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An Audit of Irish Mental Health Law for Compliance with International Human Rights Norms in Respect of Seven Categories of 'Mental Health Rights Claims': Positive and Negative Findings, and Recommendations for Reform

Doctor of Philosophy

2011

Edel Thérèse Quirke

Declaration

I, Edel Thérèse Quirke, declare that:

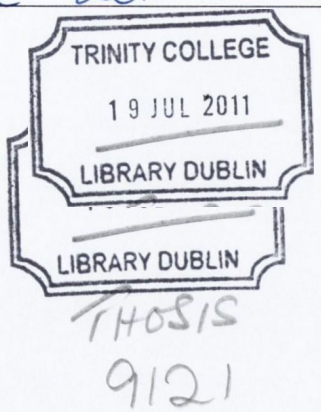
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Summary of Methods Used and Major Findings

This thesis subjects the legal regulation of the civil mental health law regime in Ireland to a 'human rights audit' subsequent to the implementation of the Mental Health Act 2001 (MHA 2001). The following structure is adopted:

1. In the Introduction, an explanation of the categories of 'mental health rights' standards chosen for the performance of the human rights audit of Irish mental health law is performed.
2. Chapter 1 provides an account of the legal structure of the provision of mental health care in Ireland, including an outline of the health system and a description of the evolution of mental health regulation culminating in a detailed explanation of the mental health law regime as established under the MHA 2001.
3. In Chapter 2, an explanation of the structure of the major international human rights protection bodies, and a detailed evaluation of the human rights standards established at an international level that are of importance to people who have mental health disabilities, is provided.
4. In Chapter 3, the human rights protections provided by the Irish Constitution to people who engage with the mental health law regime is assessed, including an analysis of the impact of the European Convention on Human Rights Act 2003 on the constitutional jurisprudence in the area of mental health.
5. Chapter 4 contains an account of the mental health law systems in England (with whom Ireland shares a common legal heritage and a shared membership of the Council of Europe) and in South Africa (which has unique constitutional provisions providing protection for a socio-economic right to health, and a mental health law regime that differs to the Irish system in a number of interesting respects).
6. In Chapter 5, the extent to which Irish constitutional, legislative, and common law provisions succeed in meeting the standards established by the international human rights provisions, and whether those international human rights provisions have in legal outcomes provided for meaningful substantive protections for mental health patients in Ireland, is evaluated.
7. Finally, the conclusions drawn are summarised at the end of the work, together with recommendations for the reform of Irish mental health law to improve the level of protection of the international human rights 'mental health claims' provided.

The findings of this work are as follows:

In the following respects, Irish mental health law succeeds in meeting the standards set at the international human rights level:

1. The right to dignity is protected in the Preamble to the Constitution and is referenced in numerous cases on the right to life, autonomy, bodily integrity, and privacy. It is also given explicit statutory protection in the Mental Health Act 2001 (MHA 2001).
2. The right to liberty is explicitly enumerated as a human right in the Constitution and is accompanied by a right to fair procedures and to bring a *habeas corpus* challenge to an unlawful detention. The grounds for a deprivation of liberty under

the mental health law are set out in exacting detail in the MHA 2001, and an automatic and independent review tribunal mechanism operates to review decisions to compulsorily admit, detain and treat people under the mental health laws. The decisions of these review tribunals are subject to scrutiny by the High Court in judicial review proceedings.

3. The rights to autonomy, bodily integrity and privacy, and the right to freedom from torture and from inhuman and degrading treatment and punishment are protected as unenumerated personal rights under the Constitution, and feature prominently in many landmark decisions of the Supreme Court on the right to life and on medical treatment. The MHA 2001 contains a presumption of capacity to consent to treatment, and detailed provisions on the administration of psychiatric treatments to patients who lack the capacity to give consent.
4. The constitutional protection of the right to substantive equality is bolstered by extensive employment law and disability law regimes that provide for reasonable accommodation of difference in order to maximise the participation in society of people with disabilities, including mental health disabilities.
5. In respect of affirmative rights, the unique Directive Principles of Social Policy in the Irish Constitution pledge support to the infirm and protection for the 'strength and health of workers', and the right to free primary education until the age of eighteen is explicitly enumerated as a protected and justiciable constitutional right. The State provides a comprehensive and high quality system of universal health care which is free of charge and available to all persons in need of its services. Finally, the MHA 2001 predicates the deprivation of liberty provisions on a 'treatability requirement' that mandates the provision of treatment aimed at the alleviation of mental disorder or the amelioration of its symptoms in order to justify any involuntary admission, detention, or treatment.

