 61, 52(1)(i).

<sup>802</sup> Health and Social Care Act 2008, sections 52(1)(c).

<sup>803</sup> Health and Social Care Act 2008, sections 38, 49, 53, 58, 83, 84.

<sup>804</sup> Health and Social Care Act 2008, section 5; schedule 1, section 3; also: [www.cqc.org.uk/aboutcqc/whoweare.cfm](http://www.cqc.org.uk/aboutcqc/whoweare.cfm) (accessed 1 May 2012)

guidance on minimizing intrusive treatments” (R2a(ii)) and maintains a register of “accredited facilities”<sup>806</sup> but not “professionals”, who are approved by local social services authorities (R2a(iv)).<sup>807</sup> While the Commission conducts “inquiries”,<sup>808</sup> “reviews and investigations”,<sup>809</sup> it does *not* outline detailed complaint procedures (R3a-R3b(vi)).

In Ireland, the Mental Health Commission establishes tribunals<sup>810</sup> to review involuntary admissions (R1, R1a(i)-(ii))<sup>811</sup> but *not* “long-term voluntary patients” (R1a(iii)); appoints an Inspector of Mental Health Services;<sup>812</sup> monitors involuntary treatments (R1a(iv));<sup>813</sup> regulates “intrusive and irreversible treatments” (R1a(v));<sup>814</sup> and is appropriately composed (R1b).<sup>815</sup> A detained patient may appeal to the Circuit Court on the grounds that they dispute the fact that they have “mental disorder”;<sup>816</sup> to the High Court “on a point of law”;<sup>817</sup> or to the High Court under the Constitution of Ireland (R1c).<sup>818</sup>

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<sup>805</sup> Health and Social Care Act 2008, sections 1, 2, 52.

<sup>806</sup> Health and Social Care Act 2008, chapter 2.

<sup>807</sup> MHA 1983, as amended by the MHA 2007, section 114.

<sup>808</sup> Health and Social Care Act 2008, section 75.

<sup>809</sup> Health and Social Care Act 2008, sections 46-51; Care Quality Commission, *How to Complain About a Health Care or Social Care Service*, Newcastle upon Tyne: Care Quality Commission, 2009.

<sup>810</sup> MHA 2001, section 33(3).

<sup>811</sup> MHA 2001, section 18.

<sup>812</sup> MHA 2001, section 50(1).

<sup>813</sup> MHA 2001, section 51.

<sup>814</sup> MHA, sections 58, 59; Mental Health Commission, *Rules Governing the Use of Electro-Convulsive Therapy*, Dublin: Mental Health Commission, 2009.

<sup>815</sup> MHA 2001, section 35. The composition of mental health tribunals, although smaller, is similar, including one medical representative, one legal representative and one other person (section 48(2)).

<sup>816</sup> MHA 2001, section 19(1); Mills, 2004.

<sup>817</sup> MHA 2001, section 19(16).

<sup>818</sup> Constitution of Ireland, article 40.

Ireland's Mental Health Commission is a "regulatory and oversight" body (R2)<sup>819</sup> which incorporates an Inspectorate (R2a(i));<sup>820</sup> provides "guidance on minimizing intrusive treatments" (R2a(ii));<sup>821</sup> maintains statistics (R2a(iii));<sup>822</sup> maintains a register of "accredited facilities"<sup>823</sup> but *not* "professionals" (R2a(iv));<sup>824</sup> reports and makes recommendations appropriately (R2a(v));<sup>825</sup> and publishes findings regularly (R2a(vi)).<sup>826</sup> It does not, however, include "members representing families of people with mental disorders" (R2b)<sup>827</sup> and, although its authority is clearly stated (R2c),<sup>828</sup> does not outline detailed complaint procedures (R3a-R3b(vi)).

Overall, WHO requirements regarding "oversight and review" (R) are met in part in England and Ireland, with the greatest deficit in both jurisdictions relating to imperfect or absent "procedures for submissions, investigations and resolutions of complaints"

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<sup>819</sup> MHA 2001, section 32(1) and 33(1).

<sup>820</sup> MHA 2001, sections 50-55.

<sup>821</sup> MHA 33(3)(e); Mental Health Commission, *Code of Practice on the Use of Physical Restraint in Approved Centres*, Dublin: Mental Health Commission, 2009. MHA 2001, section, 69(2); Mental Health Commission, *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*, Dublin: Mental Health Commission, 2009. MHA 2001, section 59(2); Mental Health Commission, *Rules Governing the Use of Electro-Convulsive Therapy*, Dublin: Mental Health Commission, 2009.

<sup>822</sup> The Mental Health Commission must prepare an annual report (MHA 2001, section 42(1)) and publish data relevant to service quality, including intrusive treatments, restraint, seclusion, etc.; e.g. Mental Health Commission, *Report on the Use of Seclusion, Mechanical Means of Bodily Restraint and Physical Restraint in Approved Centres in 2008*, Dublin: Mental Health Commission, 2009.

<sup>823</sup> MHA 2001, section 64.

<sup>824</sup> MHA 2001 does not establish a register of accredited professionals, but makes explicit use of the statutory registers maintained by the Medical Council of Ireland (section 2(1)).

<sup>825</sup> MHA 2001, sections 33(3)(d), 42(1).

<sup>826</sup> MHA 2001, section 42(1).

<sup>827</sup> MHA 2001, section 35(2).

<sup>828</sup> MHA 2001, parts 3 and 5.

(R3a-R3b(vi)). The narrow grounds for Circuit Court appeal in Ireland present further cause for concern.<sup>829</sup>

### **5.3.2.3 Special treatments, seclusion and restraint**

None of the three MHAs (1983 and 2007 in England, 2001 in Ireland) explicitly “require informed consent for major medical and surgical procedures on persons with a mental disorder” (O2), but none dispense with this requirement either. Similarly, while none of the three MHAs explicitly “allow medical and surgical procedures without informed consent, if waiting for informed consent would put the patient’s life at risk” (O2a), none forbid it. In England, the MCA 2005 permits, “in cases where inability to consent is likely to be long term”, “authorization for medical and surgical procedures from an independent review body or by proxy consent of a guardian” (O2b).<sup>830</sup> In Ireland, the Ward of Court system makes similar provision (O2b).<sup>831</sup>

None of the three MHAs “outlaw” all “irreversible treatments” on involuntary patients, although the MHAs 2007<sup>832</sup> and 2001<sup>833</sup> introduce various safeguards. Regarding psychosurgery, in England, the doctor providing the second opinion and “two other persons” involved in treatment must be satisfied the patient has capacity to consent

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<sup>829</sup> MHA 2001, section 19(1); Mills, 2004.

<sup>830</sup> MCA 2005, as amended by the MHA 2007, section 5.

<sup>831</sup> Lunacy Regulations (Ireland) Act 1871; Law Reform Commission, 2006; Leonard & McLaughlin, 2009.

<sup>832</sup> MHA 1983, as amended by the MHA 2007, section 57; safeguards for involuntary patients include requirements for consent and a second opinion prior to psychosurgery, amongst other specified treatments. Bowen, 2007; p. 99.

<sup>833</sup> MHA 2001, section 58; safeguards for involuntary patients include requirements for consent and endorsement by a mental health tribunal prior to psychosurgery.



(O3a).<sup>834</sup> In Ireland, there is no similar requirement, as the mental health tribunal prior to psychosurgery must only decide if psychosurgery “is in the best interests of the health of the patient” and does not comment on capacity.<sup>835</sup> Regarding ECT, there is, in England, a requirement for informed consent for involuntary patients except those who lack capacity, for whom a second opinion is required (O4).<sup>836</sup> There is a similar requirement for informed consent prior to ECT in Ireland, and a second opinion needed if the patient is “unable or unwilling” to consent.<sup>837</sup> None of the three MHAs prohibits unmodified ECT (i.e. without anaesthetic) (O5) or “ECT in minors” (O6), and none make reference to sterilization (O1, O1a).

None of the three MHAs provide detailed guidance regarding seclusion and restraint (P). In England, there is a Code of Practice which addresses seclusion and mechanical restraint,<sup>838</sup> but the Code is for “guidance” purposes<sup>839</sup> and “the Act does not impose a legal duty to comply” with it (although staff “must have regard to the Code”).<sup>840</sup>

The situation in Ireland is significantly more consistent with WHO requirements: the MHA 2001 states that seclusion and restraint can only be used in accordance with rules

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<sup>834</sup> MHA 1983, as amended by the MHA 2007, section 57(2).

<sup>835</sup> MHA 2001, section 58(3)(a).

<sup>836</sup> MHA 1983, as amended by the MHA 2007, section 58A.

<sup>837</sup> MHA 2001, section 59(1)(b). The inclusion of “unwilling” suggests that involuntary patients with capacity who are “unwilling” to agree to ECT are liable to be given ECT against their wishes; the College of Psychiatry of Ireland has suggested deleting the word “unwilling” so as to limit involuntary ECT to those lacking capacity (Mulholland, P., “ECT amendment proposal sent to the government”, *Irish Medical News* 2010, 35, 3).

<sup>838</sup> Department of Health, 2008.

<sup>839</sup> MHA 1983, section 118.

<sup>840</sup> Department of Health, 2008; p. 2. The Code meets many of the WHO requirements including P1 (pp. 120, 133), P2 (p. 114), P5 (pp. 112-116) and, in part, P6 (pp. 112-127).

made under the Act, violation of which constitutes an offence (P1).<sup>841</sup> The rules meet many of the WHO requirements,<sup>842</sup> although they do permit “one period of seclusion and restraint” to be “followed immediately by another” (P4).<sup>843</sup> Such is the level of concordance between the Irish rules and WHO guidelines (in both meaning and words), it appears reasonable to hypothesise that the WHO guidelines influenced the development of the Irish rules.

#### **5.3.2.4 Various other matters**

Legislation in England meets many of the WHO requirements in relation to “rights of families or other carers” (E)<sup>844</sup> except for encouraging “family members or other primary carers...to become involved in the formulation and implementation of the patient's individualized treatment plan” (E2). In Ireland, the MHA 2001 meets *none* of these requirements (E).

The position regarding research (Q) differs between the jurisdictions. Legislation in England does not provide detailed guidance regarding “clinical experimental research” (Q1) but, for those who lack capacity, the MCA 2005 permits research subject to certain safeguards,<sup>845</sup> including a requirement for “proxy consent” (Q2a) from an appropriate

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<sup>841</sup> MHA 2001, section 69(1).

<sup>842</sup> P2: Mental Health Commission, *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*, Dublin: Mental Health Commission, 2009; p. 15. P3: pp. 19, 27. P5 and 6: pp. 1-45.

<sup>843</sup> Mental Health Commission, *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*, Dublin: Mental Health Commission, 2009; pp. 22, 27.

<sup>844</sup> E1: MHA 1983, section 132(4); MHA 1983, section 132A(3), amended by MHA 2007, schedule 3, paragraph 30. E3: MHA 1983; section 11(4). E5: MHA 2007, section 8; amending MHA 1983, section 118(2B)).

<sup>845</sup> MCA 2005, section 30-34. Bowen, 2007; p. 188.

source;<sup>846</sup> that “research cannot be conducted if the same research could be conducted on people capable of consenting” (Q2b);<sup>847</sup> and it “is necessary to promote the health of the individual and that of the population represented” (Q2b).<sup>848</sup> The MHA 2001 (Ireland) states that no detained patient can participate in a clinical trial but does not meet any of the WHO requirements.<sup>849</sup>

### **5.3.3 Areas of low compliance with human rights standards**

#### **5.3.3.1 Fundamental principles**

The preambles to the MHAs 1983, 2007 (England) and 2001 (Ireland) do not mention human rights and therefore fail to accord with most WHO requirements in relation to “preamble and objectives” (A). Both jurisdictions raise some of these issues in different ways, however, as the preamble to Ireland’s MHA 2001 highlights some of the Act’s human rights-*related* goals (e.g. “to provide for the independent review of the involuntary admission of such persons...”)<sup>850</sup> and the main text of the legislation states “due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy”.<sup>851</sup>

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<sup>846</sup> MCA 2005, section 32.

<sup>847</sup> MCA 2005, section 31(4).

<sup>848</sup> MCA 2005, section 31(5).

<sup>849</sup> MHA 2001, section 70.

<sup>850</sup> MHA 2001, preamble.

<sup>851</sup> MHA 2001, section 4(3).

In England, the revised MHA 1983 states that “the Secretary of State shall prepare, and from time to time revise, a code of practice”<sup>852</sup> which “shall include a statement of the principles which the Secretary of State thinks should inform decisions under this Act”.<sup>853</sup> The MHA 2007 articulates “minimising restrictions on liberty” as one of the matters to be addressed in preparing the “statement of principles” for the Code of Practice.<sup>854</sup> These principles, however, belong in the Code of Practice rather than the legislation itself, and English legislation, like the Irish, still lacks overall commitment to “promotion and protection of the rights of people with mental disorders”, suggested by the WHO (A2b).

The MHA 2007 (England) also includes “avoidance of unlawful discrimination” as another matter to be addressed in preparing the “statement of principles” for the Code of Practice, which goes some way to meet WHO requirements (A2a).<sup>855</sup> In addition, while none of the three MHAs explicitly promote “a community-based approach” (A2d), the MHA 2007 (England) includes “minimising restrictions on liberty” as matter to be addressed in preparing the “statement of principles” for the Code of Practice,<sup>856</sup> and the MHA 2001 (Ireland) states “due regard” is to be given to the “right of the person to...autonomy”.<sup>857</sup>

Notwithstanding these expressions of selected principles, the absence of strong, rights-based preambles has, arguably, reduced emphasis on human rights in other parts of the

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<sup>852</sup> MHA 1983, section 118(1).

<sup>853</sup> MHA 1983, section 118(2A).

<sup>854</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(c).

<sup>855</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(e).

<sup>856</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(c).

<sup>857</sup> MHA 2001, section 4(3).

MHAs. One example concerns the “rights of users of mental health services” regarding information (D). Legislation in both jurisdictions articulates “rights to respect, dignity and to be treated in a humane way” (D1),<sup>858</sup> but both jurisdictions fail to meet WHO requirements regarding access to information, although the MHA 2001 (Ireland) states “due regard” is to be given to the “right of the person to...privacy”<sup>859</sup> (D2) and the MHA 2007 (England) specifies “exceptional circumstances when confidentiality may be legally breached” (D2b).<sup>860</sup> Some of these issues relating to legislation are covered by data protection legislation and/or freedom of information laws in each jurisdiction,<sup>861</sup> but are not addressed in mental health legislation, as suggested by the WHO.

Selected other issues related to human rights are addressed, at least in principle: “cruel, inhuman and degrading treatment” (D4), for example, would be grossly inconsistent with the matters to be addressed in preparing the “statement of principles” for the Code of Practice outlined in the MHA 2007 (England),<sup>862</sup> and the MHA 2001 (Ireland) states “due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy”.<sup>863</sup> None of the three MHAs, however, set out “the minimal conditions to be maintained in mental health facilities for a safe, therapeutic and hygienic environment” (D5) or make explicit “provision for educational activities; vocational training; leisure and recreational activities; and religious or cultural needs of people with mental disorders” (D8).

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<sup>858</sup> England: MHA 2007, section 8; amending MHA 1983, section 118(2B). Ireland: MHA 2001, section 4(3).

<sup>859</sup> MHA 2001, section 4(3).

<sup>860</sup> Department of Health, 2008; p. 148.

<sup>861</sup> England: Carey, P., *Data Protection (Third Edition)*, Oxford: Oxford University Press, 2009. Ireland: Kelleher, D., *Privacy and Data Protection Law in Ireland*, Dublin: Tottel Publishing, 2006.

<sup>862</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B).

<sup>863</sup> MHA 2001, section 4(3).

### 5.3.3.2 Voluntary patients

Legislation in England and Ireland promotes treatment in the least restrictive setting as an alternative to involuntary admission (G1): the MHA 2007 (England) includes “minimising restrictions on liberty” as a matter to be addressed in preparing the “statement of principles” for the Code of Practice,<sup>864</sup> and the MHA 2001 (Ireland) states “due regard” is to be given to the “right of the person to...autonomy”.<sup>865</sup> Neither jurisdiction meets any of the other WHO criteria regarding “voluntary treatment and admission”.

The MHA 1983 (England) has detailed provisions regarding consent to treatment, but these apply only to specific groups of detained patients (G2).<sup>866</sup> Similarly, the MHA 2001 (Ireland) states that “the consent of a patient shall be required for treatment”<sup>867</sup> except under specific circumstances; again, however, the term “patient” refers *only* to involuntary patients,<sup>868</sup> so Ireland’s MHA 2001 does *not* require informed consent from voluntary patients. Indeed, the MHA 2001 does not even require that voluntary patients *possess* capacity: the Act states that “voluntary patient” means “a person receiving care and treatment in an approved centre who is not the subject of an admission order to a renewal order”<sup>869</sup> (see Section 4.4.4).

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<sup>864</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(c).

<sup>865</sup> MHA 2001, section 4(1).

<sup>866</sup> MHA 1983, part IV.

<sup>867</sup> MHA 2001, section 56(a).

<sup>868</sup> MHA 2001, section 2(1).

<sup>869</sup> MHA 2001, section 2(1).

Compliance with WHO standards regarding non-protesting patients (H) differs between jurisdictions, and in both is troubling. In England, the MCA 2005 makes provision for admission (H1)<sup>870</sup> and treatment (H2)<sup>871</sup> of incapacitated, non-protesting patients but does not clearly state that patients who object must be discharged unless criteria for involuntary detention are met (H3). In Ireland, the MHA 2001 makes no specific provision for admission (H1) and treatment (H2) of incapacitated, non-protesting patients, probably because such patients are included under Ireland's distinctly paternalistic definition of "voluntary patient" which does not require capacity.<sup>872</sup> The legislation does, however, specify that when a "voluntary" patient (including incapacitated, non-protesting patients)<sup>873</sup> indicates a wish to leave, he or she must be assessed to see if criteria for involuntary detention are met.<sup>874</sup>

### **5.3.3.3 Vulnerable patient groups**

In relation to minors, the MHA 2007 (England) includes "minimising restrictions on liberty" as a matter to be addressed in preparing the "statement of principles" for the Code of Practice (Z1, minors);<sup>875</sup> emphasises age-appropriate facilities (Z2b, minors);<sup>876</sup> and requires that services "take the opinions of minors into consideration" (Z4,

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<sup>870</sup> MCA 2005, as amended by the MHA 2007, schedules A1 and 1A.

<sup>871</sup> These provisions are "long (Schedule A1 contains 13 Parts and 186 paragraphs), complex, overly bureaucratic" and, arguably, fail to meet the requirements that law should be "sufficiently accessible and foreseeable" (Bowen, 2007; p. 150).

<sup>872</sup> MHA 2001, section 2(1).

<sup>873</sup> MHA 2001, section 2(1).

<sup>874</sup> MHA 2001, section 23.

<sup>875</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(c).

<sup>876</sup> MHA 2007, section 31(3); amending MHA 1983, section 131.

minors).<sup>877</sup> Legislation does not “ban all irreversible treatments for children” (Z5, minors), although specific safeguards for certain treatments (e.g. ECT) are outlined.<sup>878</sup>

The MHA 2001 (Ireland) states that a “child” (aged under eighteen years)<sup>879</sup> can be involuntarily admitted if, amongst other criteria, “the child requires treatment which he or she is unlikely to receive unless an order is made under this section” (Z1, minors).<sup>880</sup>

The remaining WHO requirements are addressed, in part, in the Mental Health Commission’s *Code of Practice Relating to Admission of Children under the Mental Health Act 2001*,<sup>881</sup> but there is *no* “legal duty on persons working in the mental health services to comply with codes of practice”.<sup>882</sup> The MHA 2001 does not “ban all irreversible treatments for children” (Z5, minors), but psychosurgery<sup>883</sup> and ECT<sup>884</sup> require District Court approval.

Regarding women, the MHA 2007 (England) includes, as matters to be addressed in preparing the “statement of principles” for the Code of Practice, “respect for diversity

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<sup>877</sup> MHA 1983, section 131(2); Department of Health, 2008: pp. 326-354; Bowen, 2007; pp. 160-163.

<sup>878</sup> MHA 2007, section 58A, amending MHA 1983, section 58.

<sup>879</sup> MHA 2001, section 2(1).

<sup>880</sup> MHA 2001, section 25(1)(b).

<sup>881</sup> Z2a, minors: Mental Health Commission, *Code of Practice Relating to Admission of Children under the Mental Health Act 2001*, Dublin: Mental Health Commission, 2006; p. 12. Z2b, minors: pp. 12-13. Z3, minors: Certain protections are covered in the *Code of Practice* (pp. 22-23), but these do not include the WHO requirement that law “ensure that all minors have an adult to represent them”. Z4, minors: Certain issues regarding the child’s own views are mentioned in the *Code* in relation to voluntary child patients (p. 22), but the law does not fulfil the WHO requirement “to take the opinions of minors into consideration on all issues affecting them”.

<sup>882</sup> Mental Health Commission, 2006; p. 9.

<sup>883</sup> MHA 2001, section 25(12).

<sup>884</sup> MHA 2001, section 25(13)..



generally including, in particular, diversity of religion, culture and sexual orientation”<sup>885</sup> and “avoidance of unlawful discrimination” (Z1, women).<sup>886</sup> The MHA 2001 (Ireland) states “due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy” (Z1, women)<sup>887</sup> and the “right of the person to...privacy” (Z2a, women).<sup>888</sup> None of the three MHAs meet any of the other WHO requirements in relation to women.

