

International human rights law and mental illness

John Tobin

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Abstract

The Irish State has been party to a collection of international treaties and declarations that directly affect the care of those who suffer from mental disorders. These documents set up what are considered as minimum core standards that outline the standard of care that should be provided as a basic human right. This article reviews the relevant sections of these documents and reflects as to how they have been applied in Ireland. International conventions, which have the status of a treaty, are monitored and interpreted by various commissions and committees. This article draws on the comments of these bodies as to how a state should provide for those with mental illness. Areas such as the rights of children who are mentally ill and those who are detained by the state are examined in detail. Other areas covered are the right to the highest attainable level of mental health care, the right not to be subjected to a clinical trial, equal access to mental health care, and the right to be safeguarded against unjust involuntary detention.

Key words: Human rights law; Minimum core standards; Mental healthcare; Equitable distribution; Therapeutic environment; Informed consent; Involuntary detention; Right to liberty; Discrimination.

Introduction

International human rights law provides a powerful and often neglected method to advance the rights and freedoms of persons with mental disabilities. There is a need to more effectively apply these rights to the mental health needs of this vulnerable section of society. Mental health policy affects human rights and human rights violations affect mental health. The positive promotion of both mental health and human rights are mutually reinforcing. Domestic mental health law allows state authorities to detain, restrain and force treatment on those that society considers to be suffering from a major mental illness. Such legislation if used arbitrarily can lead to gross violations of individual human rights.

As of December 31, 2003, there were 3,701 patients residing in psychiatric hospitals in Ireland. During 2003 there were 23,234 admissions of which 2,349 were involuntary. Of the patients in hospital at the end of 2003, 55% were in hospital for over a year.¹ Irish psychiatric services has been undergoing changes over the last two decades, as it moves

from treating patients in large mental hospitals to care in the community. Following the guidelines set out in 1984 in the document *Planning for the Future*² the number of psychiatric inpatient beds was reduced from 11,114 in 1987 to 3,701 in 2003. This was followed, by an inadequate budget for psychiatric care in the community, as the overall budget for mental health fell from 10.6% of the health budget in 1990 to 6.8% in 2004.³ According to the World Health Organisation (WHO), within the European region, the percentage of the health budget spent on mental health varies from 3% to over 20%.⁴

Mental illness accounts for 12.9% of the overall health disability (defined as disability adjusted life years),⁵ yet in Ireland's case it is only receiving half of the appropriate allocated funding for the level of disability in the community. One of the reasons that governments may be under-funding mental health is a failure to recognise the level by which patients can benefit from treatment, and a belief that other areas of health benefit more from the financial input.⁶

Driven by the requirements of the European Convention of Human Rights and Fundamental Freedoms (ECHR),⁷ in relation to involuntary detention, the Irish Government has introduced the Mental Health Act 2001. It has replaced the Mental Treatment Act of 1945.

Under the 1945 Act a person with a mental handicap or who is mentally infirm may be classified as a "person of unsound mind" and can be involuntarily detained on broad grounds without any qualification as to their behaviour or danger to themselves or others.⁸ The Mental Treatment Act 1945 did not deal with the issue of informed consent to treatment of detained patients. It was widely assumed that consent to treatment was not required of an involuntarily detained patient, even though under common law physical treatment is unlawful without a person's consent unless the treatment is urgently necessary. If medical treatment is given without consent it may be trespass against the person in civil law, a battery in criminal law, and a breach in an individuals constitutional rights.⁹

The Mental Health Act 2001 has now been implemented at the time of writing. The Mental Health Commission (established by the Act) has established the Mental Health Review Tribunals (MHRT) to assess all involuntary admissions to psychiatric hospitals within 21 days of detention. If the involuntary detention is extended beyond the 21 days by the MHRT, it is to be reviewed again at three months and then on a yearly basis thereafter. The European Convention of Human Rights and Fundamental Freedoms was incorporated into Irish law with the European Convention on Human Rights Act 2003. This Act will be subservient to the Irish constitution.¹⁰

A survey by the Irish Psychiatric Association into Psychi-

John Tobin, MB, LL.M., MRCPsych, FRCPC, BSc, Consultant Psychiatrist, St Bricin's Military Hospital, Dublin, Ireland.

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atric services in Ireland in 2003,¹¹ led to some unsettling findings. Clinical resources were applied more generously to areas of affluence, than to areas of social deprivation. Service development had progressed without sufficient reference to socio-political or demographic realities. An impression is created that mental health resource allocation is being determined by local politics, rather than on a need basis.