However, this research also concludes that the assertion of full compliance with human rights norms was premature for the following reasons:

1. The paternalist philosophy that is adopted by the judiciary in the interpretation of the MHA 2001 is not in keeping with the human rights philosophy that the Act is intended to promote, and results in a dilution of the human rights ethos of the new mental health law regime.
2. The introduction of new legislation to replace the wardship regime with a modern capacity and guardianship system is imperative in order to protect the human rights of people who have suffered a loss of capacity.
3. The law regulating consent to mental health treatments, particularly the law relating to the administration of electro-convulsive therapy (ECT), is inadequate to safeguard mental health patients' human rights.
4. The definition of a 'mental disorder' adopted in the MHA 2001 inappropriately includes people with intellectual disabilities within its parameters for the purposes of compulsory admissions to hospital, and arguably fails to provide a legitimate basis for that inclusion in the provision of a treatability requirement to underpin the deprivation of liberty involved.
5. While the degree of 'value added' by the recognition of an enforceable right to access health care is debateable, the inability of litigants to argue an affirmative right to access to health care before the courts means that Irish law in this area falls short of a number of its commitments to socio-economic human rights under international human rights instruments.

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United Nations, *Vienna Declaration and Programme of Action of the World Conference on Human Rights* (New York: United Nations Secretariat Centre for Human Rights, 1993). G.A. Res. 48/141, U.N. GAOR, U.N. Doc. A/CONF.157/23 (1993)

Table of Abbreviations

CMH	Central Mental Hospital
CRPD	Convention on the Protection of the Rights of Persons with Disabilities
CESCR	Committee on Economic, Social and Cultural Rights
ECHR	European Convention on Human Rights
ECOSOC	United Nations Economic and Social Council
ECT	Electro-Convulsive Therapy
ECtHR	European Court of Human Rights
ESC	European Social Charter
GP	General Practice
HSE	Health Service Executive
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic Social and Cultural Rights
MHA 2001	Mental Health Act 2001
MHRT	Mental Health Review Tribunal
MHT	Mental Health Tribunal
MI Principles	United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care
NGO	Non-governmental Organisation
UDHR	Universal Declaration of Human Rights
UN	United Nations

INTRODUCTION

This thesis subjects the legal regulation of the civil mental health law regime in Ireland to a 'human rights audit'. With the commencement of the Mental Health Act 2001 (MHA 2001) on 1st November 2006 Irish mental health law was heralded as being fully in line with the international human rights instruments to which Ireland is a party.[1] The analysis in this research, while recognising the enormous step forward that the new mental health law regime under the MHA 2001 represents, concludes that the assertion of full compliance with human rights norms was premature for five reasons:

1. The paternalist philosophy that is adopted by the judiciary in the interpretation of the MHA 2001 is not in keeping with the human rights philosophy that the Act is intended to promote, and results in a dilution of the human rights ethos of the new mental health law regime;
2. The introduction of new legislation to replace the wardship regime with a modern capacity and guardianship system is imperative in order to protect the human rights of people who have suffered a loss of capacity;
3. The law regulating consent to mental health treatments, particularly the law relating to the administration of electro-convulsive therapy (ECT), is inadequate to safeguard mental health patients' human rights;
4. The definition of a 'mental disorder' adopted in the MHA 2001 inappropriately includes people with intellectual disabilities within its parameters for the purposes of compulsory admissions to hospital, and arguably fails to provide a legitimate basis for that inclusion in the provision of a treatability requirement to underpin the deprivation of liberty involved; and finally,
5. While the degree of 'value added' by the recognition of an enforceable right to access health care is debateable, the inability of litigants to argue an affirmative right to access to health care before the courts means that

[1] *See* "Tánaiste announces the full implementation of the Mental Health Act 2001" *Press Release, 6 July, 2006* (Dublin: Government Publications, 2006) <http://www.dohc.ie/press/releases/2006/20060706.html> accessed 6 September 2006.