Regarding minorities, the MHA 2007 (England) includes, as a matter to be addressed in preparing the “statement of principles” for the Code of Practice, “respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation”<sup>889</sup> and “avoidance of unlawful discrimination” (Z1, minorities).<sup>890</sup> While the MHA 2001 (Ireland) states “due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy”,<sup>891</sup> none of the three MHAs meet any of the other WHO requirements in relation to minorities.

Overall, the level of special protection offered to “vulnerable groups” as specified by the WHO varies significantly between jurisdictions and, in both, falls significantly short of WHO requirements.

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<sup>885</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(b).

<sup>886</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(e).

<sup>887</sup> MHA 2001, section 4(3).

<sup>888</sup> MHA 2001, section 4(3).

<sup>889</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(b).

<sup>890</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(e).

<sup>891</sup> MHA 2001, section 4(3).

### 5.3.3.4 Emergency treatment

Mental health legislation in England permits “emergency treatment for patients lacking capacity or competence” if “the treatment needs to be given in order to prevent harm” (M1);<sup>892</sup> outlines involuntary procedures “for admission and treatment in emergency situations” (M2);<sup>893</sup> and provides considerable detail about the roles of mental health professionals including the “responsible clinician” (M3).<sup>894</sup>

In Ireland, the MHA 2001 does not outline a separate procedure for “emergency admission/treatment” (M1) and the standard involuntary admission/treatment process requires either a “serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons”<sup>895</sup> or that “failure to admit” would “likely lead to a serious deterioration in his or her condition”;<sup>896</sup> on this basis, the Irish legislation does *not* necessarily require “high probability of immediate and imminent danger or harm” for emergency admission, although there is such a requirement if there is to be substantial police involvement.<sup>897</sup> Irish legislation does, however, outline involuntary procedures which can be used “for admission and treatment in emergency situations” (M2)<sup>898</sup> (i.e. the standard procedure) and requires

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<sup>892</sup> MHA 1983, as amended by the MHA 2007, part II; MHA 2007, section 35(1); amending MHA 1983, section 64G. Emergency admission is addressed in MHA 1983, section 4.

<sup>893</sup> MHA 1983, as amended by the MHA 2007, part II.

<sup>894</sup> MHA 2007, section 9(9); amending MHA 1983, section 34(1), and section 12(7)(a); amending MHA 1983, section 64(1).

<sup>895</sup> MHA 2001, section 3(1)(b)(i).

<sup>896</sup> MHA 2001, section 3(1)(b)(ii).

<sup>897</sup> MHA 2001, section 12(1).

<sup>898</sup> MHA 2001, part 2.

there be a “consultant psychiatrist responsible for the care and treatment of the patient” (M3).<sup>899</sup>

Both jurisdictions outline explicit procedures “after the emergency situation has ended” (M5)<sup>900</sup> but neither jurisdiction meets other WHO requirements in relation to outlawing “treatments such as ECT, psychosurgery and sterilization, as well as participation in clinical or experimental trials...for people held as emergency cases” (M6);<sup>901</sup> or explicitly stating whether “patients, family members and personal representatives have the right to appeal against emergency admission/treatment” (M7).<sup>902</sup> Regarding the “time limit for emergency admission (usually no longer than 72 hours)” (M4), the MHA 1983 (England) permits emergency admission for 72 hours<sup>903</sup> but also permits admission for “assessment” for up to 28 days,<sup>904</sup> while the MHA 2001 (Ireland) permits initial involuntary admission for 21 days, although orders can be revoked sooner if clinically indicated.<sup>905</sup>

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<sup>899</sup> MHA 2001, sections 2(1) and 15(2)

<sup>900</sup> England: MHA 1983, section 4(4). Ireland: MHA 2001, section 15.

<sup>901</sup> In Ireland, no detained patient can participate in a clinical trial (MHA 2001; section 70).

<sup>902</sup> Under the MHA 1983, as amended by the MHA 2007, the patient’s “nearest relative” can prevent the making of an application for detention for “treatment” (sections 3 and 11(4)), or guardianship (sections 7 and 11(4)), by an “approved social worker”; apply to a tribunal on the patient’s behalf, under certain circumstances (section 66(1)(ii)); and make “an order for discharge” from detention for assessment (section 23(2)(a)), treatment (section 23(2)(a) or guardianship (section 23(2)(b)), although such an order can be denied following a report from the “responsible medical officer” (section 25(1)). These provisions apply to involuntary admission in general, as opposed to emergency admission (MHA 1983, section 4).

<sup>903</sup> MHA 1983, section 4(4).

<sup>904</sup> MHA 1983, section 2(2)(a).

<sup>905</sup> MHA 2001, section 15(1).

### 5.3.3.5 Economic and social rights

The greatest single way in which mental health legislation in England and Ireland fails to comply with WHO requirements relates to economic and social rights. Regarding “discrimination” (U), the MHA 2007 (England) includes “avoidance of unlawful discrimination” as matters to be addressed in preparing the “statement of principles” for the Code of Practice,<sup>906</sup> but the MHA 2001 (Ireland) does *not* “include provisions aimed at stopping discrimination against people with mental disorders” (U1). The positions regarding housing (V) and employment (W) are similar: in England, “avoidance of unlawful discrimination” is specified as a matter to be addressed in preparing the “statement of principles” for the Code of Practice,<sup>907</sup> and is relevant but vague, while in Ireland the MHA 2001 does not include *any* relevant measures.

None of the three MHAs meet WHO requirements relating to “social security” (X1) or civil issues (Y), notwithstanding the inclusion of “avoidance of unlawful discrimination” as a matter to be addressed in preparing the “statement of principles” for the Code of Practice in England.<sup>908</sup> Some of these issues are addressed in a general sense, for all citizens, through equality legislation in England<sup>909</sup> and Ireland<sup>910</sup> but are not explicitly addressed in the MHAs.

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<sup>906</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(d).

<sup>907</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(d).

<sup>908</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(d).

<sup>909</sup> Wadham, J., Ruebain, D., Robinson, A., Uppal, S., *Blackstone's Guide to the Equality Act 2010*, Oxford: Oxford University Press, 2010

<sup>910</sup> Hughes, I., Clancy, P., Harris, C., Beetham, D., *Power to the People*, Dublin: TASC, 2007; p. 199.

While issues such as housing, employment and social security might, arguably, be better addressed through government policy rather than mental health law, the failure of MHAs in both jurisdictions to comply with many WHO standards regarding “access to mental health care” (C) is, arguably, a more pointed problem. Regarding “allocation of resources to underserved populations and specify[ing] that these services should be culturally appropriate” (C3), the MHA 2007 (England) emphasizes “equitable distribution of services”<sup>911</sup> and includes “respect for diversity” as a matter to be addressed in preparing the “statement of principles” for the Code of Practice.<sup>912</sup> Irish legislation makes no reference to these matters. Similarly, while MHAs in England<sup>913</sup> and Ireland<sup>914</sup> all emphasize treatment in the least restrictive setting, none of the MHAs explicitly “promote community care and deinstitutionalization” (C8) at policy level.

#### **5.4 Summary: Areas of high, medium and low compliance**

Legislation in England meets 92 (55.4%) of the 166 standards set out by the WHO while legislation in Ireland meets 81 standards (48.8%). The higher compliance rate in England, compared to Ireland, is chiefly attributable to the MCA 2005 in England; in Ireland, dedicated capacity legislation is currently being developed (in the form of the Mental Capacity and Guardianship Bill 2008) but has not yet been introduced.

Looking across both jurisdictions, areas of high compliance include clear definitions of mental disorder, relatively robust procedures for involuntary treatment (although

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<sup>911</sup> MHA 2007, section 8; amending MHA 1983, section 118(2C)(b).

<sup>912</sup> MHA 2007, section 8, amending MHA 1983, section 118(2B)(b).

<sup>913</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(c).

<sup>914</sup> MHA 2001, section 4(1).

provision of information remains suboptimal) and clarity regarding offences and penalties. These issues, primarily relating to compulsion and coercion, are issues of long-standing concern in asylum-based mental health-care, since the eighteenth-century and even earlier.<sup>915</sup> It is therefore reasonable that these matters are highlighted in the WHO checklist, and the high level of compliance in England and Ireland is both reassuring and historically significant, albeit that they tend to focus on the right to liberty alone, and in a broadly paternalistic fashion, and fail to engage more widely with other rights, especially for non-detained patients.

Areas of medium compliance relate to competence, capacity and consent, oversight and review procedures (which exclude long-term voluntary patients and require more robust complaints procedures), and rules governing special treatments, seclusion and restraint, as well as other, more specific matters (the rights of families, research). Many of the WHO standards in these areas relate, again, to areas of traditional concern in mental health (e.g. seclusion, restraint) but some also date from more recent decades (e.g. research). The medium level of compliance in England and Ireland again reflects a growing awareness of the human rights of the mentally ill, especially as reflected through the ECHR and related case-law. There also, however, areas of notable deficit, including the lack of reasonable and responsive capacity legislation in Ireland. The ongoing relevance of European influences in the context of these changes and deficits is explored further in Section 7.2.

Areas of low compliance relate to overall legislative commitments to promoting the rights of the mentally ill (impacting on other areas within legislation, such as

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<sup>915</sup> Shorter, 1997; Porter, 2002.

information management), definition and treatment of voluntary patients (especially non-protesting, incapacitated patients in Ireland), protection of vulnerable patient groups, and emergency treatment. The greatest single deficit in both jurisdictions relates to economic and social rights which the WHO believes should be explicitly protected in mental health legislation but which are not addressed in any detailed or substantive fashion in the mental health laws of England or Ireland.

Overall, compliance with WHO standards is highest in areas of traditional concern in asylum-based mental health services (involuntary detention and treatment) and lowest in areas of growing relevance to modern community-based mental health services (e.g. rights of voluntary patients, economic and social rights, rights to a minimum standard of care). This is a key conclusion from the present analysis: mental health legislation in both jurisdictions focuses on specific rights (e.g. the right to liberty) to the exclusion of certain others, and does so in a fashion shaped largely by paternalism (Chapter 8).

In England this situation stems primarily from the emphasis on public safety during the recent revision of legislation and in Ireland it stems from a strongly welfare-based or paternalistic tradition in mental health law. If mental health legislation focussed more broadly on economic and social rights, as the WHO suggests, it may well remedy this situation by affording greater protection of dignity and facilitating patients to exercise their own capabilities in areas other than strictly-defined mental health care (e.g. housing, employment and social participation).

These conclusions stem from this analysis of legislation based on the WHO checklist and it should be remembered that WHO checklist, while it is both comprehensive and

explicitly based on human rights standards (e.g. UDHR), is not necessarily perfect. For example, while the WHO checklist places considerable emphasis on economic and social rights, it is not clear whether or not such rights belong in a “Checklist for Mental Health *Legislation*” (my italics)<sup>916</sup> or might be best addressed through other forms of legislation or governmental mental health policy (see Chapter 8).

This issue is an important one, because, in practice, the WHO checklist may well achieve some of its aims by influencing mechanisms other than dedicated mental health *legislation*. In Ireland, for example, the level of concordance between the statutory *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*<sup>917</sup> and relevant WHO standards (Table 1, Section P) is such that it appears reasonable to conclude that the WHO standards were taken into consideration in the development of the Rules: not only do the two documents overlap in meaning, but the same phrases are used throughout both. This is consistent with the influence of other WHO documents, such as the *ICD-10 Guide for Mental Retardation*,<sup>918</sup> which is also reflected, at least in part, in revised national mental health legislation.<sup>919</sup>

Overall, then, the human rights-based analysis of mental health legislation presented in this thesis articulates clearly the substantial influence of “international human rights documents”<sup>920</sup> (e.g. UN/WHO publications) and the ECHR (and related case-law) in

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<sup>916</sup> WHO, 2005.

<sup>917</sup> Mental Health Commission, *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*, Dublin: Mental Health Commission, 2009.

<sup>918</sup> WHO, *ICD-10 Guide for Mental Retardation*, Geneva: WHO, 1996.

<sup>919</sup> See Section 4.3.1 of this thesis.

<sup>920</sup> McSherry, B., Weller, P., “Rethinking rights-based mental health laws”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 3-10), Oxford and Portland, Oregon: Hart Publishing, 2010; p. 10.



shaping mental health law. This is evidenced through both a growing *overall* emphasis on human rights and more specific instances, such as the influence of the WHO guidance on the Irish rules for seclusion and restraint.

Notwithstanding these developments, there are still clear areas of high, medium and low compliance with WHO human rights standards across the two jurisdictions, as outlined above. The next chapter presents a comparison between England and Ireland in terms of the extent to which mental health legislation in each jurisdiction reflects each of these WHO standards.

## **Chapter 6**

### **Comparison: England and Ireland**

#### **6.1 Introduction**

The consideration of mental health legislation in England and Ireland presented in Chapter 5 highlights a considerable overlap between the two jurisdictions in terms of compliance with international human rights standards. As outlined in Table 1, areas of similarity within the WHO human rights framework<sup>921</sup> include legislative provisions relating to definitions of mental disorder (B), voluntary admission and treatment (G), involuntary admission (I, J), proxy consent for treatment (K), involuntary treatment in community settings (L), determinations of mental disorder (N), oversight and review mechanisms (R), police responsibilities (S), social security (X), civil issues (Y) and offences and penalties (AZ).

Areas of dissimilarity between the two jurisdictions relate to the preambles to, and objectives of, mental health legislation (A), legislative provision regarding access to healthcare (C), rights of users of mental health services regarding information (D), rights of families or other carers (E), competence, capacity and guardianship (F), non-protesting patients (H), emergency situations (M), special treatment (O), seclusion and restraint (P), clinical and experimental research (Q), discrimination (U), housing (V), employment (W) and protection of vulnerable groups (Z).

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<sup>921</sup> WHO, 2005.

These contrasts between the two jurisdictions are explored in greater depth in this chapter. Before considering these matters, however, it is useful to outline briefly the historical relationship between mental health laws of England and Ireland (Section 6.2). This is followed by consideration of areas of contrast between the two jurisdictions in terms of mental health legislation and human rights (Section 6.3). Conclusions are presented in Section 6.4.

## **6.2 The relationship between England and Ireland**

The turbulent relationship between England and Ireland,<sup>922</sup> and eventual emergence of the Republic of Ireland (1949), had significant effects on the development of mental health legislation in Ireland.<sup>923</sup> Interestingly, England and Ireland tended not to share identical mental health laws, even when both formed part of the United Kingdom of Great Britain and Ireland (from 1 January 1801 to 6 December 1922). England's Criminal Lunatics Act 1800 did not apply to Ireland, and Ireland developed separate criminal lunacy legislation in 1838, in the form of the Criminal Lunatics (Ireland) Act.<sup>924</sup> The differences grew during the first half of the twentieth century: England's Mental Deficiency Act 1913 was not applied to Ireland,<sup>925</sup> and while England

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<sup>922</sup> Lyons, 1985; Kennedy, L., Ell, P.S., Crawford, E.M., Clarkson, L.A., *Mapping the Great Irish Famine*, Dublin: Four Courts Press Ltd., 1999; Ferriter, D., *The Transformation of Ireland 1900-2000*, London: Profile Books, 2004.

<sup>923</sup> Finnane, 1981; Barrington, R., *Health, Medicine and Politics in Ireland 1900-1970*, Dublin: Institute of Public Administration, 1987.

<sup>924</sup> Prior, P.M., "Dangerous lunacy: The misuse of mental health law in nineteenth-century Ireland", *Journal of Forensic Psychiatry and Psychology*, 2003, 14, 525-541.

<sup>925</sup> Reynolds, J., *Grangegorman*, Dublin: Institute of Public Administration, 1992; p. 212.

introduced voluntary psychiatric admission status in 1930, Ireland did not do so until the Mental Treatment Act 1945.<sup>926</sup>

Against the background of a close relationship between the two countries, combined with divergent mental health laws, the latter half of the twentieth century provided reason to imagine that mental health laws in England and Ireland might develop more similarities with each other, notwithstanding Ireland's new-found status as a republic. This was largely attributable to the fact that human rights concerns came increasingly to the fore in both jurisdictions during this period: both supported the UDHR at an early stage;<sup>927</sup> both participated in drafting, signed and ratified the ECHR (1950), and both joined the European Economic Community (1973).

Against this background, this thesis explores the extent to which mental health laws in England and Ireland have finally started to converge, at least in relation to the WHO human rights standards.<sup>928</sup> It is interesting that this limited convergence is based not on the history of partially shared law-making in England and Ireland, but rather on a deepening recognition of the importance of human rights in mental health – a recognition that is increasingly evident throughout Europe and beyond (Section 7.2).<sup>929</sup> Notwithstanding this common ground, however, this thesis also demonstrates that there

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<sup>926</sup> Kelly, B.D., "The Mental Treatment Act 1945 in Ireland: an historical enquiry", *History of Psychiatry* 2008, 19, 47-67.

<sup>927</sup> The UK voted for the UDHR at the UN in 1948; Ireland joined the UN in 1955 (Morsink, 1999).

<sup>928</sup> See Chapter 5 and Table 1 for areas of accordance with human rights standards common to both jurisdictions.

<sup>929</sup> Carpenter, M., "A third wave, not a third way?", *Social Policy and Society*, 2009, 8, 215-230; Lewis, L., "Politics of recognition" *Social Policy and Society*, 2009, 8, 257-274; Gostin et al, 2010.

are still significant differences between the jurisdictions, even in relation to human rights. These are considered next.

### **6.3 Legislative differences relating to human rights and mental illness**

From a human rights perspective, areas of dissimilarity between mental health legislation in England and Ireland can be grouped into five categories:

- 6.3.1 Principles and objectives
- 6.3.2 Balance between privacy and disclosure of information
- 6.3.3 Protection of vulnerable groups
- 6.3.4 Specific aspects of clinical management
- 6.3.5 Competence and capacity

#### **6.3.1 Principles and objectives**

The preambles to the MHAs 1983, 2007 (England) and 2001 (Ireland) do not mention human rights and therefore fail to accord with most WHO requirements in relation to “preamble and objectives” (A). English legislation rates slightly higher than Irish legislation in this regard, however, owing to its inclusion of specific matters to be addressed in preparing the “statement of principles” for the Code of Practice<sup>930</sup> which go some but not all of the way toward meeting WHO requirements in relation to objectives of legislation (A), resource-allocation to optimize access to care (C), discrimination (U), housing (V) and employment (W).

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<sup>930</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B).

Ireland's MHA 2001 requires that the "best interests of the person shall be the principal consideration with due regard being given to the interests of other persons",<sup>931</sup> but does not specify the principles required by the WHO (A, C, U, V and W). This reflects a strong paternalistic or welfare-based tradition in Irish mental health law.<sup>932</sup> The absence of "fundamental principles" in the Irish legislation may also reflect the Irish legal system's strong reliance on the Constitution of Ireland which establishes principles of democratic government,<sup>933</sup> outlines "fundamental rights",<sup>934</sup> and is commonly invoked in rights-related mental health cases (Chapter 4). England, by contrast, does not have a single core constitutional document thus, arguably, increasing the likelihood that mental health legislation would include a statement of "fundamental principles", as the MHA 2007 outlines for its Code of Practice.<sup>935</sup>

### **6.3.2 Balance between privacy and disclosure of information**

There are significant differences between England and Ireland in terms of the balance between privacy and disclosure of information. While both jurisdictions fail to meet the majority of WHO requirements in relation to rights of mental health service-users regarding information (D2-5) (Section 5.3.3.1), Irish mental health legislation, unlike English mental health legislation, explicitly protects rights to confidentiality (D2) and privacy (D6).<sup>936</sup>

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<sup>931</sup> MHA 2001, section 4(1).

<sup>932</sup> Whelan, 2009; pp. 26-31.

<sup>933</sup> Constitution of Ireland, article 16.

<sup>934</sup> Constitution of Ireland, articles 40-44.

<sup>935</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B).

<sup>936</sup> MHA 2001, section 4(3).

By contrast, English mental health legislation explicitly lays down “exceptional circumstances when confidentiality may be legally breached” (D2b). Unlike Irish mental health legislation, English mental health legislation also entitles families and carers “to information about the person with a mental disorder (unless the patient refuses the divulging of such information)” (E1),<sup>937</sup> gives families and carers “the right to appeal involuntary admission and treatment decisions” (E3),<sup>938</sup> and promotes the involvement of families and carers “in the development of mental health policy, legislation and service-planning” (E5).<sup>939</sup>

These areas, relating to privacy and disclosure of information, are, arguably, covered by other, non-mental health legislation in both England and Ireland, in, for example, English common law on breach of confidence, England’s Data Protection Act 1998 and Freedom of Information Act 2000, and Ireland’s Data Protection Act 1998 and Freedom of Information Act 1997.<sup>940</sup> The WHO Resource Book, which forms the focus of the analysis in this thesis, however, presents a “Checklist for Mental Health *Legislation*” (my italics), implicitly suggesting that these matters should be covered in dedicated mental health legislation. This is consistent with the idea that the rights of the mentally ill require *additional* legislative protection, based on strong historical evidence that general legislation does not have sufficient regard for the particular violations of rights and impairments of capacity occasionally experienced by the mentally ill (Section 2.2).

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<sup>937</sup> MHA 1983, section 132(4); MHA 1983, section 132A(3), amended by MHA 2007, schedule 3, paragraph 30.