Specialist psychiatric services such as forensic, old age, child and adolescent psychiatry are poorly available outside the capital. A dedicated adolescent psychiatric service is not available to 88% of the population. Only 6% of women had access to peri-natal psychiatric care. Fifty-nine per cent of the country had no access to a dedicated forensic psychiatric service. Though, it was recently pointed out by O'Neill¹² that 80% of those who meet the criteria for admission to the only forensic unit in Ireland (The Central Mental Hospital) come from the most socially deprived areas of Dublin City.

There appears to be a lack of central and long term planning associated with an inadequate budget. At a time of crisis in the health services generally, mental health, an area that is associated with stigma, is being starved of resources. This is despite international undertakings by the Irish Government to provide the best attainable healthcare for those suffering from mental illness. It would appear that at this time of plenty in the Irish economy that a new approach needs to be taken to encourage the Irish Government to take responsibility for the neglected mental health services.

People with mental illness and disabilities can experience some of the harshest living conditions that exist in any society.¹³ Their hardship comes from stigma, neglect, and lack of legal protection. One approach to improve their living conditions is to tackle this neglect as a denial of human rights to a marginalised and vulnerable section of the population. The human rights aspect of mental health is accepted by the Irish Government by their signing and ratification of human rights documents that refer to health and mental health. The 1993 World Conference on Human Rights, meeting in Vienna, issued a declaration, which has since become known as the Vienna Declaration. It stated that among other things, all governments were under an obligation to adjust or adopt legislation that would ensure access to work, welfare, education and independent living to physically and mentally disabled persons.¹⁴

Human rights law

The human rights standards established by the international and regional bodies are meant to be considered as the minimum core standards that are applicable. These standards are evolving over time and it is incumbent upon the Irish Government to at least keep pace with these changes. While international human rights law has grown significantly over the last 35 years, the development of international law to protect the rights of those with mental illness has been slow and limited. Overall, human rights forums have been generally unresponsive to the situation and specific needs of people with disabilities.¹⁵

The first international recognition of a right to healthcare was in the Universal Declaration of Human Rights (UDHR), adopted in 1948.¹⁶ Article 25 recognises *inter alia* the right to a standard of living adequate for health and well being, and to medical care. There is no specific mention of mental health.

Table 1: International treaties and declarations relevant to mental health

- UN Universal Declaration of Human Rights (1948), Article 25.
- UN Convention on Economic, Social and Cultural Rights (1966), Article 12.
- UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991).
- UN Declaration on the Rights of Disabled Persons (1975).
- UN Convention on the Elimination of all Forms of Discrimination against Women (1979), Article 12.
- UN Convention on the Rights of the Child (1989), Article 25.
- UN International Covenant on the Elimination of all forms of Racial Discrimination (1966).
- UN Body of Principles for the Protection of all Persons under any Form of Detention or Imprisonment (1988).
- UN Standard Rules on Equalisation of Opportunities for Persons with Disabilities (1993).
- UN International Covenant on Civil and Political Rights (1966), Article 7.
- European Convention of Human and Fundamental Rights (1950), Council of Europe.

It is in article 12 of the UN Convention on Economic, Social and Cultural Rights (ICESCR)¹⁷ that the issue of mental health is first addressed. It states; *"The state parties to the present covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"*. Section 2(d) of Article 12 states that there should be *"the creation of conditions which would assure to all, medical service and medical attention in the event of sickness"*.

The importance of this document (Ireland ratified it on the Dec 8, 1989) lies in the fact that there is a level of accountability built into it. Ireland has submitted two periodic reports to the Committee on Economic, Social and Cultural Rights (CESCR), under article 40 of the Covenant. The CESCR monitors the implementation of the ICESCR and interprets the Convention. The area of justiciability of the rights in regard to this convention is in dispute and is discussed elsewhere.¹⁸ They are regarded by some states, as general directives, rather than as binding human rights.¹⁹

Currently the only sanction to a state for the denial of these rights is international embarrassment. General Comment No: 14 by the CESCR says that the progressive realisation of the right to health over a period of time should not be interpreted as depriving states parties of their obligation to move as expeditiously and effectively as possible towards the full realisation of Article 12.²⁰

The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and the resources available to a state. Because article 2.2 of the ICESCR uses words like "steps to be taken" in relation to the states parties and "to achieve full realisation", the implication is that the rights are to develop over time. The question to be asked is how long should elapse until these rights are firmly based in international law, rather than just being aspirational?

The most specific and detailed international document in

relation to mental health is the *UN Principles for the Protection of Persons with Mental Illness and the improvement of Mental Health Care (MI Principles)*.²¹ This document not only deals with the "right to the best available mental health care", it also deals with issues relating to discrimination, mental incapacity, confidentiality, treatment and involuntary detention.