Irish law in this area falls short of a number of its commitments to socio-economic human rights under international human rights instruments.

Types of 'mental health rights' claims

The analysis in this thesis is founded on an assessment of Irish mental health law's ability to safeguard the human rights guaranteed by the international human rights instruments to which Ireland is a party.[2] For the purposes of this analysis, the types of international human rights that are articulated by mental health service users in the construction of legal claims alleging violations of their human rights within the arena of mental health service provision have been categorised into seven groupings of rights:

1. Claims that argue a violation of the claimant's right to dignity;
2. Claims that argue a violation of the claimant's right to liberty;
3. Claims that argue a violation of the claimant's rights to autonomy, bodily integrity, and / or privacy;
4. Claims based in an alleged failure to provide the claimant with fair procedures in the administration of a civil compulsory admission, detention and / or treatment regime;
5. Claims based in the right to freedom from torture and from inhuman and degrading treatment and punishment;
6. Claims that argue a violation of the claimant's right to equality; and

[2] For analyses of the utility of the human rights philosophy to mental health issues, and of the contributions the human rights philosophy has made in the area of mental health, as well as some of its shortcomings, *see* for example Stein, Michael Ashley, and Lord, Janet E., "Future Prospects for the United Nations Convention on the Rights of Persons with Disabilities" *in* Quinn, Gerard and Arnardóttir, Oddný Mjöll, eds, *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Leiden: Brill, 2008), 17-40; Ó'Cinnéide, Colm, "Extracting Protections for the Rights of Persons with Disabilities from Human Rights Frameworks: Established Limits and New Possibilities" *in* Quinn, Gerard and Arnardóttir, Oddný Mjöll, eds, *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Leiden: Brill, 2008), 163-200; Walker, Penelope, "Lost in Translation: Human Rights and Mental Health Law" *in* McSherry, Bernadette and Walker, Penelope, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), 51-72; Bartlett, Peter, Lewis, Oliver, and Thorold, Oliver, *Mental Disability and the European Convention on Human Rights* (Leiden: Brill, 2007), Chapter 1: Introduction: The European Convention on Human Rights and Mental Disability, and Bartlett, Peter and Sandland, Ralph, *Mental Health Law: Policy and Practice*, 2nd edn (Oxford: Oxford University Press, 2007), Chapter 1: Conceptualising Mental Health Law.

7. Claims that are based on 'affirmative rights', meaning claims that argue for a positive entitlement to the provision of a particular service (for example, an entitlement to access to a certain standard of health or health care, or an entitlement to access to education).

This seven-category list of the types of rights claims made by litigants in the mental health context is longer than the four-category classification proposed by Lawrence Gostin and Lance Gable in their analysis of the impact of international human rights in mental health law. Gostin's and Gable's list is comprised of: (a) liberty violations; (b) dignity violations; (c) inequality violations; and (d) entitlement violations (affirmative rights claims).[3]

The longer list used here – with the addition of fair procedures claims; autonomy, bodily integrity, and privacy claims; and claims based in the right to freedom from torture and inhuman and degrading treatment and punishment – has been constructed by this author to take account of the types of rights claims frequently encountered before the European Court of Human Rights (ECtHR), and also to provide a framework for the discussion of the types of constitutional rights claims made in Ireland in the mental health context.

The 'fair procedures' category is included because the vast majority of mental health cases in this jurisdiction take the form of challenges to the validity of a compulsory detention, and are mounted on the basis of a fair procedures argument, often in the form of a *habeas corpus* application.[4] While these cases could theoretically fall within the 'liberty/freedom' categorisation, given their prominence in the Irish constitutional jurisprudence as the primary expression of rights language in mental health cases before the Irish courts, it was felt that 'fair procedures claims' in that context merited an individual categorisation. A similar rationale underpins the adoption of an individual category for 'autonomy, bodily integrity and privacy claims', which could be encompassed within Gostin's and Gable's 'dignity' categorisation or within the

[3] Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83, at 86-87.

[4] *See* Keys, Mary "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 24 *Dublin University Law Journal* 26 and Murray, Claire, "Safeguarding the Right to Liberty of Incapable Compliant Patients with a Mental Disorder in Ireland" (2007) 29 *Dublin University Law Journal* 279.