<sup>938</sup> E3: MHA 1983; section 11(4).

<sup>939</sup> E5: MHA 2007, section 8; amending MHA 1983, section 118(2B)).

<sup>940</sup> England: Carey, 2009. Ireland: Kelleher, 2006.

Overall, then, Irish mental health legislation places explicit emphasis on privacy (consistent with dignity and autonomy), while English legislation places explicit emphasis on circumstances under which families or carers can become involved in care and/or access information (consistent with a more paternalistic approach). This difference between the jurisdictions reflects the enhanced involvement of families in mental health care in England compared to Ireland: in Ireland, a family member may apply for involuntary detention of another family member<sup>941</sup> but their formal involvement in the process ends there.

In England, by contrast, the MHA 1983, permitted the patient's "nearest relative" to make an application for detention for "assessment"<sup>942</sup>, "treatment"<sup>943</sup> or guardianship;<sup>944</sup> prevent the making of an application detention for "treatment"<sup>945</sup> or guardianship<sup>946</sup> by an "approved social worker"; apply to a tribunal on the patient's behalf, under certain circumstances;<sup>947</sup> and make "an order for discharge" from detention for assessment,<sup>948</sup> treatment<sup>949</sup> or guardianship.<sup>950</sup> The MHA 2007 introduced certain changes in relation to the "nearest relative" (Section 3.4.4),<sup>951</sup> but the role remains substantially more important than the role of the relative in Irish legislation, thus, arguably, necessitating

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<sup>941</sup> MHA 2001, section 9(8).

<sup>942</sup> MHA 1983, sections 2 and 11.

<sup>943</sup> MHA 1983, sections 3 and 11.

<sup>944</sup> MHA 1983, sections 7 and 11.

<sup>945</sup> MHA 1983, sections 3 and 11(4).

<sup>946</sup> MHA 1983, sections 7 and 11(4).

<sup>947</sup> MHA 1983, section 66(1)(ii).

<sup>948</sup> MHA 1983, section 23(2)(a).

<sup>949</sup> MHA 1983, section 23(2)(a).

<sup>950</sup> MHA 1983, section 23(2)(b).

<sup>951</sup> MHA 2007, section 23(2); amending MHA 1983, section 29(1); MHA 2007, section 23(4); amending MHA 1983, section 29(2).



the English legislation's clear articulation of circumstances under which the "nearest relative" can access information.

### **6.3.3 Protection of vulnerable groups**

Mental health legislation in both England and Ireland fails to meet the majority of WHO requirements in relation to "protection of vulnerable groups" (Z): English legislation meets five of the 13 criteria in this section, while Irish legislation meets just three (Section 5.3.3.3) (Table 1). The standards met in English legislation are met through general rather than specific provisions; with regard to limiting "involuntary placement of minors in mental health facilities to instances where all feasible community alternatives have been tried" (Z1, minors), for example, the MHA 2007 includes "minimising restrictions on liberty" as a matter to be addressed in preparing the "statement of principles" for the Code of Practice.<sup>952</sup> Only to this rather generalized and limited extent can English legislation be deemed to meet this standard.

Irish legislation is slightly more specific in relation to this standard, stating that a "child" (aged under eighteen years)<sup>953</sup> can be involuntarily admitted if, amongst other criteria, "the child requires treatment which he or she is unlikely to receive unless an order is made under this section" (Z1, minors).<sup>954</sup> Irish legislation does not, however, meet other requirements in relation to children, while English legislation emphasizes

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<sup>952</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(c).

<sup>953</sup> MHA 2001, section 2(1).

<sup>954</sup> MHA 2001, section 25(1)(b).

age-appropriate facilities (Z2b, minors)<sup>955</sup> and requires that services “take the opinions of minors into consideration” (Z4, minors).<sup>956</sup>

English legislation also meets WHO standards in relation to equality for women (Z1, women)<sup>957</sup> and avoidance of discrimination against minorities (Z1, minorities),<sup>958</sup> while Irish legislation meets requirements for equality (Z1, women)<sup>959</sup> and privacy for women (Z2a, women).<sup>960</sup> Again, most of these requirements are met through statements of general principle rather than specific provision for named groups, in both jurisdictions.

Overall, legislation in both jurisdictions meets a minority of WHO standards in relation to “protection of vulnerable groups” (Z), and most of the standards which are met are met through statements of general principles (e.g. the MHA 2007’s list of matters to be addressed in preparing the “statement of principles” for the Code of Practice),<sup>961</sup> along with a small number of specific provisions in each jurisdiction (e.g. English legislation’s emphasis on age-appropriate facilities for minors).<sup>962</sup> These disparities reflect English legislation’s greater overall emphasis on specific matters to be addressed in preparing the “statement of principles” for the Code of Practice,<sup>963</sup> and Ireland’s greater reliance on sets of rules, such as the Mental Health Commission’s *Code of*

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<sup>955</sup> MHA 2007, section 31(3); amending MHA 1983, section 131.

<sup>956</sup> MHA 1983, section 131(2); Department of Health, 2008: pp. 326-354; Bowen, 2007; pp. 160-163.

<sup>957</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(e).

<sup>958</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B)(e).

<sup>959</sup> MHA 2001, section 4(3).

<sup>960</sup> MHA 2001, section 4(3).

<sup>961</sup> MHA 2007, section 8.

<sup>962</sup> MHA 2007, section 31(3); amending MHA 1983, section 131.

<sup>963</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B).

*Practice Relating to Admission of Children under the Mental Health Act 2001*,<sup>964</sup>

although there is *no* “legal duty on persons working in the mental health services to comply with codes of practice”.<sup>965</sup>

Overall, both jurisdictions are weak on the “protection of vulnerable groups” (Z), although English mental health legislation is marginally stronger in this respect.

Interestingly, notwithstanding legislation’s failure to meet specific WHO requirements in relation to vulnerable groups, there is still *overall* evidence of a welfare-based or paternalist approach to the interpretation of mental health legislation in courts and mental health services, especially in Ireland (see Sections 4.4.6, 5.4 and 7.3).

#### **6.3.4 Specific aspects of clinical management**

There are significant differences between England and Ireland in terms of specific aspects of the management of individuals with mental illness. For example, while both jurisdictions fail to meet many of the WHO requirements in relation to emergency situations (M), English legislation, unlike Irish legislation, makes explicit provision for “emergency treatment for patients lacking capacity or competence” if “the treatment needs to be given in order to prevent harm” (M1).<sup>966</sup> English legislation, unlike Irish

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<sup>964</sup> Z2a, minors: Mental Health Commission, 2006; p. 12. Z2b, minors: pp. 12-13. Z3, minors: Certain protections are covered in the *Code of Practice* (pp. 22-23), but these do not include the WHO requirement that law “ensure that all minors have an adult to represent them”. Z4, minors: Certain issues regarding the child’s own views are mentioned in the *Code* in relation to voluntary child patients (p. 22), but the law does not fulfil the WHO requirement “to take the opinions of minors into consideration on all issues affecting them”.

<sup>965</sup> Mental Health Commission, 2006; p. 9.

<sup>966</sup> MHA 2007, section 35(1); amending MHA 1983, section 64G. Emergency admission is addressed in MHA 1983, section 4.

legislation,<sup>967</sup> also requires that a doctor providing the requisite second opinion and “two other persons” involved in treatment must be satisfied the patient has capacity to consent to psychosurgery (O3a).<sup>968</sup>

By contrast, Irish legislation meets five of the six WHO requirements in relation to “seclusion and restraint” (P) while English legislation meets none of them (Section 5.3.2.3). Ireland’s relatively high compliance is attributable to the MHA 2001’s requirement that seclusion and restraint only be used in accordance with rules made under the Act, violation of which constitutes an offence (P1).<sup>969</sup> The rules accord so precisely with the WHO requirements (in content and phraseology),<sup>970</sup> it appears reasonable to hypothesise that the WHO guidelines influenced the development of the Irish rules. English legislation’s failure to meet any WHO standards in relation to seclusion and restraint may also reflect the relatively greater role that considerations of risk and safety played in the evolution of mental health legislation in England<sup>971</sup> compared to Ireland, where human rights were the overwhelmingly dominant driver of change.

### **6.3.5 Competence and capacity**

The largest single difference between English and Irish mental health legislation relates to competence and capacity. Irish mental health law, for example, does not define

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<sup>967</sup> MHA 2001, section 58(3)(a).

<sup>968</sup> MHA 1983, as amended by the MHA 2007, section 57(2).

<sup>969</sup> MHA 2001, section 69(1).

<sup>970</sup> P2: Mental Health Commission, *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*, Dublin: Mental Health Commission, 2009; p. 15. P3: pp. 19, 27. P5 and 6: pp. 1-45.

<sup>971</sup> Expert Committee, 1999; p. 70.

“competence” and “capacity” (F2), and does not meet two of the three WHO requirements regarding non-protesting patients (H1 and H2) (Table 1). By contrast, England’s MCA 2005 makes provision for admission (H1) and treatment (H2)<sup>972</sup> of incapacitated, non-protesting patients although, unlike Irish legislation,<sup>973</sup> it does not clearly state that patients who object must be discharged unless criteria for involuntary detention are met (H3). Owing to its more extensive capacity legislation, England also meets two of the three WHO requirements regarding “clinical and experimental research” involving individuals “unable to give informed consent” (Q2a<sup>974</sup> and Q2b<sup>975</sup>); Ireland meets none of these requirements.

The two key problems in Ireland are that (a) the MHA 2001 includes incapacitated, non-protesting patients under the definition of “voluntary patient”, which does not include a requirement for capacity;<sup>976</sup> and (b) there is no dedicated capacity legislation. In Ireland, dedicated capacity legislation is currently being developed (in the form of the Mental Capacity and Guardianship Bill 2008) but has not yet been introduced.<sup>977</sup> These factors account in large part for the difference between England and Ireland in relation to competence and capacity, and reflect the limited impact of human rights standards in Ireland in relation to capacity, although this may be remedied soon.<sup>978</sup>

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<sup>972</sup> MCA 2005, as amended by the MHA 2007, schedules A1 and 1A.

<sup>973</sup> MHA 2001, sections 2(1) and 23.

<sup>974</sup> MCA 2005, sections 30-34. Bowen, 2007; p. 188.

<sup>975</sup> MCA 2005, section 31(4-5).

<sup>976</sup> MHA 2001, section 2(1).

<sup>977</sup> Leonard & McLaughlin, 2009.

<sup>978</sup> Joint Committee on Justice, Defence and Equality, 2012.

## 6.4 Conclusions

There are notable dissimilarities between English and Irish mental health legislation in relation to WHO human rights standards. These dissimilarities relate, in the first instance, to the principles and objectives of mental health legislation, where the differences are chiefly attributable to English legislation's articulation of specific matters to be addressed in preparing the "statement of principles" for the Code of Practice,<sup>979</sup> and Ireland's reliance on the Constitution of Ireland<sup>980</sup> in this regard, reflecting the fact that responses to human rights discourse are shaped in part by the pre-existing legal landscape in each jurisdiction.

There is also significant dissimilarity between the two jurisdictions in the balance between privacy and disclosure of information, and measures to protect vulnerable groups. Both jurisdictions meet a minority of WHO standards in relation to vulnerable groups and only do so in piecemeal fashions, through articulation of general principles rather than specific provisions.

Differences between the jurisdictions are also apparent in relation to more specific aspects of clinical management, with English legislation (in contrast to Irish) making specific provision for emergency treatment, and Irish legislation (in contrast to English) requiring that seclusion and restraint only be used in accordance with legally-binding rules. This difference reflects Ireland's apparently greater engagement with WHO standards in devising rules for seclusion and restraint, and the relatively greater

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<sup>979</sup> MHA 2007, section 8; amending MHA 1983, section 118(2B).

<sup>980</sup> Hogan & Whyte, 2003.

importance attached to public safety in the development of new legislation in England compared to Ireland, where human rights concerns were the dominant driver of reform.

Finally, there are significant differences between the two jurisdictions in relation to competence and capacity, where Ireland's notable deficiencies are attributable to the inclusion of incapacitated, non-protesting patients under the definition of "voluntary patient" and the absence of dedicated capacity legislation.

Notwithstanding these dissimilarities, there are also substantial similarities between the two jurisdictions relating to definitions of mental disorder (B), voluntary admission and treatment (G), involuntary admission (I, J), proxy consent for treatment (K), involuntary treatment in community settings (L), determinations of mental disorder (N), oversight and review mechanisms (R), police responsibilities (S), social security (X), civil issues (Y) and offences and penalties (AZ) (Table 1). These strong similarities, in combination with the dissimilarities, highlight several important themes which recur in various ways throughout this thesis.

First, it is apparent that human rights concerns have played a significant role in recent revisions of mental health laws in both England and Ireland, albeit that the outcome of this process is slightly different in the two jurisdictions, owing, at least in part, to their differing pre-existing legal landscapes. The impact of the ECHR and its associated case-law is, however, apparent in both. This important "European dimension" to recent changes is explored in greater depth in Section 7.2 of this thesis.

Second, both jurisdictions present slightly different mixes of approaches which prioritise autonomy and approaches which prioritise paternalism or welfare-based concerns. England's failure to meet any WHO standards in relation to seclusion, for example, appears to reflect the greater role that public safety played in the evolution of mental health legislation in England compared to Ireland, where rules governing seclusion are significantly more compliant with WHO standards. By way of contrast, the fact that voluntary patients do not need to possess capacity in Ireland points to a distinctly paternalistic approach to voluntary patients, compounded by a lack of dedicated capacity legislation in Ireland (unlike England). This contrast between the jurisdictions is likely attributable to the especially strong paternalistic or welfare-based tradition in Irish mental health law.<sup>981</sup>

Third, neither jurisdiction makes strong or consistent reference to dignity or human capabilities in their mental health legislation or associated case-law. This is a point of significant similarity between the two jurisdictions: while mental health law in both England and Ireland provides a certain amount of support for certain human rights and dignity in various specific ways, neither jurisdiction places explicit, strong or overall emphasis on dignity, the exercise of human capabilities, or promotion of broader social participation for the mentally ill in their mental health law.

This situation is explored in greater depth throughout the remainder of this thesis. The next chapter commences this task by exploring the European dimension to recent developments in mental health law, examining key values in relation to human rights in mental health (especially dignity), and examining the potential relevance of a "third

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<sup>981</sup> Whelan, 2009; pp. 26-31.



wave” of human rights in mental health.<sup>982</sup>

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<sup>982</sup> Klug, 2000.

## **Chapter 7**

### **Human rights and mental health law: an evolving relationship**

#### **7.1 Introduction**

This thesis is centrally concerned with the protection of human rights through mental health law in England and Ireland. The considerations of human rights and mental health law in England and Ireland presented in Chapter 5 highlighted areas of high, medium and low compliance with WHO human rights standards. Chapter 6 compared England with Ireland and identified areas of similarity and dissimilarity between the jurisdictions with regard to the protection of human rights through mental health legislation.

Against the background of those analyses, the present chapter examines three key themes which have informed the emerging emphasis on human rights in mental health law in England and Ireland over the past decade, and are likely to continue to inform change.

First, Section 7.2 examines the European dimension to human rights protections in mental health law and policy, recognizing the role of the ECHR and related case-law in shaping mental health law, and the emergent role of the EU in shaping mental health policy, with a strong emphasis on human rights. Second, Section 7.3 explores certain key values underpinning these developments, with particular emphases on dignity and

human capabilities, as well as paternalistic or welfare-based approaches to interpreting mental health legislation. Dignity is chosen as a particular focus owing to its long-standing centrality in human rights discourse<sup>983</sup> and, in particular, the CRPD, which includes “respect for inherent dignity” as a key principle.<sup>984</sup> Third, Section 7.4 examines the potential relevance of a “third wave” of human rights in the context of the mentally ill.<sup>985</sup>

## **7.2 The European dimension and mental health policy**

There is a diverse range of mental health traditions, policies and laws across Europe.<sup>986</sup> This diversity may account for the fact that the EU has become involved in mental health policy only relatively recently and, even then, in a gradual, incremental fashion.<sup>987</sup> The most significant EU involvement in this area to date occurred in 2005, when the Health and Consumer Protectorate Director-General of the European Commission published a Green Paper on mental health and launched a consultation process.<sup>988</sup> This led to the establishment of an EU “Consultative Platform”<sup>989</sup> and, in

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<sup>983</sup> Edmundson, 2004; Ishay, 2004; Hunt, 2007.

<sup>984</sup> CRPD, article 3.

<sup>985</sup> Klug, 2000; 2001.

<sup>986</sup> Conrady, J., Roeder, T., “The legal point of view”, in Kallert, T.W. and Torres-González, F. (eds), *Legislation on Coercive Mental Health Care in Europe* (pp. 349-374), Frankfurt: Peter Lang, 2006.

<sup>987</sup> Kelly, B.D., “The emerging mental health strategy of the European Union”, *Health Policy*, 2008, 85, 60-70.

<sup>988</sup> Health and Consumer Protectorate Director-General. *Improving the Mental Health of the Population: Towards a Strategy on Mental Health for the European Union*, Brussels: European Commission, 2005.

<sup>989</sup> Kelly, B.D., “The emerging mental health strategy of the European Union”, *Health Policy*, 2008, 85, 60-70.

2008, the *European Pact for Mental Health and Well-being*, published by the EU with the WHO.<sup>990</sup>

The issue of human rights emerged as an especially important concern throughout this process, owing to both the existence of legal mechanisms whereby individuals with mental disorder may be detained in psychiatric facilities and evidence of social exclusion of the mentally ill.<sup>991</sup> The strong emphasis on human rights is consistent with the EU's involvement in others areas of law-making,<sup>992</sup> including health law,<sup>993</sup> and the EU *Charter of Fundamental Rights* (2000). Against this background, the EU's *European Pact for Mental Health and Well-being* places especially strong emphases on promoting social inclusion of the mentally ill and protecting human rights, including economic and social, as well as civil and political, rights.<sup>994</sup>

The EU's emphasis on human rights in mental health policy has remained consistent in the years since the *European Pact for Mental Health and Well-being* was published in 2008. In September 2011, the EU published a "paper to present first outcomes of the implementation of the European Pact for Mental Health and Well-being", titled *Mental*

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<sup>990</sup> EU, *European Pact for Mental Health and Well-being*, Brussels: EU, 2008.

<sup>991</sup> Gillon, R., *Philosophical Medical Ethics*, London: Wiley, 1997; Kelly, 2005; Pilgrim, D., "New 'mental health' legislation for England and Wales", *Journal of Social Policy*, 2007, 36, 79–95.

<sup>992</sup> Hervey, T.K., McHale, J.V., *Health Law and the European Union*, Cambridge: Cambridge University Press, 2004; Jans, J.H., De Lange, R., Prechal, S., Widdershoven, R., *Europeanisation of Public Law*, Groningen: Europa Law Publishing, 2006

<sup>993</sup> Hervey & McHale (2004) identify "rights" as a key "thematic concern" in the EU's involvement in health law (pp. 391-392), based on the importance the EU accords to "rights-based approaches" in relation to "access to healthcare services" (p. 156) and health information privacy (pp. 163-166), amongst other areas.

<sup>994</sup> EU, 2008.

*Well-being: For a Smart, Inclusive and Sustainable Europe*.<sup>995</sup> This publication reported on the proceedings of five “thematic conferences in each of the priority areas” identified by the EU, between 2009 and 2011. The EU priority areas were depression and suicide (conference in Budapest, 2009), mental health of young people (Stockholm, 2009), mental health in work-places (Berlin, 2011), mental health of older people (Madrid, 2010) and social inclusion (Lisbon, 2010). These conferences all maintained the EU’s emphasis on human rights as a key element in mental health policy and law in all of these contexts.<sup>996</sup>

This emphasis on human rights in the context of health is consistent with the UDHR which outlines a “right to a standard of living adequate for [...] health and well-being [...] including food, clothing, housing and medical care and necessary social services”.<sup>997</sup> Similarly, article 12 of the UN’s *International Covenant on Economic, Social and Cultural Rights* outlines a right to “the enjoyment of the highest attainable standard of physical and mental health”, to be advanced “progressively, consistent with other specific programmes”.<sup>998</sup> The ECHR, by contrast, does not outline any rights to health or health-care, although, like the UDHR,<sup>999</sup> it does articulate certain other rights of particular relevance to *mental* health-care, including the right to liberty.<sup>1000</sup>

As discussed in earlier chapters of this thesis, the emphasis on human rights in recent revisions of mental health law in England and Ireland is demonstrably consistent with

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<sup>995</sup> EU, *Mental Well-being: For a Smart, Inclusive and Sustainable Europe*, Brussels: EU, 2011.

<sup>996</sup> EU, 2011; p. 13.

<sup>997</sup> UDHR, article 25(1).

<sup>998</sup> This text was drafted in the 1960s (Ishay, 2004; p. 224).

<sup>999</sup> UDHR, article 3.