MI Principle 16 emphasises that patients should be treated in the least restrictive environment, which improves their autonomy, thus indicating that there is a preference to the development of care in the community rather than in institutions. This is consistent with the 1984 document *Planning for the Future*, under which the Irish mental health care services are being developed. The MI Principles have been criticised for promoting a medical model and paternalistic approach to those with mental illness, rather than using a human rights based perspective.²²

The area of the mentally disabled is addressed in the UN Declaration on the Rights of Disabled Persons (1975).²³ The Disability Declaration asserts an extensive set of civil, political, economic, social and cultural rights. Article 6 addresses "medical, psychological and functional treatment". Articles 5 and 9 endorse the effort to care for the disabled in the community. It provides for people with disability to live in an environment where they are as self reliant as possible.

The MI Principles are considered as a set of guidelines to be developed by the states parties, rather than as a legally binding document.²⁴ The MI Principles can also be used as a guide to interpreting the relevant sections of the binding conventions. Its current status would be that of soft law.²⁵ It has been described as "the most complete set of standards for the protection of the rights of persons with disability at an international level".²⁶

The MI Principles apply also to those who have been admitted to mental health facilities and who do not suffer from a mental illness. In this way it gives protection to those who are inappropriately placed in a psychiatric hospital for social or political reasons. Historically in Ireland, people had been admitted to psychiatric institutions for behavioural problems that were not culturally acceptable, and may have been secondary to their social environment. They could remain in these institutions because of a lack of facilities or other services to meet their needs.

At present there are no conventions, which are legally binding, as opposed to declarations, which are aspirational, specifically addressing the human rights of the mentally ill. On the November 28, 2001, the UN General Assembly, at the instigation of Mexico, adopted a resolution calling for the creation of an Ad Hoc Committee "to consider proposals for a comprehensive and integral international convention to protect and promote the rights and dignity of persons with disabilities".²⁷ Such disabilities would include mental disabilities. It is not yet certain that the United Nations will adopt a Convention on the Rights of People with Disabilities. Even if they did so governments would have to ratify it before it could become legally binding. This process is certainly well into the future. In the meantime States are obliged to abide by the requirements of existing international law.

Other documents giving recognition to the health rights (which include mental health) of vulnerable groups are; Article 12 of the Convention on the Elimination of all Forms of

Discrimination against Women (CEDAW) (1979),²⁸ and Article 25 of the Convention on the Rights of the Child (CRC) (1989).²⁹ Article 25 of the CRC asserts "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health". Ireland signed the CEDAW on the Dec 23, 1985; it is yet to be ratified. The CRC was ratified by Ireland in 1992.

Article 5(e)(4) of the International Covenant on the Elimination of all forms of Racial Discrimination (ICERD),³⁰ includes "the right to public health, medical care, social security, and social services".

Pursuant to the World Conference on Human Rights in Vienna in 1993, the UN General Assembly adopted a resolution known as the "Standard Rules on Equalisation of Opportunities for Persons with Disabilities" (Standard Rules).³¹ These recommendations became known as the 'Standard Rules' and are of relevance to those suffering from mental disorder though not specifically targeted at mental disability. They recommended representation for those with disabilities and their support organisations, in the public process of the formation of domestic law that may affect them.

The Standard Rules also gives recommendations that disability rights principles be incorporated into existing domestic law and for new legislation to be adopted where necessary to improve the human rights of the disabled. By recognising and respecting the right of people who have received psychiatric care to be involved in mental health planning and legislation, the Standard Rules provide a protection against the delivery of a discriminatory and an inappropriate mental health care services.

General Comment No: 5³² of the CESCR recognises that the Standard Rules should be used as a guide to interpreting Article 12 of the ICESCR. The Standard Rules unlike the MI Principles have provided for a supervisory committee and a Special Rapporteur. The Standard Rules give guidance on the active participation of the disabled in society, and it is considered that for the mentally disabled they are complementary to the MI Principles.³³ Together they both establish the human rights norms in the area of mental disability.

Right to the highest attainable mental healthcare

General Comment No: 14 (para 36) of the CESCR states that state parties have to provide a sufficient number of hospitals and clinics and other health related facilities. It also says that they have to promote the development of institutions providing counselling and mental health services, with a due regard to an equitable distribution throughout the country. General Comment No: 14 (para 12) says that the services have to be available, accessible, acceptable and of good quality.

As has already been noted from the Irish Psychiatric Association's document *The Stark Facts*, the distribution of psychiatric resources is very uneven in Ireland. The greatest resources are in the areas of greatest affluence. The Irish Government came under criticism from the Amnesty International (AI) report on services for the mentally ill in 2003.³⁴ The report was prepared by interviewing service users and providers as well as the examination of the reports of the Inspector of Mental Hospitals. AI noted that the ultimate

responsibility for mental health services lay with the Irish Government. The report recognised that despite significant efforts, Irish mental health care policy and service provision remained out of step with international best practice and fails to comply with international human rights law.