'autonomy' principle under the Convention on the Rights of Persons with Disabilities (CRPD). These types of claims are given a separate categorisation in this work in light of the primary importance of this grouping of rights in the development of the unenumerated rights doctrine in Irish constitutional law.[5] Finally, the 'freedom from torture and inhuman and degrading treatment and punishment' category, while capable of being discussed under the 'dignity' umbrella, is felt to merit separate discussion given the weight of the jurisprudence of the ECtHR on the application of Article 3 of the European Convention on Human Rights (ECHR) in mental health cases. Aside from the constitutional fair procedures jurisprudence, this Article 3 case law, together with the Article 5 case law (protecting the right to liberty), represents the most significant body of jurisprudence directly applicable in this jurisdiction on human rights in mental health cases.[6]

The list used in this work, while longer than Gostin's and Gable's list, is shorter than the list of General Principles adopted in the CRPD.[7] The CRPD General Principles are more policy driven than rights driven, with a strong focus on the provision of particular services rather than on the mounting of rights arguments. Thus, dignity, autonomy and liberty are grouped together in a single global principle founded on respect for one's choices and independence, and equality appears in four different guises (as non-discrimination; equality of opportunity; accessibility; and gender equality). The remaining General Principles protect participation and inclusion in society; respect for diversity; and the need for a particular respect for the evolving capacities of children with disabilities.[8] A brief explanation of the ways in which these categories of claims are mounted in the mental health sphere will now be given, before a more detailed analysis is undertaken of the specifics of the arguments made and the particulars of the international human rights claims made.

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[5] *See* Keys, Mary, "Issues for the New Mental Health Act" (1997) 3 *Medico-Legal Journal of Ireland* 97 and Donnelly, Mary, "Treatment for Mental Disorders and Protection of Patients' Rights", *Mental Health and Human Rights Seminar, Centre for Criminal Justice and Human Rights, Law Faculty, University College Cork*, 25th October 2007 (University College Cork, 2007) <http://www.ucc.ie/law/docs/mentalhealth2007/Mary%20Donnelly_conference%20paper_25Oct2007.doc> accessed 10 January 2011.

[6] *See* Gostin, Lawrence O., "Human Rights of Persons with Disabilities: The European Convention on Human Rights" (2000) 23 (2) *International Journal of Law and Psychiatry* 125.

[7] United Nations, *Convention on the Rights of Persons with Disabilities* (New York: United Nations Secretariat Centre for Human Rights, 2008); (2006) G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611; 13 December 2006, 93 U.N.T.S. 3, Article 3.

[8] *See* United Nations Enable, *Guiding Principles of the Convention* (United Nations, 2007) <http://www.un.org/esa/socdev/enable/convinfoguide.htm> accessed 24 October 2009.

Dignity claims may be presented as an argument for an entitlement to be treated in a certain fashion, that, it is argued, will safeguard the claimant's dignity.[9] Dignity claims may also take the form of a claim to a right not to be subjected to certain treatment, that, it is argued, diminishes the claimant's dignity. Dignity as a human rights concept is generally argued alongside another right, for example, in the mental health context, challenges to compulsory detentions that are alleged to be unnecessary, or improperly effected, may give rise to dignity claims. The unlawful administration of an unwanted medical treatment against a person's wishes may give rise to a human rights claim that the treatment has infringed that person's right to bodily integrity, but will also give rise to a claim that it has degraded that person, and thereby infringed their right to dignity. Similarly, a treatment regime in an institution that allows a mental health patient very little control over the routine or content of their days may be challenged on the grounds that it infringes the patient's right to liberty, or to freedom from inhuman and degrading treatment. This may further give rise to a claim that the treatment regime has degraded the patient, and infringed their right to dignity. Dignity claims also arise where the rights to life, to privacy, to fair procedures, to equality, and to health or education entitlements are engaged. In fact, almost any human rights claim that is made in the sphere of mental health is capable of encompassing a right to dignity claim.[10]

Liberty claims are twofold – on the one hand they form the lynchpin of arguments against arbitrary or unlawful detentions or imprisonment, and on the other hand they are the very heart of the 'right to be let alone' argument that Mary Ann Glendon describes as being the core of much of the common law's theory of rights.[11] In the

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[9] *See* generally Feldman, David, "Human Dignity as a Legal Value – Part 1 (1999) Winter *Public Law* 683; Rabkin, Jeremy, "What We Can Learn About Human Dignity from International Law" (2003-2004) 27 *Harvard Journal of Law and Public Policy* 145; Vorhaus, John, "On Degradation Part Two: Degrading Treatment and Punishment" (2003) 32 *Common Law World Review* 65; Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83; and O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005), 267.