<sup>1000</sup> ECHR, article 5.

the EU's emphasis on rights and the ECHR. In England, this emphasis on rights finds particularly strong roots in the Human Rights Act 1998, implemented explicitly in order to give further effect to the ECHR,<sup>1001</sup> and the Richardson Committee's emphasis on protecting and promoting rights through the MHA 2007, as well as public safety (Chapter 3).<sup>1002</sup>

In Ireland, human rights were the sole key driver of reform, as reflected in the Human Rights Commission Act 2000 and European Convention on Human Rights Act 2003.<sup>1003</sup> Regarding mental health law in particular, both the government<sup>1004</sup> and the Law Society<sup>1005</sup> acknowledged Ireland's non-compliance with the ECHR, and, in 2000, an Irish applicant argued in the European Court of Human Rights that the lack of an automatic, independent review of psychiatric detention breached ECHR rights (Chapter 4).<sup>1006</sup> These developments contributed in large part to the emergence of the MHA 2001 and significant reform of Irish mental health services, with increased emphasis on human rights.<sup>1007</sup>

The EU's strong emphasis on human rights in *both* mental health law and policy merits particular attention, especially in light of the finding in this thesis that mental health legislation in England and Ireland provides robust protection for certain rights (e.g. right to liberty) but not others (e.g. economic and social rights) (Chapter 5). Does mental

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<sup>1001</sup> Human Rights Act 1998, preamble.

<sup>1002</sup> Expert Committee, 1999; p. 120.

<sup>1003</sup> Bacik, 2001.

<sup>1004</sup> Department of Health, 1995; p. 13.

<sup>1005</sup> Law Reform Committee, 1999.

<sup>1006</sup> *Croke v Ireland* (2000) ECHR 680.

<sup>1007</sup> Mental Health Commission, *A Recovery Approach Within the Irish Mental Health Services*, Dublin: Mental Health Commission, 2008.

health policy have a particular role to play in protecting those rights which are not adequately protected through legislation?

The *Oxford Reference English Dictionary* defines a “policy” as “a course or principle of action adopted or proposed by a government, party, business, or individual etc.”<sup>1008</sup>

*Mental health* policy is an especially broad term:

The term “mental health policy” (in most developed societies including Britain) at the turn of the twenty-first century, refers to legal arrangements, policy directives and service investments ...which have accumulated over the past hundred years. It is partly about the control of mad behaviour, partly about promoting well-being, partly about ameliorating distress, and partly about responding to dysfunction.<sup>1009</sup>

Mental health policy is, then, a complex concept, commonly involving multiple actors and layers of decision-making which are often “difficult to encapsulate”.<sup>1010</sup> In the midst of this complex matrix, however, it is readily apparent that mental health policy is inextricably linked with mental health legislation: like the EU, the WHO argues that “mental health legislation is essential to complement and reinforce mental health policy” and “provides a legal framework for achieving the goals of mental health policy”.<sup>1011</sup>

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<sup>1008</sup> Pearsall & Trumble, 1996; p. 1120.

<sup>1009</sup> Rogers, A., Pilgrim, D., *Mental Health Policy in Britain (Second Edition)*, Basingstoke: Palgrave, 2001; p. 226.

<sup>1010</sup> Lester, H., Glasby, J., *Mental Health Policy and Practice*, Basingstoke: Palgrave MacMillan, 2006; p. 18

<sup>1011</sup> WHO, *Improving Health Systems and Services for Mental Health*, Geneva: WHO, 2009; p. 12.

Legislation is especially important in the context of *mental* health because “the psychiatric system is a system of institutions, but also a system of legal relations, where clinical power is conferred on mental health professionals”.<sup>1012</sup> This close relationship between law and policy can generate substantial tensions: as England’s MHA 2007 evolved, for example, the Joint Parliamentary Scrutiny Committee on the English Mental Health Bill 2004 stated that the primary purpose of the legislation was to improve mental health services, while the government responded that its primary purpose was to bring people under compulsion.<sup>1013</sup>

Consistent with these tight links between mental health law and policy, this thesis argues that, just as European-level factors (e.g. ECHR) have had a substantial influence on mental health *law* in England and Ireland (Chapters 3 and 4), European-level actors (e.g. EU) are now starting to have similar influence on policy too.<sup>1014</sup> For the most part, this involvement in policy is strongly informed by human rights concerns: in 2011, for example, the EU reported on the “EU Compass for Action of Mental Health and Well-being”,<sup>1015</sup> an online resource aimed at influencing national mental health policy in directions outlined by the EU, with a strong emphasis on human rights in *both* law and

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<sup>1012</sup> Fennell, P., “Mental health law: history, policy and regulation”, in Gostin, L., McHale, J., Fennell, P., Mackay, R.D. and Bartlett, P. (eds), *Principles of Mental Health Law and Policy* (pp. 3-70), Oxford: Oxford University Press, 2010; p. 68.

<sup>1013</sup> Fennell, P., “Mental health law: history, policy and regulation”, in Gostin, L., McHale, J., Fennell, P., Mackay, R.D. and Bartlett, P. (eds), *Principles of Mental Health Law and Policy* (pp. 3-70), Oxford: Oxford University Press, 2010; p. 70.

<sup>1014</sup> Kelly, B.D., “The emerging mental health strategy of the European Union”, *Health Policy*, 2008, 85, 60-70.

<sup>1015</sup> [http://ec.europa.eu/health/mental\\_health/eu\\_compass/index\\_en.htm](http://ec.europa.eu/health/mental_health/eu_compass/index_en.htm) (website verified 10 February 2013).



policy.<sup>1016</sup> Taken together, these various initiatives will hopefully increase consistency between law and policy, through a shared emphasis on human rights.

Increased EU involvement in mental health policy is consistent with the EU's broader influence on general health policy at national level, an increasing influence which is mediated through "a complex and dynamic inter-twinning of top-down and bottom-up processes... a soft variant, a transfer of ideas and of the ways problems are perceived".<sup>1017</sup> This has resulted in increased EU involvement in health issues ranging from food safety<sup>1018</sup> to bioethics,<sup>1019</sup> and, increasingly, mental health law and policy.

Against this backdrop, it is possible that certain rights of the mentally ill which are poorly protected through mental health legislation (e.g. economic and social rights) might be addressed through mental health policy, which is also increasingly informed by human rights considerations, as emphasised by the EU and WHO. The position of voluntary patients, for example, is poorly addressed in current mental health legislation, which places strong emphasis on detained patients. Perhaps a mental health policy that placed greater emphasis on the importance of effective mental health services for *all* patients would provide greater support for the economic and social rights and dignity of

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<sup>1016</sup> EU, 2011; p. 18.

<sup>1017</sup> Steffen, M., Lamping, W., Lehto, J., "Introduction: the Europeanization of health policies", in Steffen, M. (ed), *Health Governance in Europe* (pp. 1-17), London: Routledge, 2005; p. 6. See also: Hervey & McHale, 2004; McKee, M., MacLehose, L., Nolte, E., "Health and enlargement", in McKee, M., MacLehose, L. and Nolte, E. (eds), *Health Policy and European Union Enlargement* (pp. 1-5), Berkshire, England: McGraw-Hill/Open University Press, 2004.

<sup>1018</sup> Clergeau, C., "European food safety policies", in Steffen, M. (ed), *Health Governance in Europe* (pp. 113-133), London: Routledge, 2005.

<sup>1019</sup> Lafond, F.D., "Towards a European bioethics policy?", in Steffen, M. (ed), *Health Governance in Europe* (pp. 152-173), London: Routledge, 2005.

voluntary patients, who constitute the strong majority of those accessing mental health services.<sup>1020</sup>

Protecting the economic and social rights of the mentally ill is an important task: there is strong evidence that individuals with mental illness in England, Ireland and elsewhere are at substantially increased risk of poverty, homelessness, unemployment, poor physical health and social exclusion, compared to individuals without mental illness.<sup>1021</sup> This situation is attributable to both the historical exclusion of the mentally ill from full participation in society, and the fact that individuals with mental illness occasionally lack capacity or opportunity adequately to assert their rights for themselves.<sup>1022</sup>

These factors render it even more important that there are strong protections for all human rights, including economic and social rights, amongst the mentally ill. While both England and Ireland provide free legal representation to help protect the right to liberty for detained patients at appeals against detention, this representation is generally concerned only with the right to liberty (and, to a certain extent, treatment), and patients do not always benefit from legal representation or assertive advocacy in respect of other rights, such as economic and social rights.

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<sup>1020</sup> Kelly et al, 2004; p. 67; McSherry, B., “The right of access to mental health care: voluntary treatment and the role of law”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 379-396), Oxford and Portland, Oregon: Hart Publishing, 2010.

<sup>1021</sup> Kelly, 2005; Scull, 2005; Kelly, B.D., “Social justice, human rights and mental illness”, *Irish Journal of Psychological Medicine*, 2007, 24, 3-4; p. 3. See also: Callard, F., Sartorius, N., Arboleda-Flórez, K., Bartlett, P., Helmchen, H., Stuart, H., Taborda, J., Thornicroft, G., *Mental Illness, Discrimination and the Law: Fighting for Social Justice*, Chichester: John Wiley and Sons Ltd., 2012.

<sup>1022</sup> Sayce, 2000.

As a result, while this thesis demonstrates that mental health legislation provides protections for certain human rights (e.g. right to liberty) (Chapter 5), and while other areas of law such as human rights law may provide protection for other rights (e.g. right to life) (Section 3.3.2.4), there are still significant deficits in the protection of certain other rights amongst the mentally ill, such as economic and social rights, as envisioned by the WHO.<sup>1023</sup>

This deficit might be remedied, at least in part, if the emphasis that the ECHR and EU place on human rights in law and policy was complemented by an emphasis on human dignity, a concept which is central to the CRPD but markedly absent from the processes leading to legislative reform in England and Ireland, and receives scant attention in mental health legislation in both jurisdictions. As argued in Chapter 1, the enhancement of dignity is strongly linked with the opportunity to exercise human capabilities,<sup>1024</sup> but the idea that mental health law might fundamentally aim to facilitate patients in exercising such capabilities does not feature significantly in either jurisdiction. While legislation in England and Ireland does provide free legal aid and advocacy services to certain patients (e.g. detained patients) in relation to specific matters (e.g. appealing detention orders), it does not provide robust support for exercise of capabilities more broadly (e.g. in relation to housing, employment, social participation, and various other issues of relevance to voluntary patients).

Against the background of these deficits in mental health legislation, recent EU initiatives underpinning the importance of human rights in mental health *policy* are greatly to be welcomed. There is strong historical evidence to demonstrate the potential

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<sup>1023</sup> WHO, 2005.

<sup>1024</sup> Seedhouse and Gallagher, 2002; Nussbaum, 2011.

of policy, rather than law, to effect transformational change in mental health services: in Ireland, for example, mental health legislation did not change significantly between 1945 and 2006, and yet, between 1963 and 2003, the number of psychiatric inpatients decreased by 81.5% (from 19,801 to 3,658).<sup>1025</sup> This was a result of changes in policy rather than law, and while it raises unresolved issues about the right to treatment (see Section 8.4.1), it nonetheless demonstrates the power of policy rather than law to increase the liberty afforded to the mentally ill.<sup>1026</sup>

That is not to suggest that legal protections of the right to liberty should be neglected, but rather that an exclusive focus on liberty alone “fails to address or even acknowledge a range of broader social injustices and denials of human rights commonly experienced by individuals with enduring mental illness”.<sup>1027</sup> Other areas of public policy, such as social policy and equality policy,<sup>1028</sup> may be well-suited to protecting some of these rights,<sup>1029</sup> but mental health policy is now also recognised by the EU and WHO as a uniquely important vehicle for protecting and promoting rights amongst the mentally ill.

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<sup>1025</sup> Kelly, B.D., “Penrose’s Law in Ireland: an ecological analysis of psychiatric inpatients and prisoners”, *Irish Medical Journal*, 2007, 100, 373-374. “Penrose’s Law” suggests that as psychiatric inpatient populations decline, prison populations rise. In Ireland, however, the psychiatric inpatient population declined by 16,143 between 1963 and 2003, and the prison population rose by just 16.4% of this number (2,642); even if all of the increase in the prison population was attributable to discharged psychiatric patients, there was still a net “liberation” of 13,501.

<sup>1026</sup> Department of Health, *The Psychiatric Services: Planning for the Future*, Dublin: Stationery Office, 1984. See also: Viney, M., “Mental illness”, *Irish Times*, 1968, 23–30 October.

<sup>1027</sup> Kelly, B.D., “Social justice, human rights and mental illness”, *Irish Journal of Psychological Medicine*, 2007, 24, 3-4; p. 3. See also: Callard et al, 2012; p. 185.

<sup>1028</sup> Sayce, 2000.

<sup>1029</sup> Alwan A., “Foreward”, in WHO, *Mental Health and Development* (p. vii), Geneva: WHO, 2010.

Findings from this thesis confirm that economic and social rights, amongst others, are not adequately protected through mental health law alone (Section 5.3.3.5). It is likely that mental health policy, informed by an awareness of human rights as outlined by the ECHR and EU, can help to remedy these deficits, and, most importantly, help promote the dignity and capabilities of involuntary *and* voluntary users of mental health services.

### 7.3 Key values underpinning human rights

Chapter 5 of this thesis presented a consideration of mental health legislation within a human rights-based framework and Section 7.2 demonstrated an ongoing emphasis on human rights at European level, in terms of both mental health law and policy. It is important to emphasise that rights-based approaches to any matter, including mental health-care, occur in specific social and political contexts, and these contexts may limit opportunity to articulate and observe such rights. The *legal* observance of many civil rights, for example, requires relatively ready access to an independent court system.<sup>1030</sup>

Mental health legislation may meet this requirement, at least in part, by ensuring access to mental health tribunals, free legal representation and advocacy,<sup>1031</sup> but these measures presume the *existence* of an independent court system and *availability* of public resources to fund legal representation and advocacy for the underprivileged. On

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<sup>1030</sup> Osiatyński, 2009; p. 103.

<sup>1031</sup> In England and Ireland, detained individuals have free legal representation at mental health tribunals. In England, the MHA 2007 requires that the “appropriate national authority shall make such arrangements as it considers reasonable to enable persons (“independent mental health advocates”) to be available to help qualifying patients”, although not all patients qualify (MHA 2007, section 30(2), amending MHA 1983, section 130A(1)).

this basis, while human rights themselves may be “universal”,<sup>1032</sup> the effectiveness of human rights-based approaches to specific issues, such as mental health care, relies on a set of assumptions which all societies may not meet; i.e. the existence of an independent court system, clear legislative provisions relating to mental illness, democratic governance and the (related) likelihood that human rights concerns will inform change.<sup>1033</sup>

Many of these requirements reflect other human rights: the necessity for an independent court system, for example, is underlined in the ECHR which states that “in the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law”.<sup>1034</sup> In addition, “everyone who is deprived of his liberty by arrest or detention” shall be entitled to “take proceedings by which the lawfulness of his detention shall be decided speedily by a court”.<sup>1035</sup> On this basis, the rights that mental health legislation may seek to protect (e.g. right to liberty) are inextricably linked with other rights (e.g. right to access a court system).

The situation is rendered more complex in countries where a rights-based approach to mental health care may not rest easily with certain societal practices and cultural beliefs, especially countries with “markedly different resource, professional and cultural”

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<sup>1032</sup> UDHR, preamble; Cassese, 1992.

<sup>1033</sup> Prins, H., “Can the law serve as the solution to social ills?”, *Medicine, Science and Law*, 1996, 36, 217-220; Richardson, G., “Rights-based legalism: some thoughts from the research”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 181-202), Oxford and Portland, Oregon: Hart Publishing, 2010; Rose, N., “Unreasonable rights: mental illness and the limits of law”, *Journal of Law and Society*, 1985, 12, 199-218.

<sup>1034</sup> ECHR, article 6(1).

<sup>1035</sup> ECHR, article 5(4).

contexts than the “economically advantaged countries” in which human rights discourse is most prevalent (e.g. UK, Ireland, US).<sup>1036</sup> This emphasises the importance of human rights as *one element* within a broader approach to social justice, combined with political activity and social advocacy.<sup>1037</sup>

As discussed in Section 1.4, the idea of dignity is central to the idea of rights, and “there is arguably no human right which is unconnected to human dignity”.<sup>1038</sup> The idea of shared human capabilities is, in turn, central to the idea of dignity:

The fundamental, shared quality of human beings gives rise automatically to an irrebuttable presumption of human dignity, which attaches to individuals by virtue of their membership of the human species. An umbrella of rights may be justified as preventing interference with this general human dignity.<sup>1039</sup>

Dignity is the central value here, and Feldman writes that law can “provide a circumscribing circle of rights which, in some of their effects, help to preserve the field for a dignified life”.<sup>1040</sup>

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<sup>1036</sup> Bartlett, P., “Thinking about the rest of the world: mental health and rights outside the ‘first world’”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 397-418), Oxford and Portland, Oregon: Hart Publishing, 2010; pp. 397-398; Fennell, P., “Institutionalising the community: the codification of clinical authority and the limits of rights-based approaches”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 13-50), Oxford and Portland, Oregon: Hart Publishing, 2010.

<sup>1037</sup> Bartlett, 2010; pp. 417-418.

<sup>1038</sup> Feldman, 2002; p. 130.

<sup>1039</sup> Feldman, 2002; p. 129.

<sup>1040</sup> Feldman, 2002; p. 128.

The idea of dignity is important to *all* individuals with mental disorder and not just the minority who are subjected to involuntary detention and treatment.<sup>1041</sup> For the majority of patients, who engage voluntarily with mental health services, the key issue is *not* loss of dignity through violation of rights by mental health professionals or the state, but simple access to services: Petrilia notes that “access to care rather than protection from care is the dominant issue for most individuals” with mental illness in the US today.<sup>1042</sup> An approach which recognizes human dignity as a key value underpinning human rights permits a nuanced response to such a situation, aiming to achieve optimal observance of rights and, if not quite a right to medical care,<sup>1043</sup> at least a basic level of care consistent with human dignity.<sup>1044</sup>

There may, however, be tensions between differing approaches to dignity in mental health settings, especially when the individual in question lacks insight into their situation and, temporarily, lacks the capability to exercise their own rights or promote their own dignity.<sup>1045</sup> For example, an individual with schizophrenia, who is untreated, homeless and shouting at passers-by on the street is, by most objective standards, in an undignified position, but the individual may not perceive this indignity subjectively, owing to the effects of illness. An individual *without* schizophrenia in a similar position

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<sup>1041</sup> Kelly et al, 2004; p. 67.

<sup>1042</sup> Petrilia, J., “Rights-based legalism and the limits of mental health law”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 357-378), Oxford and Portland, Oregon: Hart Publishing, 2010; p. 377.

<sup>1043</sup> UDHR, article 25(1).

<sup>1044</sup> McSherry, B., “The right of access to mental health care: voluntary treatment and the role of law”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 379-396), Oxford and Portland, Oregon: Hart Publishing, 2010.

<sup>1045</sup> “Insight is the patient’s degree of awareness and understanding that they are ill. Patients may exhibit complete denial of their illness or may show some awareness that they are ill” (Kaplan, H.I., Sadock, B.J., *Concise Textbook of Clinical Psychiatry*, Baltimore: Williams and Wilkins, 1996; p. 11).



is more likely to perceive their situation differently, experience subjective indignity, and take remedial action.

This situation highlights both conceptualisations of dignity outlined by Beyleveld and Brownsword; i.e. “dignity as empowerment” and “dignity as constraint” (Section 1.4).<sup>1046</sup> The idea of “dignity as empowerment” focuses on advancing the individual’s autonomy, whereas “dignity as constraint” reflects the idea that “dignity represents an ‘objective value’ or good (reaching beyond the individual) such that, if an act violates this value, human dignity is compromised irrespective of whether the party so acting freely agrees to perform the act in question”.<sup>1047</sup> If the individual with mental disorder lacks insight into his or her situation, he or she may violate this shared, objective idea of dignity, possibly resulting in involuntary detention and treatment.

Feldman notes the importance of the objective aspect of dignity for “people who lack the capacity to cultivate the subjective aspect of dignity”, noting that “very young children and patients in a persistent vegetative state can be regarded as having intrinsic human dignity in this objective sense, in that responsible beings owe a moral, and often a legal, duty to have regard to their interests and rights when making decisions affecting their welfare”.<sup>1048</sup>

The objective conceptualisation of dignity may, however, be interpreted with excessive paternalism, and this, in turn, points a broader problem with legislation-based solutions

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<sup>1046</sup> Beyleveld & Brownsword, 2001; p. vii.

<sup>1047</sup> Beyleveld & Brownsword, 2001; p. 34.

<sup>1048</sup> Feldman, 2002; p. 127.

to problems experienced by individuals with mental disorder who have reduced insight into their own mental state or behaviour:

The enlightenment rule of law takes the autonomous, fully rational self-determining person as its subject... The problem created by the exclusion of people who lack rationality is resolved by welfare principles and best interest determinations. Welfare and best interests principles characterise people who lack rationality as wholly dependent. Those principles render their views, wishes and preferences irrelevant to the decision-making process.<sup>1049</sup>

Ireland has an especially strong tradition of this kind of paternalism in mental health law, reflecting the emphasis that the Constitution of Ireland places on welfare-based concern for the vulnerable.<sup>1050</sup> Consistent with this, the Irish Supreme Court makes it explicit that the Court should approach certain medical matters “from the standpoint of a prudent, good and loving parent”.<sup>1051</sup> Against this background, many argue that Irish courts have interpreted the MHA 2001 with excessive paternalism, resulting in significant criticism (Section 4.4.6).

The explicit paternalism may, on the one hand, reflect the Irish state’s constitutional obligation to protect the vulnerable,<sup>1052</sup> but it may also represent a disproportionately

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<sup>1049</sup> Weller, P., “Lost in translation: human rights and mental health law”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 51-72), Oxford and Portland, Oregon: Hart Publishing, 2010; pp. 71-72.