The Amnesty report focused on areas such as the physical conditions in which patients were looked after. It noted that many of the hospitals and mental health units were substandard, with overcrowding, and poor living conditions. Because of overcrowding, the right to privacy may be interfered with. Because patients can spend a prolonged period of time in an institution, the denial of this right can cause undue suffering in what are a vulnerable and marginalised group.

This is contrary to Article 12 of the UDHR and Article 17 of the UN International Convention on Civil and Political Rights (ICCPR),³⁵ which states that, "no one shall be subjected to arbitrary or unlawful interference with his privacy". General Comment No: 14 of the CESCR notes that the health facilities, should be appropriate and of good quality. For services to be of appropriate quality, they must also be culturally acceptable, medically appropriate, and provided in a safe and clean environment.

MI Principle 13(2) states; "*the environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age*".

The European Court of Human Rights has been considered to have too high a threshold in relation to what can be considered as inhuman and degrading treatment so as to breach Article 3 of the ECHR, and cases in this regard have been unsuccessful when involving institutional care.³⁶

The case of *Price v. UK*³⁷ in 2001 may open the way for the Court to deal more effectively with cases of severe neglect and ill treatment as cruel, inhuman, or degrading treatment. In this judgement the Court stressed the importance of the context in relation to the ill treatment and its level of severity. It believed that that the ill treatment must attain a minimum level of severity if it is to fall within the scope of the ECHR. The assessment of this severity depends on all the circumstances of the case, such as its duration, its physical and mental effects and in some cases, the sex, age, and state of health of the victim.

In one earlier judgement it did recognise that "*positions of inferiority and powerlessness, which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with*".³⁸

When a person is admitted as an involuntary patient to a psychiatric hospital it is to be presumed that the purpose of the detention is to be therapeutic. Such detention can only take place in a facility equipped to provide minimally adequate care and treatment.

In the case of *Aerts v. Belgium*³⁹ in 1998, the European Court was of the opinion that "the aim of the detention and the conditions in which it took place" did not provide the appropriate balance between medical care and therapeutic environment. Within psychiatric facilities there are times when patients are placed in seclusion. There is no other medical area where this kind of practice can be found other than for the control of contagious diseases. The Inspector of Mental Hospitals in his 2003 report noted the variation between the utilisation of seclusion by different hospitals, and was pleased

to observe the reduction in its use. MI Principle 11 says that it can only be deployed when it is the only means available to prevent immediate or imminent harm to the patient or others. It should not be used longer than necessary. The use of seclusion as a tool of administrative convenience because of a lack of staff is clearly prohibited.

The utilisation of seclusion or restraint may amount to inhuman or degrading treatment, but unlike torture it does not require malevolent intent.

The emphasis placed by the Irish Government on developing care in the community, away from the large institutions of the past, is in keeping with the best international practice and is consistent with the development of patient autonomy as delineated by human rights documents. MI Principle 9(4) recognises that "*the treatment of every patient shall be directed towards preserving and enhancing personal autonomy*". The emphasis placed on 'every patient' is very important. This prevents the long-term incarceration of individual patients, with no long term planning for their eventual reintegration into society.

General Comment No 5 (Para 5 on Article 12 of the ICESCR) states that the right to physical and mental health implies that there should be access to medical and social care that will allow a person with disabilities to become independent, prevent further disabilities, and support their social integration. This is in keeping with the Standard Rules (No: 3), which says that the rehabilitative services should be designed to enable individuals to reach and sustain their optimum level of independence and functioning.

The right not to be subjected to clinical trials

Section 70 of the new Irish Mental Health Act (2001) states that "*a person suffering from a mental disorder who has been admitted to an approved centre under this Act shall not be a participant in a clinical trial*". What this section is saying is, that those who are mentally ill and are subject to an order removing their individual liberty, are not allowed to be subjects in a clinical trial. This is independent of their competence and capacity to give consent. This is progressive legislation and is ahead of some of the international recommendations and conventions. The fact that a patient's liberty has been removed implies that the patient is under duress and any consent given is not completely free.

In what is a more worrying statement, the MI Principle 10 says: "*Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose*".

Even for 1991 when the MI principles were declared, this was a retrograde step. After acknowledging the need for informed consent, it carves out an exception to the rule, which allows experimentation on those unable to give free consent and have lost their liberty, which in many ways seriously devalues this principle. The attitude taken in allowing an independent review body to make a decision on behalf of a patient is paternalistic at best and open to abuse at worst.