[10] For an example of a mental health case in which dignity was argued as a component of the argument that the applicant's right to liberty had been infringed, *see* the European Court of Human Rights decision in *HL v United Kingdom* (2004) Application No. 45508/99, (2004) ECHR 471, discussed in detail below.

[11] Glendon, Mary Ann, *Rights Talk: The Impoverishment of Political Discourse* (The Free Press: New York, 1993), *see* generally Chapter Three: 'The Lone Rights Bearer'. *See* also Murray, Claire, "Safeguarding the Right to Liberty of Incapable Compliant Patients with a Mental Disorder in Ireland"

mental health context liberty claims have an immediately obvious relevance for those patients who have been compulsorily detained in mental hospitals for treatment. Mental health patients may mount challenges to the validity of these detentions using the language of the right to liberty on a number of bases: (a) that the detention is founded on legal provisions that are contrary to human rights principles; (b) that while the legal regime may be sound, its manner of implementation falls short of human rights norms; and (c) that the otherwise lawful detention was arbitrary or capricious.[12] Mental health patients may also use the language of liberty claims to argue against the use of community treatment orders, or other forms of monitoring behaviour. Liberty claims have been brought by patients who have not been formally detained, and who therefore in the legal sense remain possessed of the full extent of their right to liberty. These patients have mounted arguments that that their liberty has nonetheless been infringed, either by a failure to make clear to them that their liberty is not restricted, or by a regime that treats them as non-detained patients but with an implicit threat of formal detention should they object to treatment.[13]

Autonomy, bodily integrity, and privacy claims may arise in mental health cases in relation to treatments administered to a person without their consent; or in the form of challenges to detention; or to particular features of the administration of treatments or the regime within the place of detention.[14] An autonomy claim may be made where a patient refuses consent to a particular treatment that is felt to be necessary, the paradigm of autonomy being often described as being the right to make decisions others would not make for themselves. Autonomy claims can be mounted to argue for an assessment of a patient's ability to make autonomous decisions before consent is dispensed with. Similarly, where a treatment or detention regime operates a uniform routine this may give rise to an autonomy claim in that the patient is not afforded any

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(2007) 29 *Dublin University Law Journal* 279; Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83; and O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005), 247.

[12] *See* for example *Winterwerp v Netherlands* (1979) Application No. 6301/73, [1979] 2 EHRR 387, discussed in detail below.

[13] *See* for example *HL v United Kingdom* (2004) Application No. 45508/99, (2004) ECHR 471, discussed in detail below.

[14] *See* Hogan, Gerard, "Unenumerated Personal Rights: Ryan's Case Reevaluated" (1990-1992) xxv-xxvii *Irish Jurist (n.s.)* 95; Humphreys, Richard, "Interpreting Natural Rights" (1993-1995) xxviii-xxx *Irish Jurist (n.s.)* 221; Murray, Claire, "Safeguarding the Right to Liberty of Incapable Compliant Patients with a Mental Disorder in Ireland" (2007) 29 *Dublin University Law Journal* 279; Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.

opportunity to make their own decisions about the management of their day, or about how they spend their time.

Where a treatment is administered against a person's wishes, a very clear bodily integrity claim arises. Bodily integrity claims may also arise in relation to aspects of a hospital regime that are not necessarily linked to mental health treatment – for example the diet provided; or the hygiene facilities in place. Finally, privacy claims may be mounted in the mental health context where detained patients challenge the degree of observation to which they are subjected; or the scrutiny of their correspondence; or the monitoring of the time they spend with visitors or family. Mental health patients may also mount privacy arguments regarding the protection of their medical records and data, arguments which assume particular importance in the light of the stubborn persistence of pervasive stigma surrounding mental illness.[15]