<sup>1050</sup> Constitution of Ireland, article 40(1) and (3). See also: Whelan, 2009; pp. 26-31.

<sup>1051</sup> *Re A Ward of Court (Withholding Medical Treatment) (No. 2)* [1996] 2 IR, [1995] 2 ILRM 40; p. 99.

<sup>1052</sup> Kennedy, 2012.

disempowering interpretation of the Constitution, at least in certain cases. In England, the tendency towards paternalism is less pronounced overall and is generally attributable to public safety concerns rather than a perceived obligation to protect the vulnerable (Section 3.3.1). In both jurisdictions, however, there is clear difficulty achieving an optimal balance between measures fundamentally rooted in the advancement of patient autonomy and measures stemming from paternalistic or welfare-based concerns.

This difficulty may be addressed, at least in part, by mental capacity legislation which assumes a nuanced approach to mental capacity, facilitates careful evaluation of the individual's capacity to make specific decisions, and offers supported decision-making procedures when they are needed.<sup>1053</sup> Even in England, however, which has revised both its capacity and mental health legislation relatively recently, there is still evidence of significant paternalism in mental health law (Section 3.5), reflecting a real difficulty integrating the concepts of human rights, dignity, capabilities and welfare-based concerns in a balanced fashion.

Any proposed solution to this dilemma that is based solely in mental health or capacity legislation will be subject to the intrinsic limitations of legal approaches to such problems; i.e. requirements for an independent court system, financial resources to access courts, and certain standards of democratic governance. In addition, developing ever more detailed mental health or capacity legislation has the distinct demerit of

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<sup>1053</sup> In England: the MCA 2005. In Ireland, dedicated capacity legislation is being developed but has not yet been introduced (Joint Committee on Justice, Defence and Equality, 2012).

expanding the remit and complexity of such legislation,<sup>1054</sup> and potentially reinforcing the discriminatory assumption that individuals with mental illness or impaired capacity are sufficiently dangerous as to require elaborate legislation in order to maintain public safety.<sup>1055</sup>

A further complexity associated with exclusively legal solutions to dilemmas relating to mental disorder or impaired capacity stems from the fact that not all human needs are best met through dedicated legal assurances of specific rights:

Although human rights protect important human needs (primarily, security-related ones), rights are not identical to needs. A great majority of needs cannot be claimed as rights; they are fulfilled by mechanisms other than human rights. Some needs are fulfilled as a result of exchange, others via charity, and still others by the political, not judicial, allocation of public resources.<sup>1056</sup>

This situation is reflected, at least in part, in the rights-based analysis presented in this thesis: while revisions of mental health legislation in England and Ireland have resulted in stronger protections for the civil rights of the mentally ill, the greatest deficit is in the protection of social and economic rights *through mental health law* (see Section

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<sup>1054</sup> Certain parts of the MCA 2005, as amended by the MHA 2007 (England), are “long (Schedule A1 contains 13 Parts and 186 paragraphs), complex, overly bureaucratic” and, arguably, fail to meet the requirements that law should be “sufficiently accessible and foreseeable” (Bowen, 2007; p. 150).

<sup>1055</sup> Campbell, T., Heginbotham, C., *Mental Illness: Prejudice, Discrimination and the Law*, Aldershot: Dartmouth Publishing Group, 1991; Campbell, T., “Mental health law: institutionalised discrimination”, *Australian and New Zealand Journal of Psychiatry*, 1994, 28, 554-559.

<sup>1056</sup> Osiatyński, 2009; p. 104.

5.3.3.5). This supports the idea that mental health legislation may be best suited to the protection of negative rights (e.g. prohibitions on torture and degrading treatment) rather than positive rights (e.g. right to access health-care).<sup>1057</sup>

In other words, while “constitutional rights should guarantee basic needs”, and “constitutional principles should assure that the needs of vulnerable populations and those most underprivileged are not neglected by political process”,<sup>1058</sup> these are not necessarily the only or even best mechanisms for meeting social needs of fulfilling positive rights to health-care, housing, etc.:

The most important mechanism of state intervention into social spheres consists of the regulation, adoption, and implementation of general policies; creation of mechanisms and institutions that enable the satisfaction of collective needs; and, exceptionally, direct provision of goods and services to the needy.<sup>1059</sup>

This emphasis on human *needs* may be usefully complemented by an emphasis on human *nature*; i.e. a combination of shared observations about the state of being human, including, for example, the existence of human needs *and* an individual sense of human dignity. This is consistent with the importance Nussbaum attaches to human

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<sup>1057</sup> Edmundson, 2004; Ishay, 2004; Hunt, 2007. ECHR principles have been evoked in relation to treatment, but while rulings indicate that treatment, when provided, must be based on medical necessity and in the patient’s best interests (*R (PS) v Responsible Medical Officer* [2003] EWHC 2335 (Admin)), there is no automatic right to treatment (e.g. for an individual with untreatable personality disorder, detained on the basis of public protection) (*Hutchison Reid v UK* (2003) 37 EHRR 211).

<sup>1058</sup> Osiatyński, 2009; p. 142.

<sup>1059</sup> Osiatyński, 2009; p. 142.

capabilities,<sup>1060</sup> which were discussed in Section 1.4 of this thesis but were notably absent from the process of legislative reform in England and Ireland in recent years.

Broader recognition of these kinds of values (especially dignity and capabilities) would not only complement rights-based considerations of mental health care (such as that presented in this thesis) and help realise the “general principles” of the CRPD,<sup>1061</sup> but also acknowledge the intrinsically complex, multi-faceted nature of mental health care and decision-making.

In the absence of this kind of broader recognition of the centrality of dignity and capabilities in protecting and promoting the rights of the mentally ill, at least some of the deficits in current legislation could still be addressed through relatively minor modifications of existing legal mechanisms. The examination of national mental health legislation in this thesis, for example, highlights deficits in “oversight and review” procedures, related chiefly to the existing complaint mechanisms which lack the robustness recommended by the WHO (Table 1).<sup>1062</sup> Complaints mechanisms already exist in both English and Irish mental health services, but placing them on a stronger and more accountable footing would bring both jurisdictions into greater accordance with the WHO human rights standards.

Mental health tribunals represent another existing legal mechanism which might be modified to address some of these concerns and promote patient dignity and exercise of capabilities. The role of tribunals could, for example, be broadened to place greater

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<sup>1060</sup> Nussbaum, 1992; 2000; 2011.

<sup>1061</sup> UN, 2006, article 3; Kämpf, 2010; p. 150.

<sup>1062</sup> Section 5.3.2.2.

emphasis on the involvement of carers, families and friends in treatment of mental illness and promotion of mental wellness.<sup>1063</sup> As a result, reformed tribunals could offer enhanced opportunity to both protect basic rights and help shape treatment that is accessible, participative and sustainable.<sup>1064</sup> This could be achieved through tribunals making non-binding treatment recommendations at the level of the individual and policy recommendations at the level of the institution, or providing opportunity for resolution of complaints, thus providing “procedural ‘negative’ rights with a more meaningful role as well as strengthening the claim for a ‘positive’ right to health care.”<sup>1065</sup>

This approach is consistent with the broader use of “international human rights documents” (such as the WHO checklist, explored in Chapter 5) to move “mental health laws towards more positive rights of social participation”,<sup>1066</sup> with particular emphases on promoting dignity and autonomous exercise of capabilities by the mentally ill. This theme is reflected further in the idea of a “third wave” in human rights,<sup>1067</sup> which is considered next.

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<sup>1063</sup> Carney, T., “Involuntary mental health treatment laws: the ‘rights’ and the wrongs of competing models?”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 257-274), Oxford and Portland, Oregon: Hart Publishing, 2010; pp. 272-274.

<sup>1064</sup> Donnelly, M., “Reviews of treatment decisions: legalism, process and the protection of rights”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 275-298), Oxford and Portland, Oregon: Hart Publishing, 2010; p. 295.

<sup>1065</sup> Zuckerberg, J., “Mental health law and its discontents: a reappraisal of the Canadian experience”, in McSherry, B. and Weller, P. (eds), *Rethinking Rights-Based Mental Health Laws* (pp. 299-326), Oxford and Portland, Oregon: Hart Publishing, 2010; p. 326.

<sup>1066</sup> McSherry & Weller, 2010; p. 10.

<sup>1067</sup> Klug, 2000.

#### 7.4 Human rights and mental illness: the third wave

Klug describes the emergence of three “waves” of rights over the past two centuries.<sup>1068</sup>

The first wave concerned concepts that emerged from the Enlightenment and focussed on civil and political rights. The second wave developed in response to the Second World War and focussed not just on protecting individuals from tyranny but also creating a sense of moral purpose for mankind and a fairer world for everyone, rooted in the concept of dignity. This was associated with increased emphasis on social and economic rights in the UDHR (the second generation of human rights) *and* an emergent emphasis on the achieving equality between individuals, as opposed to simply equality before the law (a feature of the first wave).

Klug contends that there is now a third wave emerging, rooted in the concepts of mutuality or participation:

Whilst there is still the same recognition of the values of dignity, equality and community as in the second wave (and liberty, autonomy and justice as in the first) there is now a growing emphasis on participation or mutuality. In legal terms the net of liability is spreading ever wider under international human rights law. Corporations, charities and even private individuals in some circumstances are increasingly held responsible for upholding the rights of others (even if, under international law, this is indirectly through their governments).

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<sup>1068</sup> Klug, 2000; 2001.



More definitively than at the dawn of the second wave, it is now established that states are not the only - nor always the main - abusers of power. As significantly, there is a new emphasis on seeking to uphold fundamental human rights through trade agreements, education and persuasion as well as through litigation. Aided by new technology such as the world-wide web, a cross-cultural dialogue on human rights is developing which involves a far wider set of participants than the jurists and standard-setters who dominated the second wave.<sup>1069</sup>

In England, the Human Rights Act 1998 can, arguably, be construed as reflecting certain elements of this “third wave”. For example, the Human Rights Act 1998 implicitly recognises the potential for bodies other than the state to infringe on human rights, and makes it unlawful for public authorities in the UK to act in a way that is incompatible with the ECHR<sup>1070</sup> (unless an act of Parliament dictates otherwise, in which case a “declaration of incompatibility” can be made by a higher court).<sup>1071</sup>

The extent of this provision is not entirely clear, however, owing to certain difficulties with the term “public authority”. The term includes bodies such as courts, tribunals,<sup>1072</sup> local authorities, National Health Service trusts and parole boards. Individuals some of whose functions are of a public nature<sup>1073</sup> are “public authorities” in respect of those

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<sup>1069</sup> Klug, 2001; p. 367.

<sup>1070</sup> Human Rights Act 1998, section 6(1).

<sup>1071</sup> Human Rights Act 1998, section 6(2).

<sup>1072</sup> Human Rights Act 1998, section 6(3)(a)

<sup>1073</sup> Human Rights Act 1998, section 6(3)(b)

activities only; doctors, for example, may be “public authorities” in respect of public but not private patients.<sup>1074</sup>

Difficulties with this distinction were highlighted in *R (Heather) v Leonard Cheshire Foundation*, in which a care home (in receipt of government funding and regulated by government) was deemed not to be a public authority for the purposes of the Human Rights Act 1998; the word “public” being interpreted as meaning “governmental”.<sup>1075</sup> The law was amended in 2008 so that all private care homes are now covered by the Human Rights Act 1998.<sup>1076</sup> This change is broadly consistent with Klug’s suggestion that the “net of liability is spreading”.<sup>1077</sup> It is notable that, in this instance, the “net of liability is spreading” through the will of parliament rather than the courts, arguably indicating governmental commitment to human rights (at least at that time).

There is also evidence that this “liability” is substantial in magnitude, especially in the context of mental health care. The case of *Savage v South Essex Partnership NHS Foundation Trust*,<sup>1078</sup> for example, involved the suicide of a detained patient who escaped from a mental health facility, and it was alleged that the NHS Trust had failed to protect the patient’s ECHR right to life.<sup>1079</sup> The House of Lords concluded that the

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<sup>1074</sup> Wadham et al, 2007; pp. 72-76.

<sup>1075</sup> *R (Heather) v Leonard Cheshire Foundation* [2002] EWCA Civ 366, [2002] 2 All ER 936. See also: *Aston Cantlow and Wilmcote with Billesley PCC Church Council v Wallbank* [2003] UKHL 37, [2004] 1 AC 546.

<sup>1076</sup> Health and Social Care Act 2008, section 145.

<sup>1077</sup> Klug, 2001; p. 367.

<sup>1078</sup> *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74; *Savage v South Essex Partnership NHS Foundation Trust* [2010] EWHC 865 (QB). The UK Supreme Court later declared that this obligation can extend to voluntary patients, even when on home leave (*Rabone and Anor v Pennine Care NHS Trust* [2012] UKSC 2).

<sup>1079</sup> ECHR, article 2(1): “Everyone’s right to life shall be protected by law”.

NHS Trust indeed had a duty to reasonably protect psychiatric patients from taking their own lives.

In addition, it can be argued that the Human Rights Act 1998 exerts a “horizontal effect” relevant to disputes between *private* parties, not by creating new rights in relation to private parties (direct horizontal effect) but requiring courts (which are public bodies) to act in accordance with the ECHR<sup>1080</sup> (indirect horizontal effect):<sup>1081</sup>

The 1998 Act does not create any new cause of action between private persons. But if there is a relevant cause of action applicable, the court as a public authority must act compatibly with both parties’ Convention rights.<sup>1082</sup>

Do these developments have particular relevance in the field of mental disorder and disability rights? In the first instance, O’Brien notes that the first UN convention of the twenty-first century, the CRPD, focused on the rights of disabled people and was consistent with the themes of social solidarity and interdependence in observance of rights:

The Convention is notable for welding together human rights principles that are variously indebted to the core principles of autonomy, equality, proportionality and dignity in such a way that the Convention as a whole

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<sup>1080</sup> Human Rights Act 1998, sections 6(1) and 8. In Ireland, by contrast, courts are not covered by the analogous provision of the European Convention on Human Rights Act 2003 (see Section 2.7.3).

<sup>1081</sup> Morgan, J., “Privacy in the House of Lords, Again”, *Law Quarterly Review* 2004, 120, 563-566.

<sup>1082</sup> *Campbell v Mirror Group Newspapers Ltd.* [2004] UKHL 22, [2004] 2 AC 457 (HL).

discloses a commitment to a vision of the good society founded on the principle of solidarity and democratic participation... This vision is one concrete expression of what Francesca Klug has called the ‘third wave’ of human rights.<sup>1083</sup>

Individuals with mental disability and/or mental disorder are often engaged with a broad range of health and social care providers, including psychiatrists, nurses, social workers and various others, as well as, on occasion, mental health tribunals, lawyers and judges.<sup>1084</sup> This diverse network of individuals and services has a substantive influence on the experiences of individuals with mental disorder and, in some cases, the extent to which they can enjoy both civil and political rights (e.g. right to liberty) and social and economic rights.

The majority of such actors are, however, agents of the state to greater or lesser degrees, and would be considered public bodies under the Human Rights Act 1998. Consistent with this, Carpenter argues that the 1998 Act still fundamentally belongs to the second wave of human rights; i.e. it emphasizes equality between individuals and strengthens anti-discrimination measures, but does not have *sufficient* regard for the diverse network of factors and actors which create the landscape in which rights are articulated, protected and/or infringed.<sup>1085</sup> Not least amongst these actors are individuals with mental disorder themselves, whose perspectives on their own rights would provide an

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<sup>1083</sup> O’Brien, N., “Equality and human rights”, *The Political Quarterly*, 2008, 79, 27-35; pp. 31-32.

<sup>1084</sup> Gabbard, G.O., Kay, J., “The fate of integrated treatment”, *American Journal of Psychiatry*, 2001, 158, 1956-1963.

<sup>1085</sup> Carpenter, 2009; p. 223.

additional and vital dimension to the emergence of a meaningful third wave of human rights in this group, but whose voices are often ignored.<sup>1086</sup>

In Ireland, these kinds of concerns about the rights of individuals in minority groups have tended to focus on a number of specific groupings, including the Irish “travelling community”,<sup>1087</sup> migrants,<sup>1088</sup> and individuals with mental illness.<sup>1089</sup> In 2004, Amnesty International drew particular attention to the position of individuals with mental illness, noting reports of “inhuman conditions for prisoners suffering from mental illness” in Ireland and concluding that “mental health policy and service provisions did not comply with international best practice and human rights standards”.<sup>1090</sup> This thesis argues that the implementation of the MHA 2001 (between 2001 and 2006) has helped protect the rights of the mentally ill in Ireland to a certain extent, but that there are still areas of significant deficit (Chapter 4). A similar situation pertains in England, where the MHA 2007 has helped address some but not all human rights concerns (Chapter 3).

The concept of a “third wave” is of relevance here owing to its expansive recognition of the myriad actors involved in observing or violating rights. Individuals with mental illness, however, appear notably reliant on a broad range of *state* rather than *private* actors for the protection of rights, a situation they share with certain other groups whose rights are commonly the subject of concern; e.g. children in care, migrants,

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<sup>1086</sup> Lewis, 2009; Spander, H., Calton, T., “Psychosis and human rights”, *Social Policy and Society*, 2009, 8, 245-256.

<sup>1087</sup> Hughes et al, 2007.

<sup>1088</sup> Fanning, B., “Racism, rules and rights”, in Fanning, B. (ed), *Immigration and Social Change in the Republic of Ireland* (pp. 6-26), Manchester and New York: Manchester University Press, 2007.

<sup>1089</sup> Kelly, 2001.

<sup>1090</sup> Amnesty International, *Amnesty International Report 2004*, London: Amnesty International Publications, 2004; p. 228.

prisoners.<sup>1091</sup> Consistent with this, it is increasingly apparent that all actors engaged in “functions of a public nature”<sup>1092</sup> in England have quite substantial obligations to prevent violations of ECHR rights. Although welcome in terms of human rights protections, this situation is subject to the considerable caveat that judicial interpretations of the term “functions of a public nature” in England are both complex and evolving.<sup>1093</sup>

In Ireland, the analogous requirement that “every organ of the State shall perform its functions in a manner compatible with the State's obligations under the Convention provisions”<sup>1094</sup> is also limited by a relatively restrictive definition of “organ of the State”, which explicitly excludes courts.<sup>1095</sup> Other aspects of this definition have not yet been comprehensively clarified in the Irish parliament or courts, so it remains unclear what, precisely, constitutes an “organ of the State”, although it is reasonable to assume that public health services, which provide the vast majority of mental health services, constitute “organs of the State”<sup>1096</sup> and thus have a positive obligation to protect ECHR rights.

Overall, Klug’s idea of a “third wave” of human rights<sup>1097</sup> has considerable significance in relation to the mentally ill, not least because individuals with mental disorder

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<sup>1091</sup> Amnesty International, 2004.

<sup>1092</sup> Human Rights Act 1998, section 6(3)(b).

<sup>1093</sup> Wadham et al, 2007; pp. 72-76.; *R (Heather) v Leonard Cheshire Foundation* [2002] EWCA Civ 366, [2002] 2 All ER 936; *Aston Cantlow and Wilmcote with Billesley PCC Church Council v Wallbank* [2003] UKHL 37, [2004] 1 AC 546.

<sup>1094</sup> European Convention on Human Rights Act 2003, section 3(1).

<sup>1095</sup> European Convention on Human Rights Act 2003, section 1(1).

<sup>1096</sup> Mullan, 2008.

<sup>1097</sup> Klug, 2000.

commonly experience discrimination and social exclusion at the hands of state *and* non-state actors alike, and may also lack the opportunity or support to challenge this discrimination in a robust or effective fashion.<sup>1098</sup> Acknowledging the broad diversity of actors relevant to the violation or promotion of rights in this group is an important step forward in promoting dignity and the autonomous exercise of capabilities amongst the mentally ill.

## **7.5 Conclusions**

This chapter examined three key themes which have informed the emerging emphasis on human rights in mental health law in England and Ireland over the past decade, and are likely to continue to inform change. These are: the European dimension to recent developments in human rights protections through mental health law and policy in England and Ireland (stemming especially from the ECHR and EU) (Section 7.2); key values underpinning human rights (especially dignity, human capabilities, and paternalistic or welfare-based concerns) (Section 7.3); and the potential relevance of a “third wave” of human rights<sup>1099</sup> in the context of mental disorder (Section 7.4).

Regarding the European dimension of recent developments (Section 7.2), the emphasis on human rights in the reform processes in both England and Ireland is consistent with the ECHR and the EU’s emphasis on human rights in many areas of law and policy, including mental health. This reflects a broader convergence of national, European and global concern about the human rights of the mentally ill, as reflected in the UN

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<sup>1098</sup> Kelly, B.D., “The power gap: freedom, power and mental illness”, *Social Science and Medicine*, 2006, 63, 2118-2128; Callard et al, 2012.

<sup>1099</sup> Klug, 2000; 2001.

*Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*<sup>1100</sup> and *WHO Resource Book on Mental Health, Human Rights and Legislation*<sup>1101</sup> (Section 5.2).

The EU places particular emphasis on the role of human rights in shaping policy as well as law. This is consistent with the idea that mental health policy may complement law in promoting the rights, dignity and capabilities of the mentally ill: mental health law already provides robust protections for certain rights (e.g. right to liberty) but not others (e.g. economic and social rights) (Chapter 5), and it is possible that mental health policy may be better suited to the promotion of rights not adequately addressed through legislation, especially rights of particular concern to voluntary patients.