There is an increasing recognition that those who are without liberty and are in the custody of the state are unable to

consent freely. They may have the capacity to consent, but the loss of liberty is a form of duress that leaves a doubt as to whether any consent given by the person is truly free. This is an uncomfortable thought for those of us who treat patients who are held involuntarily. They may agree to take the treatment provided, but are they truly consenting? At least the 2001 Mental Health Act recognises that there is a problem in regard to the involuntary detained giving free consent to participate in clinical trials which unlike accepted treatments is not required for the patients well being.

The strongest language in relation to clinical trials is in Article 7 of the International Covenant on Civil and Political Rights (ICCPR), which addresses the area of torture. It says "In particular, no one shall be subjected without his free consent to medical or scientific experimentation". The statement is clear and does not allow any exception from "free consent".

The history of the origin of this clause is interesting. It is a reaction to the horrors of the quasi-medical experimentation and the killing of the mentally ill and social un-desirables in Nazi Germany.⁴⁰ It is clear that the drafters of the ICCPR intended to link the protection against torture, inhuman and degrading treatment with protection against possible coercive medical practices. Article 7 is non-derogable, it can never be utilised even under conditions of emergency. Article 7 does not allow for surrogate consent to experimentation upon an individual who is not capable of informed consent. The Ethical Principles for Medical Research involving Human Subjects (Declaration of Helsinki), the guidelines prepared by the World Medical Association does allow for surrogate consent.⁴¹

Involuntary detention

Mental health legislation has to be concerned with the physical protection of mentally incapacitated persons, their carers and the public. To this end legislation is created to provide for the involuntary detention of mentally incapacitated persons in certain circumstances, under the *parens patriae* power vested in the State. Any restriction on the liberty of such people and any interference with their rights must be kept to a minimum, and their dignity and self-respect fostered. Mental disability may entail restricting or modifying the exercise of natural justice, it cannot negate the essence of that right.

According to MI Principle No: 16 involuntary treatments can only be justified if the appropriate treatment "*can only be by admission to a mental health facility in accordance with the principle of the least restrictive alternative*". If a person can receive appropriate treatment in the community, involuntary commitment could not be justified.

MI Principle 16(2) permits detention for a "short period" which must be specified by domestic law, "for observation and preliminary treatment pending review". The criterion for admission is looser in the MI Principles than it is in some domestic legislation. MI Principle 16(1b) allows for involuntary admission to prevent "serious deterioration" in the mental state, while many domestic legal systems only allow involuntary admission when there is a physical risk to self or others [42]. The criteria laid out in part two of the new Irish Mental Health Act 2001 allows involuntary admission of those suffering from a mental disorder who are a risk to themselves and

others. It also allows admission in order to prevent serious deterioration in someone who is seriously ill, and who will benefit from the involuntary admission to the approved centre (designated psychiatric facility).

The area of involuntary detention in Ireland has long been problematic. The new Mental Health Act, which was fully enacted at the end of 2006 will allow review after 21 days of involuntary detention. The old Mental Treatment Act of 1945, allowed appeal to the President of the High Court, the Inspector of Mental Hospitals and Minister for Health and Children. There was no automatic independent review of involuntary detention under this Act.

MI Principle 17(2) states that inter alia "*a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law*".

The Inspector of Mental Hospitals has noted the fact that many psychiatric patients are unaware of their right to appeal against involuntary admission.⁴³ MI Principle 12(1) states that; "*A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all of his or her rights in accordance with these principles and under domestic law, which information shall include an explanation of those rights and how to exercise them*".

It is perturbing as to why the Irish Government chose to object to article 4.3 of the Council of Europe Recommendations for the Legal Protection of Persons suffering from Mental Disorders placed as Involuntary Patients.⁴⁴ The Recommendations state; "*He should be informed of his right to appeal against the decision ordering or confirming the placement and if he requests it or the judge considers it would be appropriate, have the benefit of the assistance of a counsel or another person*".⁴⁵

It could be perceived that the Irish government's reluctance to accept this article lies with concerns in relation to paying the cost of counsel through the free Legal Aid Scheme. These recommendations will eventually be submitted to the Council of Ministers. If they are accepted, the states, will not be obliged to implement them, but will be expected to use them as a form of guidance for the national legislation.⁴⁶

In the Concluding Observations of the Human Rights Committee, which monitors compliance with the ICCPR, to the 2nd report submitted by Ireland in 2000, the Committee expressed concern about the lack of prompt review of detention on mental health grounds.⁴⁷ They recommended that it should occur within a few days of loss of liberty.