Fair procedures claims arise where a person argues that their right to fair procedures within legal processes has been infringed.[16] It is most often thought of within the criminal law context, where the decisions taken by courts have profound implications for the rights of the accused to their good name, their property, and their liberty – but fair procedures is also of crucial importance in mental health cases. For example, a decision to detain a person in a treatment centre or to administer a treatment without consent will fall within the types of decision that must be taken in accordance with the due process model of fair procedures, in consequence of the severe infringement of the patient's rights that will occur as a result of the decision. Fair procedures requires that a person be given the opportunity to hear the reasons for the proposed infringement of their rights, and that they have an opportunity to put forward their argument against the proposed action. This requires that mental health tribunals provide a fair hearing for detained patients in the consideration of the legality of their detention or the utilisation of treatment without their consent, including the appointment of a legal representative for them and an advocate in circumstances where they are unable to instruct their representation. Where a legal regime for

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[15] *See* for example *Herczegfalvy v Austria* (1992) Application No. 10533/83, [1992] 15 EHRR 437, discussed in detail below.

[16] *See* Cook, Timothy, "Substantive Due Process Rights of Mentally Disabled Clients" (1983) 7 (4) *Mental Disability Law Reporter* 346, Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.

compulsory treatment or detention provides no mechanism for review, or where the review mechanisms provided are insufficiently stringent, claims may be mounted arguing that patients' rights to fair procedures have been infringed.[17]

Claims based on the right to freedom from torture and inhuman and degrading treatment and punishment are often made in tandem with claims that a person's rights to privacy and to bodily integrity have been infringed.[18] The essential characteristics of the torture and degrading treatment claims are that the claimant has been subjected to unlawful actions of such barbaric or inhuman nature that they go beyond even breaches of the rights to autonomy, bodily integrity, or privacy, and that the respondent has had an invidious purpose in treating the claimant as they have. Breaches of the right to freedom from torture have been argued in mental health cases involving the allegedly cruel use of restraints or seclusion, but these arguments have not found favour in the international human rights courts. Arguments founded in the right to freedom from inhuman or degrading treatment have fared better – in claims challenging detentions, or the use of seclusion or confinement, without any therapeutic rationale or without access to therapeutic regimes. It has further been accepted that the potential for breaches of the right to freedom from inhuman and degrading treatment is engaged in the mental health context.[19]

Equality claims may also be presented as 'freedom from discrimination' claims. They are presented as arguments to an entitlement to be treated in the same manner as other people in society, or in the same manner as others in society who are similarly situated.[20] In the mental health context this may arise as a right between detained patients to enjoy the same standards of review of the legality of their detention; or as a right between voluntary patients (who are not subject to compulsory detention and

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[17] *See* for example *Winterwerp v Netherlands* (1979) Application No. 6301/73, [1979] 2 EHRR 387, discussed in detail below.

[18] Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.

[19] *See* for example *Herczegfalvy v Austria* (1992) Application No. 10533/83, [1992] 15 EHRR 437, discussed in detail below.

[20] Kimber, Cliona "Equality Disability (Part I)" (2001) 6 (9) *Bar Review* 494; Kimber, Cliona, "Equality Disability (Part II)" (2001) 7 (2) *Bar Review* 66; Smith, Olivia, "Side-Stepping Equality? Disability Discrimination and "Generally Accepted Qualifications" (2008) 30(1) *Dublin University Law Journal* 279; Doyle, Oran J., *Constitutional Equality* (Dublin: Thomson Round Hall, 2004); Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83; and O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005), 630.

treatment) to enjoy the same entitlements in respect of consent to treatment. Equality claims may also arise for mental health service users in other areas where discrimination between persons is prohibited. For example, both employment law and disability services regulation prohibit discrimination on the grounds of disability, including mental illness. Finally, equality claims may arise within affirmative rights claims, where a mental health service user may seek to mount an argument that a disparity in the service provision afforded to mental health care when compared with other health care services amounts to discrimination and therefore a breach of equality rights.[21]

The final type of rights claim that may arise in mental health cases are affirmative rights claims based on arguments for entitlements.[22] These arise clearly in the form of claims founded on the concept of a right to health or to health care, but may also arise in the form of claims based on a right to education. The basis for arguments for a right to health care is easy to grasp within the mental health context, the correlation between a right to health and to mental health concerns being immediately obvious. The basis for arguments founded on education is perhaps less immediately apparent, but a mental health service user, particularly a minor, may mount a mental health type claim using the concept of entitlement to education in two ways. First, it may be argued that the provision of certain mental health treatments or services are essential to the ability of the claimant to participate in education. Secondly, it may be asserted that the provision of education is an essential component in the claimant's mental health treatment needs, and that the failure to provide education (either to a minor, or to an adult who argues that by virtue of their mental disability they require ongoing educational services) is detrimental to their mental health to a degree sufficient to amount to a violation of human rights.