Given the EU's growing engagement with other areas of health policy and law, it is likely that the EU will increase its involvement in mental health policy in future years, further elaborating its emphasis on policy as a vehicle for advancing the rights of the mentally ill and, hopefully, promoting the dignity and autonomous exercise of capabilities of this group.

Regarding values underpinning human rights (Section 7.3), it is readily apparent that protection of specific rights (e.g. right to liberty) is intrinsically linked with other rights (e.g. right to access a court system). The idea of dignity is central to all of these rights and critically important to voluntary and involuntary mental health patients alike. The fact that certain individuals with mental disorder may have an impaired subjective sense of dignity has commonly contributed to paternalistic or welfare-based interpretations of

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<sup>1100</sup> UN, 1991.

<sup>1101</sup> WHO, 2005.



mental health legislation; this trend is especially apparent in Ireland, where it also finds roots in the emphasis that Ireland's Constitution places on protecting the vulnerable.

As a result, both England and Ireland demonstrate real difficulty integrating the concepts of human rights, dignity, capabilities and welfare-based concerns in a balanced fashion. Law is not the only mechanism for addressing this dilemma, however, and solutions rooted in social or mental health policy, in addition to law, as recommended by the EU, are likely to help (Section 7.2). In addition, relatively minor adjustments to existing legal frameworks could also assist in further promoting rights and dignity. These adjustments could reasonably include strengthening complaints procedures in mental health services and altering the nature and purpose of mental health tribunals so as to promote broader participation, enhancement of dignity, and advancement of patients' exercise of their own capabilities.<sup>1102</sup>

The idea of a "third wave" of human rights<sup>1103</sup> is also useful in this broader context, chiefly through its expansive recognition of the myriad actors involved in observing or violating the rights of the mentally ill. Individuals with mental illness, however, like migrants, prisoners and certain other groups, are especially likely to be reliant on a broad range of *state* rather than private actors, including mental health and social services, tribunals and courts.

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<sup>1102</sup> Zuckerberg, 2010.

<sup>1103</sup> Klug, 2000; 2001.

Most bodies engaged in such activities come under the remit of the Human Rights Act 1998 in England<sup>1104</sup> and European Convention on Human Rights Act 2003 in Ireland, and have a resultant positive obligation to protect ECHR rights, with the notable exception of the courts in Ireland, which are not covered by this positive obligation.<sup>1105</sup> Nonetheless, the recognition of a broad range of state and non-state actors as being relevant to human rights still makes the idea of the “third wave” important for the mentally ill, who commonly experience discrimination and social exclusion at the hands of state *and* non-state actors alike, and may also lack the opportunity or support to challenge this discrimination in a robust or effective fashion.<sup>1106</sup>

Overall, the growing emphasis placed on the human rights of the mentally ill by national and trans-national bodies, the potential to modify mental health policy and existing legal mechanisms to enhance observance of dignity and rights, and the reliance of the mentally ill on myriad actors for the protection of rights, all converge on the importance of mental health law, human rights law *and* mental health policy in articulating and protecting the rights of the mentally ill, as well as promoting their dignity and autonomous exercise of capabilities.

This situation is further explored in the final chapter of this thesis, which summarises key arguments from earlier chapters, sets out overall conclusions, and suggests useful directions for future research.

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<sup>1104</sup> Subject to the caveat that judicial interpretation of the term “functions of a public nature” in England are both complex and evolving (see: Section 7.4).

<sup>1105</sup> European Convention on Human Rights Act 2003, sections 1(1) and 3(1).

<sup>1106</sup> Kelly, B.D., “The power gap: freedom, power and mental illness”, *Social Science and Medicine*, 2006, 63, 2118-2128; Callard et al, 2012.

## Chapter 8

### Conclusions

#### 8.1 Introduction

This thesis began by highlighting the plight of the mentally ill in early nineteenth-century Ireland, when an individual with mental illness was likely to be consigned to “a hole in the floor of the cabin, not high enough for the person to stand up in, with a crib over it to prevent his getting up. This hole is about five feet deep, and they give this wretched being his food there, and there he generally dies.”<sup>1107</sup>

Two centuries later, in central London, a man with schizophrenia was found dead, with heart disease and hypothermia, in “a dirty, damp and freezing flat, with mould growing on the floor and exposed electrical wires hanging off the walls. His boiler had broken, the bathroom ceiling had collapsed, and neighbours began to complain about the smell. His brother, Anthony Coombe, describing the scene as ‘squalor’, said: ‘Even an animal couldn't have lived in that’.”<sup>1108</sup>

This thesis focuses on the two centuries between these two reports and examines two key research questions. First, to what extent, if any, have human rights concerns influenced recent revisions of mental health legislation in England and Ireland?

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<sup>1107</sup> Committee of the House of Commons (of Great Britain, then including Ireland) , quoted in Shorter, 1997; pp. 1-2.

<sup>1108</sup> Harding, 2010.

Second, to what extent, if any, have recent developments in mental health law in both jurisdictions assisted in protecting and promoting the human rights of the mentally ill?

This concluding chapter presents a brief summary of key arguments from each chapter of this thesis (Section 8.2), overall conclusions in response to these two key research questions (Sections 8.3) and useful directions for future research (Section 8.4).

## **8.2 Summary of key arguments**

Chapter 1 of this thesis commenced with a consideration of the nature and burden of mental disorder, concluding that mental disorder is common, costly and complex.

Following an outline of research methodology, three key concepts were explored:

human rights, human dignity and paternalism. Human rights are entitlements which one may legally or morally claim because one is a human being. Human dignity, which has both subjective and objective dimensions, results from the match between circumstances and capabilities: an individual experiences dignity if he or she is in circumstances which permit exercise of his or her capabilities.<sup>1109</sup> This is consistent with Nussbaum's theory of human capabilities which proposes that certain human capabilities are essential to the definition of a "human being".<sup>1110</sup>

The third key concept underpinning this thesis is paternalism, which is the claim by government or others to take responsibility for the welfare of a given individual.

Ireland has a particularly strong history of paternalism in mental health law, stemming, at least in part, from the Irish Constitution's emphasis on the State's responsibility to

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<sup>1109</sup> Seedhouse & Gallagher, 2002; p. 371.

<sup>1110</sup> Nussbaum, 1992; 2000; 2011.

protect its citizens and meet welfare obligations towards the vulnerable. The extent to which mental health law in England and Ireland is or is not disproportionately paternalistic recurs repeatedly through this thesis, and is linked with the ideas of both dignity and human rights.

Chapter 2 explored the emergence of the idea of human rights, with particular reference to the UDHR (1948) and ECHR (1950), and examined expressions of human rights in national legislative form (Human Rights Act 1998 in England, European Convention on Human Rights Act 2003 in Ireland). Chapter 2 argued that the history of the mentally ill is largely a history of social exclusion and denial of rights: while social and legal reforms relating to the mentally ill gathered pace throughout the nineteenth century, these often involved expansive institutional provision, associated with further denial of rights and erosion of dignity, rather than enhancing opportunity for autonomous exercise of human capabilities. An approach to mental disorder informed explicitly by human rights only gathered strength following the UDHR and ECHR, and, in 1991, the UN's *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*.<sup>1111</sup>

Chapter 2 demonstrated that these developments, especially the ECHR and its incorporation into national legislation, have had significant effects on the ways in which the human rights of the mentally ill have been interpreted by European and national courts. Many of the resultant cases represented significant advances for the protection of specific rights and enhancement of dignity, albeit that cases have tended to focus on areas of traditional concern in asylum-based mental health services (involuntary

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<sup>1111</sup> UN, 1991.

detention and treatment) and not on other issues which are also important to the mentally ill (e.g. the position of voluntary patients, and economic and social rights). Notwithstanding this caveat, the analysis in Chapter 2 demonstrates that human rights concerns had assumed significant prominence and importance prior to recent revisions of mental health legislation in England and Ireland.

Chapter 3 explored recent reform of mental health legislation in England, and concluded that the MHA 2007 made a number of important changes with the potential to protect human rights, enhance dignity and promote the exercise of various capabilities, albeit with qualifications. Key changes include replacing the “treatability test” with a requirement that appropriate medical treatment is available; expanding professional roles (although it is unclear whether renewal orders made out without medical doctors meet ECHR requirements); increasing patient autonomy in deciding their “nearest relative”; revising supervised community treatment procedures; introducing new safeguards regarding ECT; and automatic referral to the Mental Health Review Tribunal for patients admitted for assessment.

Overall, these changes meet many, although not all, of the expectations of mental health service-users and service-providers. The reforms present a mixture of increased protections for certain human rights and measures which support dignity and capabilities, as well as measures which are clearly paternalistic in tone and content. There are, for example, improved safeguards regarding involuntary ECT, which support the right to bodily integrity; in the final analysis, however, it is still permitted to administer ECT to individuals against their wishes, albeit only under very specific circumstances. The MHA 2007 also results in increased autonomy for the patient in

selecting his or her nearest relative, a measure which clearly supports the exercise of specific capabilities, although if a patient wishes to displace their “nearest relative”, the court still must be of the opinion that the patient’s nominee is “a suitable person to act as such”<sup>1112</sup> (a distinctly paternalistic requirement).

Similarly, the MHA 2007 outlines a system of “independent mental health advocates” with substantial potential to enhance patient dignity and exercise of specific capabilities. However, not all patients qualify for this service and this limitation significantly reduces the effectiveness of this measure in supporting rights, dignity and capabilities across mental health services more broadly, especially for voluntary patients (who constitute the majority of mental health service-users).<sup>1113</sup>

Chapter 4 examined mental health legislation in Ireland, arguing that Ireland’s MHA 2001 also introduced important reforms to promote rights, dignity and capabilities, albeit again with qualifications. Key improvements include removing detention orders of indefinite duration; new involuntary admission procedures; automatic review of detention orders by tribunals; free legal representation and independent psychiatric opinions for detained patients; and establishment of the Mental Health Commission to oversee standards. These measures hold strong potential to protect specific rights (e.g. right to liberty), enhance patient dignity, and promote the exercise of specific capabilities (especially in relation to reviews of involuntary detention).

As in England, however, these potential benefits are accompanied by significant caveats, often indicating strong paternalistic or welfare-based considerations. Specific

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<sup>1112</sup> MHA 2007, section 23(3); amending MHA 1983, section 29(1A)

<sup>1113</sup> Kelly et al, 2004; p. 67.

human rights concerns relate to lack of clarity regarding the extent to which procedural aberrations are over-looked by tribunals; absence of cumulative tribunal case-law; restrictions on grounds for civil proceedings in Circuit and High Courts; the fact that the burden of proof lies with the patient in the Circuit Court; and the notably paternalistic definition of voluntary patient, which does not require an individual to possess capacity in order to become or remain a voluntary patient. Critically, there is also evidence of arguably excessive emphasis on paternalism and welfare-based concern in the interpretation of the MHA 2001 in the Irish courts, and it is not yet clear whether or not this trend is proportionate to the strong paternalistic and welfare-based obligations outlined in the Irish Constitution.

Against the background of these generally positive developments, Chapter 5 examined the extent to which national mental health legislation in England and Ireland now accords with international human rights standards, as reflected in the WHO *Resource Book on Mental Health, Human Rights and Legislation*.<sup>1114</sup> Areas of high compliance include definitions of mental disorder, involuntary treatment procedures, and offences and penalties. Areas of medium compliance relate to capacity and consent, oversight and review, and rules governing special treatments, seclusion and restraint. Areas of low compliance relate to promoting rights, voluntary treatment, vulnerable groups and emergency treatment. The greatest single deficit relates to economic and social rights which are not addressed substantively in the mental health laws of England or Ireland.

Overall, compliance with WHO standards is highest in areas of traditional concern in *asylum-based* mental health services (involuntary detention and treatment) and lowest

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<sup>1114</sup> WHO, 2005 (see Section 5.2 for a discussion of this instrument).



in areas of relevance to modern *community-based* mental health services (e.g. rights of voluntary patients, economic and social rights, rights to a minimum standard of care). Moreover, mental health legislation in both jurisdictions not only focuses on specific rights (e.g. right to liberty) to the virtual exclusion of certain others, but it does so in a fashion commonly shaped by paternalism rather than the principle of autonomy. In England this situation stems primarily from the emphasis on public safety during the development of the MHA 2007 and in Ireland it stems from a long-standing welfare-based and paternalistic tradition in mental health law. If mental health legislation focussed more broadly on economic and social rights, as the WHO suggests, it may well remedy this situation by affording greater protection of dignity and promoting a broader array of rights and capabilities in areas other than strictly-defined mental health care (i.e. in areas such as housing, employment and social participation, which are commonly problematic for the mentally ill).<sup>1115</sup>

Building on this analysis, Chapter 6 compared England and Ireland with regard to protection of human rights through mental health legislation. Areas of similarity across the jurisdictions include definitions of mental disorder, voluntary treatment, involuntary admission, proxy consent for treatment, involuntary community treatment, oversight and review, police responsibilities, social security, civil issues, and offences and penalties. These similarities, and the nature of their emergence, underline the role that human rights concerns (mediated especially through the ECHR and related case-law) have played in recent reforms of mental health legislation in both England and Ireland.

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<sup>1115</sup> Callard et al, 2012.

The outcomes of these reforms differ somewhat between the jurisdictions owing, at least in part, to their differing pre-existing legal landscapes; e.g. the presence of dedicated mental capacity legislation in England and the strong emphasis on welfare and protecting the vulnerable in Ireland's Constitution. Specific dissimilarities between the two jurisdictions in relation to protection of human rights through mental health law relate to principles and objectives of mental health legislation, the balance between privacy and disclosure of information, protection of vulnerable groups, specific aspects of clinical management (emergency treatment, seclusion, restraint), and issues related to competence and capacity. These differences also reflect the different factors influencing reform in the two jurisdictions, especially the emphasis on public safety in England and the strong tradition of welfare-based concern in Irish mental health law.

Overall, both jurisdictions present slightly different mixes of approaches which prioritise autonomy and dignity on the one hand, and protectionist, paternalist and welfare-based concern for the vulnerable on the other. Overall, however, neither jurisdiction makes strong, consistent or frequent reference to dignity or human capabilities throughout their mental health legislation or associated case-law. This is a point of significant similarity between England and Ireland: while mental health law in both jurisdictions provides a certain amount of support for certain human rights and dignity in various specific ways, neither jurisdiction places strong, explicit or overarching emphasis on dignity, the exercise of human capabilities, or promotion of broader social participation for the mentally ill in their mental health law.

Chapter 7 draws together these and other key themes from the first six chapters of this thesis by focussing on three areas of relevance to recent and future developments in

mental health law in England and Ireland. These are: the influence of European factors (e.g. ECHR, EU) on mental health legislation, case-law and policy; the interactions between the concepts of human rights, dignity, capabilities and paternalistic or welfare-based approaches to mental health law; and the relevance of a “third wave” of human rights for the mentally ill.<sup>1116</sup>

There is, in the first instance, clear and growing evidence of the influence of European-level factors and actors in relation to mental health law and policy, including the ECHR (focusing chiefly on the rights to liberty and respect for personal and family life) and EU (focusing chiefly on the development of mental health policies informed by human rights).

The emphasis that both the ECHR and EU place on human rights in law and policy could be usefully complemented by an emphasis on human dignity, a concept which is central to the CRPD but was markedly absent from the processes of legislative reform in England and Ireland, and receives scant attention in mental health legislation in both jurisdictions. As argued in Chapter 1, the enhancement of dignity is strongly linked with the opportunity to exercise human capabilities, but the idea that mental health law might fundamentally aim to facilitate the autonomous exercise of capabilities does not feature significantly in either jurisdiction. While legislation in England and Ireland does provide free legal aid and advocacy services to certain patients (e.g. detained patients) in relation to specific matters (e.g. appealing detention orders), it does not provide robust support for exercise of capabilities more broadly (e.g. in relation to housing, employment, social participation, or issues of particular relevance to voluntary patients).

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<sup>1116</sup> Klug, 2000.

Part of the solution may lie in further revisions to legislation and policy which emphasise not only rights at issue for detained patients, but also those at issue for voluntary patients (e.g. rights to treatment, economic and social rights) which may be best addressed through policy (as recommended by the EU) rather than just through law.

Regarding values underpinning reform, then, it is readily apparent that both England and Ireland demonstrate real difficulty integrating the concepts of human rights, dignity, capabilities and welfare-based concern in a balanced fashion. Law is not the only mechanism for addressing this dilemma, however, and solutions rooted in social policy or mental health policy, in addition to law, are likely to help, as are relatively minor adjustments to existing legal frameworks (e.g. strengthening complaints procedures and altering the nature and purpose of mental health tribunals).

Such revisions of law or policy, especially looking at economic and social rights, could usefully take account of Klug's "third wave" of human rights, owing the fact that the mentally ill have a relatively high level of reliance on a broad array of actors (chiefly state actors) for the protection of rights and facilitation of social participation.<sup>1117</sup>

Legislative requirements that public bodies act in accordance with ECHR rights go some distance toward ensuring that most actors affecting the lives of the mentally ill protect and promote their rights, but a greater overall emphasis on dignity and capabilities throughout law and policy would undoubtedly assist further, not least by

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<sup>1117</sup> Klug, 2000.

simply acknowledging the broad array of state and non-state actors involved in promoting, protecting or violating the rights and dignity of the mentally ill.

What overall conclusions can be drawn from these arguments and discussions?

### **8.3 Key conclusions**

This thesis examines two key research questions. First, to what extent, if any, have human rights concerns influenced recent revisions of mental health legislation in England and Ireland? Second, to what extent, if any, have recent developments in mental health law in both jurisdictions assisted in protecting and promoting the human rights of the mentally ill? The answers to these two questions are now considered, in turn.

#### **8.3.1 Human rights considerations have helped shape mental health legislation**

The first key conclusion from the present thesis is that human rights considerations have played roles in shaping recent revisions of mental health legislation in England and Ireland.

This is important: the history of society's treatment of the mentally ill demonstrates that the human rights of the mentally ill require special protection, not least because most jurisdictions have laws which permit involuntary detention and treatment of the mentally ill. This explains, at least in part, why mental health legislation provides relatively strong protection of the right to liberty in contrast to other rights: it is a legacy

of the tradition of detention which dominates so much of the history of asylum-based psychiatry in England and Ireland.

The concepts of human rights and human rights law are critically important for addressing these matters:

Human rights law is important in the context of mental health because of two fundamental ideas unique to global protection of rights and freedoms. First, human rights law is the only source of law that legitimizes international scrutiny of mental health policies and practices within a sovereign country. Second, human rights law provides fundamental protections that cannot be taken away by the ordinary political process.<sup>1118</sup>

The analysis presented in this thesis demonstrates that the evolution of mental health law in England and Ireland over the past six decades has been influenced strongly by human rights concerns mediated, in large part, through the ECHR and related case-law (Chapters 2, 3 and 4). The WHO has also emphasised the importance of human rights in informing mental health legislation and policy (Chapter 5).

In England, these rights-based considerations provided strong impetus for changes to mental health legislation (Chapter 3). The Richardson Committee, advising on the new English legislation, was “determined to include sufficient safeguards to ensure appropriate protection of the patient’s individual dignity, autonomy and human

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<sup>1118</sup> Gable, L., Gostin, L., “Human rights of persons with mental disabilities: The European Convention on Human Rights”, in Gostin, L., McHale, J., Fennell, P., Mackay, R.D. and Bartlett, P. (eds), *Principles of Mental Health Law and Policy* (pp. 103-166), Oxford: Oxford University Press, 2010; p. 104.

rights”.<sup>1119</sup> The examination of UK case-law presented in Section 3.3.2 and the analysis of the MHA 2007 in Section 3.4 demonstrate the extent to which human rights considerations have informed change in England. This concern with human rights was combined with concern about public safety, which also helped shape the MHA 2007, but, notwithstanding the strength of the public safety agenda, the influence of human rights concerns was still clearly apparent in the resultant legislation.

In Ireland, rights-based considerations dominated the reform debate single-handedly (Chapter 4) and remain the central driver of change today: when a review of the MHA 2001 was launched in 2011, the government emphasized the centrality of “a human rights-based approach to mental health legislation”.<sup>1120</sup> In 2012, the *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* confirmed that a “rights-based approach to mental health law should be adopted”, although it did not present specific suggestions for legislative revisions to this effect.<sup>1121</sup> Overall, however, the growing emphasis on human rights in Ireland over the past twenty years was central to the generally positive reform of mental health legislation introduced in the MHA 2001.

This is the first key conclusion from in the present thesis: human rights concerns clearly played a key role in recent revisions of mental health legislation in England and Ireland, and continue to do so. This is a welcome development, which plainly reflects growing recognition of the need to protect and promote the human rights of the mentally ill.

There is, however, a need to examine not only how law is determined but also how law

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<sup>1119</sup> Expert Committee, 1999; p. 44.

<sup>1120</sup> Culliton, G., “Review of Act is to be built on ‘human rights’”, *Irish Medical Times*, 2011, 27 May.

<sup>1121</sup> Steering Group on the Review of the Mental Health Act 2001, 2012; p. 11.

is implemented, because, as this thesis argues, there is strong evidence of possibly disproportionate paternalism and welfare-based approaches to the implementation and interpretation of mental health legislation in, for example, Ireland (Section 4.4.6). This topic, relating to the *outcome* of mental health law, is considered in Section 8.4.1.