The European Court of Human Rights stated that "*where a decision depriving a person of his liberty is one taken by an administrative body, there is no doubt that Article 5(4) (ECHR) obliges the Contracting States to make available to the person detained a right to recourse by a court*".⁴⁸ The European Court appears to view detention as a relatively long period of confinement for the purposes of Article 5 of the ECHR, when it is within an institution.⁴⁹ The European Court has found that delays of four to five months violated the ECHR.⁵⁰ The court must be vested with the ultimate power to discharge the patient, and may not act merely as an advisory body.⁵¹

In the case of *Croke v. Ireland*⁵² before the European Court

of Human Rights, the applicant stated that his right to liberty and security, as outlined under article 5 of the European Convention of Human Rights, were denied. In particular the absence of an independent and automatic review prior to or immediately after his initial detention in a psychiatric institution, and the lack of periodic review thereafter. Though the case was struck out following a friendly settlement, there was a specific agreement that the applicant "had regard to the expressed intention of the Government of Ireland to secure the enactment into law of the Mental Health Bill" in 1999. Also, the Irish Government noted in the agreement the "very special circumstances of the applicant as the first Irish person to bring this important issue before the Court".

Mental health care may involve the removal of civil liberties from the sufferer, and may result in some form of detention. There are elements of protection applicable in the International Covenant on Civil and Political Rights ICCPR. Ireland ratified this Convention on the December 8, 1989.

Article 9.1 of the ICCPR states that "Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with procedures as are established by law". The right to have prompt judicial review of the loss of liberty is covered by article 9.4 which states "Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that the court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful".

Appeal can be made to the Human Rights Committee in cases of unjust detention. Such an appeal can be made under the first Optional Protocol if the appellant is an individual and a non-state actor. The first Optional Protocol to the ICCPR was ratified by Ireland on the Dec 8, 1989. The area of involuntary detention is also addressed in article 5 of the ECHR. It states: "Everyone has the right to liberty and security of person. No one will be deprived of liberty", except in certain circumstances, such as in article 5.1.f "persons of unsound mind, alcoholics or drug addicts".

No definition is given as to what 'unsound mind' entails. The European Court of Human Rights has said that because of the fluidity of the terms usage, it should not be given a definitive interpretation. The state must establish through 'objective medical expertise' that the person is of unsound mind before detention can take place.⁵³ The European Court of Human Rights has found that the detention of a person without first obtaining medical expert opinion was unlawful in *Varbanov v. Bulgaria*.⁵⁴ If domestic law authorises emergency admission to hospital, the European Court of Human Rights accepts that "wide discretion must in the nature of things be enjoyed by the national authority empowered to order such emergency confinements".⁵⁵ Nevertheless, a thorough medical examination must, in all cases, occur promptly after the emergency admission.

The language in Article 5.1.f appears to reflect its time when it was written in 1950. To the modern reader it would appear to imply that these three categories of persons (ie. unsound mind, alcoholic, and drug addict) are being exempted from the protection being afforded to others. The ECHR also allows prompt appeal for involuntary detention. Article 5.4 states; "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".

In the case of *Winterwerp v. The Netherlands* (see Ref 52), the European Court of Human Rights found that the judicial proceedings in the Netherlands 'Mentally Ill Persons Act' had inadequate procedural protections under Article 5.4 (ECHR). This case established that civil commitment must be followed by a procedure prescribed by law, it cannot be arbitrary, the person must have a recognised mental illness, that requires confinement for the purpose of treatment. The right of individuals to bring human rights violations directly to the European Court has allowed those with mental disabilities an alternative legal venue when the domestic protections appear inadequate.

It should not be automatically accepted that when a patient is involuntarily detained that they are incapable of giving consent to the treatment being proposed or in managing their finances or looking after other aspects of their social and economic affairs.⁵⁶ To do so would further impinge on their basic human rights and inherent dignity as a person. It is important that incapacity findings should also note the areas where a patient's capacity is still functioning.

Equal access to mental health care

General Comment No: 14 (para 12b) of the Committee on Economic, Cultural and Social Rights says that health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination.

In the concluding observations of the Human Rights Committee to the Second Periodic report from Ireland in 2000 the Committee recommended that the Irish Government introduce a human rights framework into the National Health Strategy and to introduce a common waiting list for both publicly and privately insured patients. The fact that those who can afford private health insurance are able to gain faster access and more rapid inpatient mental health treatment is in contradiction to article 12(d) of the ICESCR. Article 12(d) states "the creation of conditions which would assure to all, medical services and medical attention in the event of sickness".

Recognising the progressive realisation of rights under the ICESCR, there are certain elements of the right to health that are considered immediate, and this includes protection against any form of discrimination. The gap between those in Ireland who can access mental health care rapidly because of their financial resources or the area in which they live, and those who have to wait for what is often an under-resourced service, is discrimination.