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[21] *See* for example *F. H. Zwaan De Vries v Netherlands*, Communication No. 182/1984 (9 April 1987) UN Doc. Supp. No. 40 (A/42/40) at 160 (1987), discussed in detail below.

[22] Birnbaum, Morton, "The Right to Treatment" (1960) 46 (5) *American Bar Association Journal* 499; Hogan, Gerard, "Directive Principles, Socio-Economic Rights and The Constitution" (2001) 36 *Irish Jurist (new series)* 174; Langwallner, David, "Separation of Powers, Judicial Deference and the Failure to Protect the Rights of the Individual", *In* Carolan, Eoin and Doyle, Oran, eds., *The Irish Constitution: Governance and Values* (Dublin: Thomson Round Hall, 2008); McHugh, Claire, "Socio-Economic Rights in Ireland: Lessons to be learned from South Africa and India" (2004) 4 *Hibernian Law Journal* 109; Ruane, Blathnaid, "The Separation of Powers and the Grant of Mandatory Orders to Enforce Constitutional Rights" (2000-1) 5 *Bar Review* 416; Whyte, Gerard, *Social Inclusion and the Legal System: Public Interest Law in Ireland* (Dublin: Institute of Public Administration, 2002); and Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.

As with so many of the other human rights claims, these affirmative rights claims frequently 'piggyback' on other rights claims being made by a claimant. Thus, in the context of the right to health, a claim for an entitlement to access to certain levels of health care or to particular types of treatment may be founded partially on a 'right to health' argument, but will also involve arguments based on the rights to bodily integrity, or to freedom from inhuman treatment, or to equality. This is particularly true of these entitlement based claims as they are founded on socio-economic rights arguments, which are of less persuasive force than their civil and political rights counterparts. The international human rights documents do not ascribe the same level of enforceability to the socio-economic rights to health and education as to the civil and political rights to liberty, or to fair procedures.[23] This dichotomy will be discussed in greater detail below.

Attention will now turn to the legal structure of the provision of mental health care in Ireland, and in the next Chapter the health service and the historical evolution of the contemporary statutory framework for the regulation of compulsory mental health treatment are described.

Outline of the thesis

This thesis takes the form of a human rights audit of mental health law in Ireland subsequent to the implementation of the Mental Health Act 2001 (MHA 2001). That legislation introduced an entirely new regime for the regulation of compulsory mental health treatment, and was intended to bring Irish law in this area into line with international human rights norms in the area, and in particular was intended to make Irish law compliant with the European Convention on Human Rights (ECHR). The analysis hones in on two areas in particular: (a) the merits for mental health regulation of recognising a justiciable constitutional right to access to health care; and (b) the need to introduce a modern guardianship regime to replace the centuries-old wardship

[23] *See* for example *X v Ireland*, Application No. 6839/74, 7 DR 78 (1976).

regime, and to provide protection to the category of mental patients commonly referred to as 'compliant incapacitated patients.'[24]

There has been a significant flourish of research in mental health law in Ireland as a result of the overhaul of the statutory framework in the area, and the glut of litigation that inevitably followed as the new regime 'found its feet'. Two major textbooks have been published[25] along with an updated edition of a comprehensive practitioners' text on how psychiatry interacts with law,[26] and two annotated statutes texts.[27] The number of academic articles on the topic published in legal periodicals has been considerable. A number of doctoral candidates are pursuing research in the area in various universities[28] and two PhD theses on the topic have been completed. Dr. Mary Keys in 2006 performed an empirical analysis of the failings in the Mental Treatment Act 1945 to safeguard patients' human rights under the ECHR and an evaluation of the reform proposals contained in the MHA 2001, which was not at that date fully commenced.[29] Dr. Claire Murray in 2009 successfully defended an analysis of the