The issue of paternalism is an especially important one because it reflects one of the key, recurring tensions in mental health law and services, which is evident repeatedly throughout this thesis: the need to renegotiate constantly “the deep and persistent tensions in mental health between paternalism (care and treatment) and civil liberties (autonomy and liberty)”.<sup>1122</sup> This renegotiation involves not only mental health law, but also mental health policy, social policy and other areas of law (apart from dedicated mental health law). These matters are considered next, in the context of the second key conclusion of the present thesis.

### **8.3.2 Mental health legislation protects certain human rights**

The second key conclusion of this thesis is that recent revisions of mental health legislation in England and Ireland protect some but not all of the human rights of the mentally ill. The strongest protections relate to the right to liberty: both jurisdictions are now highly compliant with WHO standards in relation to definitions of mental disorder and involuntary treatment, and moderately compliant in relation to systems for oversight and review, with the chief deficit in the latter area relating to deficient complaints procedures and *not* core processes for review of psychiatric detention *per se*.

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<sup>1122</sup> Gostin et al, 2010; p. vi.



This high level of compliance is an especially recent development in Ireland: Ireland's MHA 2001, which introduced mental health tribunals for the first time, was only fully enacted in 2006. Prior to that, Ireland's Mental Treatment Act 1945 was in gross violation of international human rights standards, and was later declared unconstitutional. The situation in England prior to its MHA 2007 was slightly better than in Ireland, but England's MHA 2007 still introduced several important advances in relation to protection of human rights, albeit with qualifications.

This thesis, however, also demonstrates several areas of low compliance with WHO human rights standards, especially in relation to promoting rights, voluntary treatment and vulnerable groups. The greatest single deficit relates to economic and social rights which are not addressed substantively in the mental health laws of England or Ireland (Chapter 5).

Interestingly, it is *not* the case that mental health legislation in England and Ireland tries and fails to protect rights in most of these areas. Rather, the legislation does not concern itself with these matters in the first instance, apart from some rather general statements of principle, especially in England.<sup>1123</sup> For the most part, mental health legislation in both jurisdictions adequately protects rights *in areas addressed by the legislation*, which are generally the areas of traditional historical concern in asylum-based mental health services (i.e. involuntary detention and treatment).

Certain other areas which the WHO includes in its "Checklist for Mental Health Legislation", such as economic and social rights, are not addressed in any substantive

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<sup>1123</sup> MHA 2007, section 8.

fashion in mental health legislation in either England or Ireland. This prompts a question: *Should* such areas be addressed in mental health legislation at all, or are general legislative measures or policy initiatives sufficient to protect these rights amongst the mentally ill?

As discussed in Chapter 2, the historical experiences of the mentally ill, especially their increased rates of incarceration, indicate a need for dedicated, pro-active protection of human rights in this group. Efforts to meet this need have generally involved dedicated mental health legislation focussed on protecting the right to liberty, a right commonly and demonstrably at issue for certain individuals with mental illness. This is consistent with an important role for mental health law in *protecting*, as opposed to just *not infringing*, certain rights, such as the right to liberty. Other areas of law, however, apart from dedicated mental health law, may also play a substantial role in protecting the rights of the mentally ill.

As discussed in Chapter 3, for example, the English Supreme Court, in 2012, found that an NHS Trust had breached its duty of care to a voluntary psychiatric inpatient who died by suicide while on leave home from a psychiatry unit in Stockport.<sup>1124</sup> This case did not involve dedicated mental health legislation, but, rather, the ECHR and Human Rights Act 1998, demonstrating that rights protections for the mentally ill can be

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<sup>1124</sup> *Rabone and Anor v Pennine Care NHS Trust* [2012] UKSC 2. See also: *Osman v UK* (2000) 29 EHRR 245; Bowcott, O., “Hospital breached duty of care to psychiatric patient, supreme court rules”, *Guardian*, 2012, 8 February; Madden, E., “Important UK Supreme Court decision on human rights”, *Irish Medical Times*, 2012, 18, 26. A similar positive obligation in relation to a *detained* patient who died by suicide was articulated by the House of Lords (*Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74; *Savage v South Essex Partnership NHS Foundation Trust* [2010] EWHC 865 (QB)) (see Section 7.4).

effective even if located in law other than dedicated mental health law. The *Rabone* case demonstrated this in relation to the right to life, but does it hold true for other rights? Do the protections of economic and social rights located in law other than dedicated mental health law (e.g. housing law) serve, in similar fashion, to protect the economic and social rights of the mentally ill?

Chapter 7 argued that, notwithstanding general legislation relating to equality, housing, etc., individuals with mental illness still experience difficulty availing of this legislation, resulting in increased rates of poverty, homelessness, unemployment, poor physical health and social exclusion. Chapter 7 goes on to argue that mental health policy, especially if informed by human rights concerns (as recommended by the EU, amongst others), may assist with addressing deficits in relation to rights for the mentally ill. The experience of psychiatric de-institutionalisation in late twentieth-century Ireland, which found its roots in policy and not law, clearly demonstrates the potentially transformative effect of policy rather than law on patients' experiences of mental health services (Section 7.2).

These arguments underline the second conclusion of the present thesis: that the protection of human rights through dedicated mental health legislation alone is limited, and other mechanisms are highly relevant for human rights protections for the mentally ill. These mechanisms include areas of law other than mental health law (e.g. human rights law), mental health policy and social policy. Amongst these mechanisms, certain ones (e.g. human rights law) may be especially relevant to the protection of certain rights (e.g. right to life), while other mechanisms (e.g. mental health policy, social

policy) may be more relevant to the protection of other rights (e.g. economic and social rights, and rights of particular relevance to voluntary patients).

In addition, a greater overall emphasis on dignity and capabilities throughout mental health law and policy would undoubtedly assist with the promotion of rights more broadly, not least by acknowledging the wide array of state and non-state stakeholders involved in protecting, promoting or violating the rights of the mentally ill, consistent with Klug's expansive vision of a "third wave" in human rights<sup>1125</sup> and the CRPD's emphasis on dignity.<sup>1126</sup>

## **8.4 Useful directions for future research**

Future research about human rights protection for the mentally ill through mental health law in England and Ireland could usefully focus on the *outcomes* of mental health legislation in both jurisdictions (Section 8.4.1); the relevance of concepts such as Klug's "third wave" of human rights<sup>1127</sup> (Section 8.4.2); and growing trans-national influences on national mental health law (Section 8.4.3).

### **8.4.1 The outcome of mental health legislation**

The examination of "human rights protection for the mentally ill through mental health law in England and Ireland" presented in this thesis focuses not only the content of legislation but also its outcome in case-law, in order to demonstrate how the legislation

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<sup>1125</sup> Klug, 2000.

<sup>1126</sup> CRPD, article 1.

<sup>1127</sup> Klug, 2001.

works in practice. This element of the thesis is extremely important: regardless of the theoretical provisions of mental health law or policy, it is the “lived experience” of mental illness that matters most to the mentally ill; i.e. real-life service provision, social exclusion or denial of rights.<sup>1128</sup> In other words, it is the *realization* of human rights protections and the experience of day-to-day justice that matter most to individuals with mental illness and their families.<sup>1129</sup>

For individuals with mental illness, issues such as involuntary detention and levels of service provision have exceptionally profound effects on the kind of lives they can actually lead. With this in mind, it is imperative that the outcomes of revisions of mental health legislation are observed with greater care: the MHA 2007 (England) and MHA 2001 (Ireland) may have been strongly influenced by the ECHR and related case-law (as demonstrated in this thesis), but what are the real-life outcomes of these influences and reforms? Have they actually resulted in greater protection of human rights for the mentally ill on a day-to-day basis?

The analysis presented in this thesis demonstrates that revisions of legislation in both jurisdictions occurred, at least in part, in response to human rights concerns and ECHR case-law (Chapters 2, 3 and 4), and that both jurisdictions are now generally compliant with WHO standards in key areas of traditional concern in asylum-based mental health services (i.e. involuntary admission and treatment) (Chapter 5). The most notable deficits relate to economic and social rights, which are not dealt with in any detail in the mental health laws of either jurisdiction and are of increasing relevance to the majority

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<sup>1128</sup> Kelly, 2005.

<sup>1129</sup> Sen, 2009; p. 10.

of mental health service-users (i.e. voluntary patients) in modern, community-based mental health services.

Again, however, both law and policy matter in relation to outcomes. As discussed in Section 7.2, for example, mental health legislation did not change significantly in Ireland between 1945 and 2006 and yet, between 1963 and 2003, the number of psychiatric inpatients decreased by 81.5%, chiefly as a result of policy rather than legislative change.<sup>1130</sup> At individual level, the role of mental health legislation in relation to liberty is more readily apparent: in the first eleven months following full implementation of the MHA 2001, approximately 12% of detention orders examined by tribunals were revoked, and the patients discharged (Section 4.4).

These developments raise important research questions. Did this apparently increased observance of the right to liberty impact negatively on access to treatment? Did it impact negatively on public safety? Did those who were released access outpatient treatment? Did their mental health deteriorate? Did they die? More research is needed on these kinds of outcomes following legislative change.

#### **8.4.2 The “third wave” of human rights in mental health**

Future research could also usefully focus on the relevance of Klug’s “third wave” of human rights in the context of the mentally ill (Section 7.4).<sup>1131</sup> Individuals with mental

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<sup>1130</sup> Kelly, B.D., “Penrose’s Law in Ireland: an ecological analysis of psychiatric inpatients and prisoners”, *Irish Medical Journal*, 2007, 100, 373-374. See also: Viney, 1968; Department of Health, 1984.

<sup>1131</sup> Klug 2000; 2001.

disorder commonly find their lives shaped by not only mental health services and laws, but also general health services, social services and societal attitudes. There is strong evidence that individuals with enduring mental disorder face challenges in all of these areas, which, along with the enduring stigma of mental illness, constitute a form of “structural violence” which limits their participation in civil and social life, and constrains many to live lives shaped by discrimination, exclusion and denial of rights, by state and non-state actors alike.<sup>1132</sup>

The broader “net of liability” for the protection of the rights of the mentally ill, articulated by Klug,<sup>1133</sup> merits closer study, especially in relation to the positive obligation of public authorities to take reasonable measures to prevent violations of ECHR rights.<sup>1134</sup> Is this positive obligation being met by all of the diverse authorities and agencies involved in shaping the lives of the mentally ill? How enforceable is this positive obligation, in real terms? Does the deficit in the protection of economic and social rights, identified in this thesis (Section 5.3.3.5), indicate that this positive obligation is not being met?

#### **8.4.3 Trans-national influences on national mental health law**

Future research could also usefully focus on the increased role of international bodies such as the EU and WHO in shaping mental health law and policy. This thesis has demonstrated the role of the ECHR in shaping recent revisions of mental health law in

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<sup>1132</sup> Kelly, 2005; Kelly, B.D., “The power gap: freedom, power and mental illness”, *Social Science and Medicine*, 2006, 63, 2118-2128; Callard et al, 2012.

<sup>1133</sup> Klug, 2001; p. 367.

<sup>1134</sup> Wadham et al, 2007.

England and Ireland (Chapters 2, 3 and 4), the effect of WHO guidelines in shaping regulatory practice (Section 5.3.2.3), and the increasing role of the EU in mental health policy (Section 7.2). Greater research is needed, however, in order to elucidate more clearly the mental health policy-making processes within the EU and WHO, and their likely effects on national law and policy in member states.<sup>1135</sup>

There is a particular need to identify the policy processes and values which underpin these developments, with particular reference to values such as human dignity<sup>1136</sup> and capabilities<sup>1137</sup> in the protection of the rights of the mentally ill. The rights-based analysis presented in this thesis demonstrates that mental health legislation in England and Ireland is now generally compliant with WHO standards in key areas of traditional concern (e.g. involuntary admission and treatment) (Section 5.3.1), but notable deficits remain in certain other areas, such as economic and social rights (Section 5.3.3.5).

Might approaches to both law and policy which are more clearly rooted in the concepts of dignity and capabilities help remedy these deficits (Section 7.3)? Do developments at the level of the EU, Council of Europe, WHO and UN support these values? Might approaches rooted in *both* mental health law and policy reach the domains of human experience which mental health legislation alone fails adequately to address in both jurisdictions?

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<sup>1135</sup> Kelly, B.D., “The emerging mental health strategy of the European Union”, *Health Policy*, 2008, 85, 60-70; Callard, F., Rose, D., “The mental health strategy for Europe: Why service user leadership in research is indispensable”, *Journal of Mental Health*, 2012, 21, 219-226.

<sup>1136</sup> Carozza, 2008; Klug, 2000; pp. 100-101; Osiatyński, 2009; p. 189.

<sup>1137</sup> Nussbaum, 1992; 2000; 2011.



Finally, future research could also usefully examine legal and other mechanisms which have evolved in diverse societies to deal with the challenges presented to societies by individuals with severe mental disorder. More specifically, there is a need to examine comparatively the ways in which other jurisdictions, apart from England and Ireland, attempt to balance the need for treatment with the right to liberty, and the public's expectation of safety with the complex therapeutic decision-making required in individual cases of mental disorder.

**Table 1: World Health Organization’s “Checklist on Mental Health Legislation” (World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation*, Geneva: World Health Organization, 2005).**

<b>Legislative issue</b>				<b>Ireland</b>	<b>England</b>
A	Preamble and objectives	1a	Does the legislation have a preamble which emphasizes the human rights of people with mental disorders?	✗	✗
		1b	Does the legislation have a preamble which emphasizes the importance of accessible mental health services for all?	✗	✗
		2a	Does the legislation specify that the purpose and objectives to be achieved include non-discrimination against people with mental disorders?	✗	✓
		2b	Does the legislation specify that the purpose and objectives to be achieved include promotion and protection of the rights of people with mental disorders?	✗	✗
		2c	Does the legislation specify that the purpose and objectives to be achieved include improved access to mental health services?	✗	✗
		2d	Does the legislation specify that the purpose and objectives to be achieved include a community-based approach?	✓	✓
B	Definitions	1	Is there a clear definition of mental disorder/mental illness/mental disability/mental incapacity?	✓	✓
		2	Is it evident from the legislation why the particular term (above) has been chosen?	✗	✗
		3	Is the legislation clear on whether or not mental retardation/intellectual disability, personality disorders and substance abuse are being covered in the legislation?	✓	✓
		4	Are all key terms in the legislation clearly defined?	✓	✓
		5	Are all the key terms used consistently throughout the legislation (i.e. not interchanged with other terms with similar meanings)?	✓	✓
		6	Are all “interpretable” terms (i.e. terms that may have several possible interpretations or meanings or may be ambiguous in terms of their meaning) in the legislation defined?	✓	✓
C	Access to mental health care	1	Does the legislation make provision for the financing of mental health services?	✗	✗
		2	Does the legislation state that mental health services should be provided on an equal basis with physical health care?	✗	✗

Legislative issue (Table 1, continued)				Ireland	England
		3	Does the legislation ensure allocation of resources to underserved populations and specify that these services should be culturally appropriate?	✗	✓
		4	Does the legislation promote mental health within primary health care?	✗	✗
		5	Does the legislation promote access to psychotropic drugs?	✗	✗
		6	Does the legislation promote a psychosocial, rehabilitative approach?	✗	✗
		7	Does the legislation promote access to health insurance in the private and public health sector for people with mental disorders?	✗	✗
		8	Does the legislation promote community care and deinstitutionalization?	✓	✓
D	Rights of users of mental health services	1	Does the legislation include the rights to respect, dignity and to be treated in a humane way?	✓	✓
		2	Is the right to patients' confidentiality regarding information about themselves, their illness and treatment included?	✓	✗
		2a	Are there sanctions and penalties for people who contravene patients' confidentiality?	✗	✗
		2b	Does the legislation lay down exceptional circumstances when confidentiality may be legally breached?	✗	✓
		2c	Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to release information?	✗	✗
		3	Does the legislation provide patients free and full access to information about themselves (including access to their clinical records)?	✗	✗
		3a	Are circumstances in which such access can be denied outlined?	✗	✗
		3b	Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to withhold information?	✗	✗
		4	Does the law specify the right to be protected from cruel, inhuman and degrading treatment?	✓	✓
		5	Does the legislation set out the minimal conditions to be maintained in mental health facilities for a safe, therapeutic and hygienic environment?	✗	✗
		6	Does the law insist on the privacy of people with mental disorders?	✓	✗

Legislative issue (Table 1, continued)				Ireland	England
		6a	Is the law clear on minimal levels of privacy to be respected?	✗	✗
		7	Does the legislation outlaw forced or inadequately remunerated labour within mental health institutions?	✗	✗
		8	Does the law make provision for educational activities; vocational training; leisure and recreational activities; and religious or cultural needs of people with mental disorders?	✗	✗
		9	Are the health authorities compelled by the law to inform patients of their rights?	✓	✓
		10	Does legislation ensure that users of mental health services are involved in mental health policy, legislation development and service planning?	✗	✓
E	Rights of families or other carers	1	Does law entitle families or other primary carers to information about the person with mental disorder (unless patient refuses the divulging of such information)?	✗	✓
		2	Are family members or other primary carers encouraged to become involved in the formulation and implementation of the patient's individualized treatment plan?	✗	✗
		3	Do families or other primary carers have the right to appeal involuntary admission and treatment decisions?	✗	✓
		5	Does legislation ensure that family members or other carers are involved in the development of mental health policy, legislation and service planning?	✗	✓
F	Competence, capacity and guardianship	1	Does legislation make provision for the management of the affairs of people with mental disorders if they are unable to do so?	✓	✓
		2	Does the law define “competence” and “capacity”?	✗	✓
		3	Does the law lay down a procedure and criteria for determining a person’s incapacity/incompetence with respect to issues such as treatment decisions, selection of a substitute decision-maker, making financial decisions?	✓	✓
		4	Are procedures laid down for appeals against decisions of incapacity/incompetence, and for periodic reviews of decisions?	✗	✗
		5	Does the law lay down procedures for the appointment, duration, duties and responsibilities of a guardian to act on behalf of a patient?	✓	✓
		6	Does the law determine a process for establishing in which areas a guardian may take decisions on behalf of a patient?	✓	✓
		7	Does the law make provision for a systematic review of the need for a guardian?	✗	✗

Legislative issue (Table 1, continued)				Ireland	England
		8	Does law make provision for patient to appeal against appointment of guardian?	✓	✓
G	Voluntary admission and treatment	1	Does the law promote voluntary admission and treatment as a preferred alternative to involuntary admission and treatment?	✓	✓
		2	Does the law state that all voluntary patients can only be treated after obtaining informed consent?	✗	✗
		3	Does law state that people admitted as voluntary mental health users should be cared for in a way that is equitable with patients with physical health problems?	✗	✗
		4	Does the law state that voluntary admission and treatment also implies the right to voluntary discharge/refusal of treatment?	✗	✗
		5	Does the law state that voluntary patients should be informed at the time of admission that they may only be denied the right to leave if they meet the conditions for involuntary care?	✗	✗
H	Non-protesting patients	1	Does law make provision for patients who are incapable of making informed decisions about admission or treatment, but do not refuse admission or treatment?	✗	✓
		2	Are the conditions under which a non-protesting patient may be admitted and treated specified?	✗	✓
		3	Does the law state that if users admitted or treated under this provision object to their admission or treatment they must be discharged or treatment stopped unless the criteria for involuntary admission are met?	✓	✗
I	Involuntary admission (when separate from treatment) & involuntary treatment (where admission & treatment are combined)	1a	Does the law state that involuntary admission may only be allowed if there is evidence of mental disorder of specified severity?	✓	✓
		1b	Does the law state that involuntary admission may only be allowed if there is serious likelihood of harm to self or others and/or substantial likelihood of serious deterioration in the patient's condition if treatment is not given?	✓	✓
		1c	Does the law state that involuntary admission may only be allowed if admission is for a therapeutic purpose?	✓	✓
		2	Does the law state that two accredited mental health care practitioners must certify that the criteria for involuntary admission have been met?	✓	✓
		3	Does the law insist on accreditation of a facility before it can admit involuntary patients?	✓	✓

Legislative issue (Table 1, continued)				Ireland	England
		4	Is the principle of the least restrictive environment applied to involuntary admissions?	✓	✓
		5	Does the law make provision for an independent authority (e.g. review body or tribunal) to authorize all involuntary admissions?	✓	✓
		6	Are speedy time frames laid down within which the independent authority must make a decision?	✓	✓
		7	Does the law insist that patients, families and legal representatives be informed of the reasons for admission and of their rights of appeal?	✗	✗
		8	Does the law provide for a right to appeal an involuntary admission?	✓	✓
		9	Does the law include a provision for time-bound periodic reviews of involuntary (and long-term “voluntary”) admission by an independent authority?	✗	✗
		10	Does the law specify that patients must be discharged from involuntary admission as soon as they no longer fulfil the criteria for involuntary admission?	✓	✓
J	Involuntary treatment (when separate from involuntary admission)	1a	Does the law set out the criteria that must be met for involuntary treatment, including: Patient suffers from a mental disorder?	✓	✓
		1b	Does the law set out the criteria that must be met for involuntary treatment, including: Patient lacks the capacity to make informed treatment decisions?	✓	✓
		1c	Does the law set out the criteria that must be met for involuntary treatment, including: Treatment is necessary to bring about an improvement in the patient’s condition, and/or restore the capacity to make treatment decisions, and/or prevent serious deterioration, and/or prevent injury or harm to self or others?	✓	✓
		2	Does the law ensure that a treatment plan is proposed by an accredited practitioner with expertise and knowledge to provide the treatment?	✓	✓
		3	Does the law make provision for a second practitioner to agree on the treatment plan?	✗	✗
		4	Has an independent body been set up to authorize involuntary treatment?	✓	✓
		5	Does the law ensure that treatment is for a limited time period only?	✓	✓
		6	Does the law provide for a right to appeal involuntary treatment?	✓	✓