MI Principle 8(1) states: "every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons".

One section of the population that is neglected is children who are suffering from mental illness. In 2001 there were 25 admissions of persons under the age of 16 years to adult psychiatric facilities.⁵⁷ There are only 20 hospital beds in the Republic of Ireland to cater for the mentally ill child and adolescent. The First Report of the Working Group on Child

and Adolescent Psychiatry recommended that there should be 144 in-patient beds for the whole country.⁵⁸

In various reports by the Inspector of Mental hospitals, he has expressed his concern at the placement of children in adult psychiatric institutions. The Inspector noted that the virtual absence of residential places for children and adolescents was a serious national shortcoming. In spite of these reports the Irish Government has been slow to act to rectify the situation. In 1998 the UN Committee on the Rights of the Child expressed concern at the lack of adequate programmes and services addressing the mental health of children in Ireland.⁵⁹

According to Article 34(c) of the UN Convention on the Rights of the Child, every child that is deprived of its liberty should be separated from adults unless it is in the child's best interest not to do so. Admitting children to adult psychiatric wards is exposing the children to an environment that is not optimal to their mental health, and could be counter-therapeutic.

The Council of Europe's white paper on involuntary treatment in the year 2000, recommended that minors subject to involuntary placement should be treated and reside in different premises from those in which adults reside. They also recommended that their education should not be ignored, and should be continued while they are detained.⁶⁰

Existing child and adolescent psychiatric services are poorly developed. Adolescents between 13-15 years old have a high rate of emergency presentations with acute psychiatric illness and after suicide attempts.⁶¹ The failure by the state to provide inpatient hospital beds for this age group is discriminatory.

An interesting area in regard to the provision of mental healthcare in Ireland is the MI Principle 7(3), which states that everyone who is receiving mental healthcare should have that "treatment suited to his or her cultural background". This implies that a special understanding of the cultural background of the Travelling Community and the various immigrant groups need to be catered for. This also presupposes a need to provide psychiatric services that are sensitive to their background of social deprivation, discrimination, and possible adverse life experiences, when relevant.

The MI Principles No: 1(4) allows for positive discrimination in such cases. It recognises that "*special measures to protect the rights, or secure the advancement of persons with mental illness shall not be deemed discriminatory*". There has been little affirmative action taken by the Irish healthcare system to look after the specific mental health needs of these groups.

The Irish Human Rights Commission has expressed its concerns to the Irish Government in regard to clause 4(3)(C) of the Immigration Bill 2004.⁶² This sub-clause allows refusal of entry into Ireland of any person suffering from a prescribed disease or a mental disorder within the meaning of the Mental Health Act 2001.

This it views as discriminatory as it blocks entry to those who may have a psychiatric illness but who do not pose a risk to others. This is severe discrimination and reflects prejudice and stigma. If the same logic were to be applied across other medical conditions, denial of entry would be in place for those with high blood pressure, and those who suffer from diabetes.

The mentally ill who break the law

The Irish Government is failing to provide its prison population with equitable access to mental health care. A study performed between 1992 and 1993 in Mountjoy Prison in Dublin found that 5% of those incarcerated had a major psychiatric illness.⁶³ It also found that a further 9% had a psychiatric diagnosis other than substance abuse. The impression was formed that as the major psychiatric institutions were being closed down, their patients were drifting into the prison system.⁶⁴ Prisoners are entitled to the same level of health care as others. This is consistent with article 2.2 of the ICESCR, which states; "*The state parties to the present covenant undertake to guarantee that the rights enunciated in the present covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status*".

The lack of adequate mental health care for prisoners is a failure of availability, and accessibility, as well as discrimination as outlined in General Comment no: 14 of the Committee on Economic, Social and Cultural Rights.

Patients in prison who need transfer to a psychiatric hospital are put on a waiting list for the Central Mental Hospital (The only forensic psychiatric facility in Ireland). There is reluctance on an already over-stretched non-forensic general psychiatric service to accept these patients. As a result such patients can spend a prolonged period of time in the nontherapeutic environment of prison, sometimes being held in seclusion in a padded cell.

There was marked criticism by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) following its visit to Ireland, in May 2002.⁶⁵ Such was their concern that they invoked Article 8 para 5 of the ECHR in regard to the use of padded cells in Cork and Mountjoy Prisons, for prisoners in need of psychiatric care and inpatient psychiatric treatment. Article 8 para 5 allows the Committee to immediately communicate observations to the competent authority. They called upon the Irish authorities to take immediate steps to discontinue this practice.