<b>Legislative issue (Table 1, continued)</b>				<b>Ireland</b>	<b>England</b>
		7	Are there speedy, time-bound, periodic reviews of involuntary treatment in the legislation?	✓	✓
K	Proxy consent for treatment	1	Does the law provide for a person to consent to treatment on a patient's behalf if that patient has been found incapable of consenting?	✓	✓
		2	Is the patient given the right to appeal a treatment decision to which a proxy consent has been given?	✓	✓
		3	Does law provide for use of "advance directives"; if so, is term clearly defined?	✓	✓
L	Involuntary treatment in community settings	1	Does the law provide for involuntary treatment in the community as a "less restrictive" alternative to an inpatient mental health facility?	✓	✓
		2	Are all the criteria and safeguards required for involuntary inpatient treatment also included for involuntary community-based treatment?	✓	✓
M	Emergency situations	1	Are criteria for emergency admission/treatment limited to situations where there is high probability of immediate & imminent danger/harm to self and/or others?	✗	✓
		2	Is there a clear procedure in law for admission/treatment in emergency situations?	✓	✓
		3	Does the law allow any qualified and accredited medical or mental health practitioner to admit and treat emergency cases?	✓	✓
		4	Does the law specify a time limit for emergency admission (usually no longer than 72 hours)?	✗	✗
		5	Does the law specify the need to initiate procedures for involuntary admission and treatment, if needed, as soon as possible after the emergency situation has ended?	✓	✓
		6	Are treatments such as ECT, psychosurgery and sterilization, as well as participation in clinical or experimental trials outlawed for people held as emergency cases?	✗	✗
		7	Do patients, family members and personal representatives have the right to appeal against emergency admission/treatment?	✗	✗
N	Determinations of mental disorder	1a	Does the legislation define level of skills required to determine mental disorder?	✓	✓
		1b	Does the legislation specify the categories of professionals who may assess a person to determine the existence of a mental disorder?	✓	✓
		2	Is the accreditation of practitioners codified in law and does this ensure that accreditation is operated by an independent body?	✓	✓

Legislative issue (Table 1, continued)				Ireland	England
O	Special treatments	1	Does the law prohibit sterilization as a treatment for mental disorder?	✗	✗
		1a	Does the law specify that the mere fact of having a mental disorder should not be a reason for sterilization or abortion without informed consent?	✗	✗
		2	Does the law require informed consent for major medical and surgical procedures on persons with a mental disorder?	✓	✓
		2a	Does the law allow medical and surgical procedures without informed consent, if waiting for informed consent would put the patient's life at risk?	✓	✓
		2b	In cases where inability to consent is likely to be long term, does the law allow authorization for medical and surgical procedures from an independent review body or by proxy consent of a guardian?	✓	✓
		3	Are psychosurgery and other irreversible treatments outlawed on involuntary patients?	✗	✗
		3a	Is there an independent body that makes sure there is indeed informed consent for psychosurgery or other irreversible treatments on involuntary patients?	✗	✓
		4	Does the law specify the need for informed consent when using ECT?	✓	✓
		5	Does the law prohibit the use of unmodified ECT?	✗	✗
		6	Does the law prohibit the use of ECT in minors?	✗	✗
P	Seclusion and restraint	1	Does the law state that seclusion and restraint should only be utilized in exceptional cases to prevent immediate or imminent harm to self or others?	✓	✗
		2	Does the law state that seclusion and restraint should never be used as a means of punishment or for the convenience of staff?	✓	✗
		3	Does the law specify a restricted maximum time period for which seclusion and restraints can be used?	✓	✗
		4	Does the law ensure that one period of seclusion and restraint is not followed immediately by another?	✗	✗
		5	Does the law encourage the development of appropriate structural and human resource requirements that minimize the need to use seclusion and restraints in mental health facilities?	✓	✗



<b>Legislative issue (Table 1, continued)</b>				<b>Ireland</b>	<b>England</b>
		6	Does law lay down adequate procedures for use of seclusion & restraints including: who should authorize it; facility should be accredited; that the reasons and duration of each incident be recorded in a database and made available to a review board; and that family members/carers and personal representatives be immediately informed when the patient is subject to seclusion and/or restraint?	✓	✗
Q	Clinical and experimental research	1	Does the law state that informed consent must be obtained for participation in clinical or experimental research from both voluntary and involuntary patients who have the ability to consent?	✗	✗
		2a	Where a person is unable to give informed consent (and where a decision has been made that research can be conducted): Does the law ensure that proxy consent is obtained from either the legally appointed guardian or family member, or from an independent authority constituted for this purpose?	✗	✓
		2b	Where a person is unable to give informed consent (and where a decision has been made that research can be conducted): Does the law state that the research cannot be conducted if the same research could be conducted on people capable of consenting, and that the research is necessary to promote the health of the individual and that of the population represented?	✗	✓
R	Oversight and review mechanisms	1	Does the law set up a judicial or quasi-judicial body to review processes related to involuntary admission or treatment and other restrictions of rights?	✓	✓
		1a(i)	Does the above body assess each involuntary admission/ treatment?	✓	✓
		1a(ii)	Does the above body entertain appeals against involuntary admission and/or involuntary treatment?	✓	✓
		1a(iii)	Does the above body review the cases of patients admitted on an involuntary basis (and long-term voluntary patients)?	✗	✗
		1a(iv)	Regularly monitor patients receiving treatment against their will?	✓	✓
		1a(v)	Authorize or prohibit intrusive and irreversible treatments (such as psychosurgery and ECT)?	✓	✓
		1b	Does the composition of this body include an experienced legal practitioner and an experienced health care practitioner, and a “wise person” reflecting the “community” perspective?	✓	✓

Legislative issue (Table 1, continued)				Ireland	England
		1c	Does the law allow for appeal of this body's decisions to a higher court?	✓	✓
		2	Does the law set up a regulatory and oversight body to protect the rights of people with mental disorders within and outside mental health facilities?	✓	✓
		2a(i)	Does the above body conduct regular inspections of mental health facilities?	✓	✓
		2a(ii)	Provide guidance on minimizing intrusive treatments?	✓	✗
		2a(iii)	Maintain statistics; on, for example, the use of intrusive and irreversible treatments, seclusion and restraints?	✓	✓
		2a(iv)	Maintain registers of accredited facilities and professionals?	✗	✗
		2a(v)	Report and make recommendations directly to the appropriate government minister?	✓	✓
		2a(vi)	Publish findings on a regular basis?	✓	✓
		2b	Does the composition of the body include professionals (in mental health, legal, social work), representatives of users of mental health facilities, members representing families of people with mental disorders, advocates and lay persons?	✗	✓
		2c	Is this body's authority clearly stated in the legislation?	✓	✓
		3a	Does the legislation outline procedures for submissions, investigations and resolutions of complaints?	✗	✗
		3b(i)	Does the law stipulate the time period from the occurrence of the incident within which the complaint should be made?	✗	✗
		3b(ii)	Does the law stipulate a maximum time period within which the complaint should be responded to, by whom and how?	✗	✗
		3b(iii)	Does the law stipulate the right of patients to choose and appoint a personal representative and/or legal counsel to represent them in any appeals or complaints procedures?	✗	✗
		3b(iv)	Does the law stipulate the right of patients to an interpreter during the proceedings, if necessary?	✗	✗

<b>Legislative issue (Table 1, continued)</b>				<b>Ireland</b>	<b>England</b>
		3b(v)	Does the law stipulate the right of patients and their counsel to access copies of their medical records and any other relevant reports and documents during the complaints or appeals procedures?	✗	✗
		3b(vi)	Does the law stipulate the right of patients and their counsel to attend and participate in complaints and appeals procedures?	✗	✗
S	Police responsibilities	1	Does the law place restrictions on the activities of the police to ensure that persons with mental disorders are protected against unlawful arrest and detention, and are directed towards the appropriate health care services?	✓	✓
		2	Does the legislation allow family members, carers or health professionals to obtain police assistance in situations where a patient is highly aggressive or is showing out-of-control behaviour?	✓	✓
		3	Does the law allow for persons arrested for criminal acts, and in police custody, to be promptly assessed for mental disorder if there is suspicion of mental disorder?	✓	✓
		4	Does the law make provision for the police to assist in taking a person to a mental health facility who has been involuntarily admitted to the facility?	✓	✓
		5	Does legislation make provision for the police to find an involuntarily committed person who has absconded and return him/her to the mental health facility?	✓	✓
U	Discrimination	1	Does the law include provisions aimed at stopping discrimination against people with mental disorders?	✗	✓
V	Housing	1	Does the law ensure non-discrimination of people with mental disorders in the allocation of housing?	✗	✓
		2	Does the law make provision for housing of people with mental disorders in state housing schemes or through subsidized housing?	✗	✗
		3	Does the legislation make provision for housing in halfway homes and long-stay, supported homes for people with mental disorders?	✗	✗
W	Employment	1	Does the law make provision for the protection of persons with mental disorders from discrimination and exploitation in the work place?	✗	✓
		2	Does the law provide for “reasonable accommodation” for employees with mental disorders, for example by providing for a degree of flexibility in working hours to enable those employees to seek mental health treatment?	✗	✗

<b>Legislative issue (Table 1, continued)</b>				<b>Ireland</b>	<b>England</b>
		3	Does the law provide for equal employment opportunities for people with mental disorders?	✗	✗
		4	Does the law make provision for the establishment of vocational rehabilitation programmes and other programmes that provide jobs and employment in the community for people with mental disorders?	✗	✗
X	Social security	1	Does legislation provide for disability grants and pensions for people with mental disabilities?	✗	✗
		2	Does the law provide for disability grants and pensions for people with mental disorders at similar rates as those for people with physical disabilities?	✗	✗
Y	Civil issues	1	Does the law uphold the rights of people with mental disorders to the full range of civil, political, economic, social and cultural rights to which all people are entitled?	✗	✗
Z	Protection of vulnerable groups (minors)	1	Does the law limit the involuntary placement of minors in mental health facilities to instances where all feasible community alternatives have been tried?	✓	✓
		2a	If minors are placed in mental health facilities, does the legislation stipulate that they should have a separate living area from adults?	✗	✗
		2b	If minors are placed in mental health facilities, does the legislation stipulate that the environment is age-appropriate and takes into consideration the developmental needs of minors?	✗	✓
		3	Does the law ensure that all minors have an adult to represent them in all matters affecting them, including consenting to treatment?	✗	✗
		4	Does the law stipulate the need to take the opinions of minors into consideration on all issues affecting them (including consent to treatment), depending on their age and maturity?	✗	✓
		5	Does legislation ban all irreversible treatments for children?	✗	✗
	Protection of vulnerable groups (women)	1	Does legislation allow women with mental disorders equal rights with men in all matters relating to civil, political, economic, social and cultural rights?	✓	✓
		2a	Does the law ensure women in mental health facilities have adequate privacy?	✓	✗
		2b	Does the law ensure that women in mental health facilities are provided with separate sleeping facilities from men?	✗	✗

<b>Legislative issue (Table 1, continued)</b>				<b>Ireland</b>	<b>England</b>
		3	Does legislation state that women with mental disorders should receive equal mental health treatment and care as men, including access to mental health services and care in the community, and in relation to voluntary and involuntary admission and treatment?	✗	✗
	Protection of vulnerable groups (minorities)	1	Does legislation specifically state that persons with mental disorders should not be discriminated against on the grounds of race, colour, language, religion, political or other opinions, national, ethnic or social origin, legal or social status?	✗	✓
		2	Does the legislation provide for a review body to monitor involuntary admission and treatment of minorities and ensure non-discrimination on all matters?	✗	✗
		3	Does the law stipulate that refugees and asylum seekers are entitled to the same mental health treatment as other citizens of the host country?	✗	✗
AZ	Offences and penalties	1	Does the law have a section dealing with offences and appropriate penalties?	✓	✓
		2	Does the law provide appropriate sanctions against individuals who violate any of the rights of patients as established in the law?	✓	✓

**Notes:**

- This table comprises the World Health Organization’s “Checklist on Mental Health Legislation” (World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation*, Geneva: World Health Organization, 2005).
- The table indicates whether legislation in Ireland and England meets (✓) or does not meet (✗) specific standards.
- See text for details and references in relation to individual standards (Chapter 5).
- This thesis focuses on civil detention, so standards which relate solely to mentally ill offenders (E4; T1-6) are omitted.

**Table 2: Table of Legislation**

### **European Union**

European Union, “Treaty on European Union”, *Official Journal*, 1992, C191.

European Union, “Treaty of Amsterdam amending the Treaty of the European Union, the Treaties establishing the European Communities and certain related acts”, *Official Journal*, 1997, C340.

European Union, “Charter of Fundamental Rights of the European Union”, *Official Journal*, 2007, C303.

European Union, “Consolidated versions of the Treaty on European Union and the Treaty on the Functioning of the European Union”, *Official Journal*, 2008, C115.

### **England**

Magna Carta 1215.

De Praerogativa Regis 1324.

Petition of Rights 1628.

Habeas Corpus Act 1679.

Bill of Rights 1689.

Vagrancy Act 1744.

Criminal Lunatics Act 1800.

Lunacy Act 1890.

Lunacy Act 1891.

Mental Deficiency Act 1913.

Mental Treatment Act 1930.

Mental Health Act 1959.

Mental Health (Amendment) Act 1982.

Mental Health Act 1983.

Mental Health Act 1983 (Remedial) Order 2001 (SI 2001/3712).

Data Protection Act 1998.

Human Rights Act 1998.

Freedom of Information Act 2000.

Criminal Justice Act 2003.

Civil Partnership Act 2004.

Domestic Violence, Crime and Victims Act 2004.

Mental Capacity Act 2005.

Mental Health Act 2007.

Health and Social Care Act 2008.

## **Republic of Ireland**

Criminal Lunatics (Ireland) Act 1838.

Lunacy Regulations (Ireland) Act 1871.

Constitution of Ireland (*Bunreacht na hÉireann*) 1937.

Mental Treatment Act 1945.

Public Authorities Judicial Proceedings Act 1954.

Domestic Violence Act 1996.

Powers of Attorney Act 1996.

Freedom of Information Act 1997.

Data Protection Act 1998.

Human Rights Commission Act 2000

Mental Health Act 2001.

European Convention on Human Rights Act 2003.

Criminal Law (Insanity) Act 2006.

Mental Capacity and Guardianship Bill 2008.

Mental Health Act 2008.

Health (Miscellaneous Provisions) Act 2009.

## **Scotland**

Mental Health (Scotland) Act 1984.



**Table 3: Table of Cases**

**European Court of Human Rights**

*Aerts v Belgium* (1998) 29 EHRR 50.

*Ashingdane v UK* (1985) 7 EHRR 528.

*Benjamin v UK* (2002) 36 EHRR 1.

*Croke v Ireland* (2000) ECHR 680.

*De Wilde, Ooms and Versyp v Belgium* (1972) 1 EHRR 438.

*E v Norway* (1990) 17 EHRR 30.

*Fox, Campbell and Hartley v UK* (1990) 13 EHRR 157.

*Guzzardi v Italy* (1980) 3 EHRR 333.

*Herczegfalvy v Austria* (1991) 15 EHRR 437.

*HL v UK (Bournewood)* (2004) 40 EHRR 761

*HM v Switzerland* (2004) 38 EHRR 314.

*Hutchison Reid v UK* (2003) 37 EHRR 211.

*Johnson v UK* (1997) 27 EHRR 296.

*Kolanis v UK* (2006) 42 EHRR 12.

*LR v France* App no 33395/96 (ECHR, 27 June 2002)

*Megyeri v Germany* (1992) 15 EHRR 584.

*Munjaz v UK* App no 2913/06 (ECHR, 17 July 2012)

*Nikolova v Bulgaria* (2001) 31 EHRR 3.

*Nowicka v Poland* (2003) 1 FLR 417.

*Osman v UK* (2000) 29 EHRR 245.

*Pereira v Portugal* (2003) 36 EHRR 49.

*Van der Leer v Netherlands* (1990) 12 EHRR 567.

*Winterwerp v Netherlands* (1979) 2 EHRR 387.

*X v UK* (1981) 4 EHRR 181.

*X v UK* (1981) 4 EHRR 188.

## **England**

*Aston Cantlow and Wilmcote with Billesley PCC Church Council v Wallbank* [2003] UKHL 37, [2004] 1 AC 546.

*Campbell v Mirror Group Newspapers Ltd.* [2004] UKHL 22, [2004] 2 AC 457 (HL)

*R v Deputy Governor of Parkhurst Prison, ex parte Hague and Weldon* [1992] 1 AC 58.

*R (C) v London South and West Region Mental Health Review Tribunal* [2001] EWCA Civ 1110, [2002] 1 WLR 176.

*R (D) v Secretary of State for the Home Department* [2002] EWHC 2805 (Admin), [2003] 1 WLR 1315.

*R (H) v Mental Health Review Tribunal* [2002] EWHC 1522 (Admin), [2002] QB 1.

*R (H) v Secretary of State for Health* [2005] UKHL 60, [2006] 1 AC 441.

*R (Heather) v Leonard Cheshire Foundation* [2002] EWCA Civ 366, [2002] 2 All ER 936.

*R (KB) v Mental Health Review Tribunal* [2003] EWHC 193 (Admin), [2004] QB 936.

*R (M) v Secretary of State for Health* [2003] EWHC 1094 (Admin), [2003] 1 MHLR 88.

*R (Munjaz) v Mersey Care NHS Trust* [2003] EWCA Civ 1036, [2004] QB 395.

*R (Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58, [2006] 2 AC 148.

*R (N) v Ashworth Special Hospital Authority* [2001] EWHC 339 (Admin), [2001] HRLR 46.

*R (PS) v Responsible Medical Officer* [2003] EWHC 2335 (Admin).

*Rabone and Anor v Pennine Care NHS Trust* [2012] UKSC 2.

*Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74.

*Savage v South Essex Partnership NHS Foundation Trust* [2010] EWHC 865 (QB).

## **Republic of Ireland**

*AMC v St Lukes Hospital, Clonmel* [2007] IEHC 65.

*Blehein v The Minister for Health and Children and others* [2008] IESC 40.

*C v Clinical Director of St. Patrick's Hospital and Anor* [2009] IEHC 13.

*Croke v Smith* [1994] 3 IR 529.

*Croke v Smith (No. 2)* [1998] 1 IR 101.

*D Han v The President of the Circuit Court and Doctor Malcolm Garland and Doctor Richard Blennerhassett and Doctor Conor Farren and Professor Patrick McKeon and the Mental Health Commission and the Mental Health Tribunal* [2008] IEHC 160.

*EF v The Clinical Director of St Ita's Hospital* [2007] JR 816.

*EH v St. Vincent's Hospital and Ors* [2009] IESC 46.

*FW v Dept. of Psychiatry James Connolly Memorial Hospital* [2008] IEHC 283.

*H v Clinical Director of St. Vincent's Hospital and Ors* [2009] IEHC 69.

*JB v The Director of the Central Mental Hospital and Dr. Ronan Hearne and the Mental Health Commission and the Mental Health Tribunal* [2007] IEHC 201).

*JF v DPP* [2005] 2 IR 174.

*JH v Vincent Russell, Clinical Director of Cavan General Hospital* [2007] unreported High Court judgment

*MD v Clinical Director of St Brendan's Hospital and Anor* [2007] IEHC 183.

*MM v Clinical Director Central Mental Hospital* [2008] IESC 31.

*MR v Cathy Byrne, administrator, and Dr. Fidelma Flynn, clinical director, Sligo Mental Health Services, Ballytivnan, Co. Sligo* [2007] IEHC 73.

*Patrick McCreevy v The Medical Director of the Mater Misericordia Hospital in the City of Dublin, and the Clinical Director of St. Aloysius Ward Psychiatric Unit of the Mater Misericordia Hospital in the City of Dublin and the Health Service Executive and, by order, the Mental Health Tribunal* [2007] SS 1413.

*PL v Clinical Director of St. Patricks University Hospital and Dr. Séamus Ó Ceallaigh* [2012] IEHC 15.

*Q v St Patrick's Hospital* [2006] O'Higgins J, *ex tempore*, 21 December 2006.

*Re A Ward of Court (Withholding Medical Treatment) (No. 2)* [1996] 2 IR, [1995] 2 ILRM 40.

*SM v The Mental Health Commissioner, The Mental Health Tribunal, The Clinical Director of St Patrick's Hospital, Dublin, Attorney General and the Human Rights Commission* [2008] JR 749.

*TH v DPP* [2006] 3 IR 520.

*TO'D v Harry Kennedy and Others* [2007] IEHC 129.

*TS v Mental Health Tribunal, Ireland, The Attorney General, The Minister for Health and Children, The Mental Health Commission, Bola Oluwole and Ciaran Power* [2007] JR 1562.

*WQ v Mental Health Commission* [2007] IEHC 154.

*Z v Khattak and Anor* [2008] IEHC 262.

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