Ireland ratified the European Convention for the Prevention of torture and Inhuman or Degrading Treatment or Punishment on the 14th of March 1988. The Convention uses the power of moral persuasion and relies on government cooperation. Its systematic monitoring of places of detention helps assure compliance with the standards set in Article 3 of the ECHR ("no one will be subject to cruel, inhuman or degrading treatment or torture").

The whole area of the use of padded cells in prisons has been contentious. The CPT report of 2002 describes them as dirty and with poor lighting. Section 38 of the report describes how the mentally ill prisoners were provided with disposable chamber pots and a mattress with dirty blankets. The prisoner could be left in their underwear in the cell all day. It is rightly recognised that such conditions are anti-therapeutic and could lead to further deterioration in the person's mental state. It was the CPT's opinion that such treatment was inhuman and degrading. Such prolonged isolation in such degrading circumstances constitutes cruel, inhuman, and degrading treatment contrary to article 7 of the ICCPR. General Comment No: 5 (para 12) of the CESCR makes it

clear that under Article 12 of the ICESCR, governments are required to provide healthcare services in such a way that the persons concerned are able to maintain full respect for their rights and dignity.

In the case of *Ashingdane v. UK*⁶⁶ (1985), the European Court of Human Rights held that the lawfulness of a patient's detention would be questionable if the person were incarcerated in appalling conditions with no consideration being given to their treatment.

MI Principle 2 states; "*all persons with a mental illness or who are being treated as such persons shall be treated with humanity and respect for the inherent dignity of the human person*".

In a letter dated August 6, 2002 the Irish authorities informed the CPT of their undertaking that "no mentally ill prisoner who is awaiting transfer to the Central Mental Hospital will be held in a padded cell in prison unless this is unavoidably necessary as an immediate and time limited measure" (cf section 39 CPT report 2002). They also committed themselves to eliminate delays in the provision of inpatient psychiatric care for mentally ill prisoners.

The CPT criticised the Central Mental Hospital. As with their two previous reports into the physical conditions in the Central Mental Hospital, the CPT was critical of the unsanitary and dilapidated state of some of the buildings, and recommended immediate rectification of this denial of human rights (cf section 135 CPT report 2002).

The unacceptable physical conditions in the Central Mental Hospital have been pointed out in many of the annual reports of the Inspector of Mental Hospitals. The conditions are described as de-humanising. Given that many of the patients can spend many years in these conditions, their right to adequate housing is being contravened as outlined in article 25 of the UDHR and article 11 of the ICESCR. It is not just in the Central Mental Hospital that poor conditions have been reported. There are poor hospital conditions, for the psychiatrically ill, in many parts of the country. Governments are required to provide adequate funding for the basics needed to protect against suffering that can be caused by lack of proper staffing at an institution, as well as basic hygiene, privacy and the provision of an environment that is respectful of individual dignity.

Conclusion

In 2002, the United Nations Commission on Human Rights appointed a Special Rapporteur with a mandate to focus on the right to the enjoyment of the highest attainable standard of physical and mental health. In his first report in 2003 he promoted the right to health as a fundamental human right, and wished to identify good practices for the right to health at the community, national, and international level.

One area he wished to explore is the intersection between the right to health and prejudicial action.⁶⁷ No other area of healthcare has suffered more from prejudicial action than the area of mental health. The Irish State has failed its citizens in this regard and has only partially honoured its international obligations in the way it looks after the mentally ill. Why commit to international treaties and declarations if there is not the concomitant will to enact their provisions?

By taking a human rights approach on behalf of our patients we have the potential of being more successful in

improving the lives of those who are voiceless and do not form a voting constituency. In order to do this we must be aware of and make reference to, those documents that the Irish Government and the international community consider represent the minimum core standards of what provides a mental health service.

These Declarations and Conventions have recognised the basic requirements of mental health care over the last 58 years since the signing of the Declaration of Human Rights in 1948, up to the Rights of the Child in 1989. The importance of this health related issue was recognised in such diverse documents as to be included in the Convention on the Elimination of all Forms of Discrimination against Women and the International Covenant on the Elimination of all Forms of Racial Discrimination.

How long do we have to wait to see the standard of treatment and the living conditions of those suffering from mental illness being brought up to what is internationally considered to be the minimal core values? There is hope that the recent expert report *A Vision for Change*,⁶⁸ will lead to a major improvement in mental health care. Its success will be measured in its implementation in full, not just the implementation of those parts of the recommendations that are of little financial significance.

Those working in the area of mental health will have to redouble their commitment to utilising the human rights model on behalf of their patients. In this way we are increasing our abilities to act as representatives on their behalf.

Declaration of Interest: None.

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