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[24] Compliant incapacitated patients have been the subject of much academic commentary following a landmark ruling by the European Court of Human Rights in respect of the peculiarly vulnerable position they occupied under the Mental Health Act 1983 (England). Compliant incapacitated patients are frequently present in mental hospitals as voluntary patients (that is, patients who are not subject to compulsory detention or treatment), but who do not realise that they are free to leave and as such have more in common with involuntary patients (that is, patients who are subject to compulsory detention and treatment). Significant space is devoted below to the discussion of the European Court of Human Rights case law on compliant incapacitated patients and the consequences of this jurisprudence for Irish mental health law – see §§ 1.4.2; 2.4.2; 3.6; 4.1.2; and 5.2.2 below.

[25] O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005); Whelan, Darius, *Mental Health Law and Practice: Civil and Criminal Aspects* (Dublin: Thomson Round Hall, 2009); and Ryan, Damien, *The Mental Health Acts 2001–2009: Case Law and Commentary* (Dublin: Blackhall Publishing, 2010).

[26] Casey, Patricia; Brady, Paul; Craven, Ciaran; and Dillon, Aisling, *Psychiatry and the Law*, 2nd ed. (Dublin: Blackhall Publishing, 2009).

[27] Keys, Mary, *The Mental Health Act 2001* (Dublin: Round Hall Sweet and Maxwell, 2002) and Kennedy, H., *The Annotated Mental Health Acts* (Dublin: Blackhall Publishing, 2007).

[28] At University College Cork, Suzanne Doyle is researching a thesis entitled "The Compatibility of Ireland's Mental Health Laws with the UN Convention on the Rights of Persons with Disabilities" and is being supervised by Dr. Darius Whelan and Dr. Mary Donnelly. At NUI Galway, under the supervision of Dr. Mary Keys, Fiona Morrissey is a PhD candidate completing a thesis on the use of advance directives in mental health care. There are also a number of doctoral candidates at NUI Galway, the University of Limerick, and at University College Dublin performing research into mental health issues as they impact on the criminal law.

[29] Keys, Mary, *The Enforcement of the Rights of Mental Disordered People and the European Convention on Human Rights* (University of Cardiff: Unpublished PhD Thesis, 2006).

contribution made by feminist theories of human rights to the legal regulation of mental health in Ireland.[30]

It is submitted that this research is novel in five respects:

1. It is the first doctoral thesis in Ireland to perform an audit of the performance of the MHA 2001 against the international human rights standards deriving from the United Nations framework of human rights protections, in addition to those deriving from the ECHR protections;

2. It is the first doctoral thesis in Ireland to perform this type of evaluation after the commencement of the entirety of the MHA 2001, and is thus the first doctoral thesis to utilise the precedents developed in the litigation consequent upon the commencement of the MHA 2001 in evaluating the effectiveness of the MHA 2001 in promoting a human rights based mental health law regime;

3. It is the first doctoral thesis in Ireland to consider the merits of the provision of a justiciable constitutional protection for a right of access to health care;

4. It is the first doctoral thesis in Ireland to consider the impact of the lack of a modern guardianship regime on Irish mental health law from the perspective of an audit of the Irish legislative mental health regime assessing its compliance with international human rights norms; and

5. It is the first doctoral thesis in Ireland to perform a comparative analysis of the approaches taken in other jurisdictions (England and South Africa) to these questions, and to measure Irish law against the efforts of these other countries.

The focus of this thesis is on the private law regime governing the regulation of mental health services and on the civil commitment mechanisms that provide for detention and compulsory treatment. The measures utilised within the Irish criminal

[30] Murray, Claire, *Feminism, Rights and Mental Health Law: Analysing the Contribution of Feminist Theories of Rights to Irish Mental Health Law* (University College Cork: Unpublished PhD Thesis, 2009).

law system in dealing with people with mental disabilities or mental illness are complex and are beyond the scope of this work. The recent reforms undertaken in Irish criminal law in respect of the insanity rules and fitness to plead have been the subject of significant academic analysis elsewhere.[31]

This thesis adopts the following structure. In this Chapter, an introduction to the categories of 'mental health rights' standards chosen for the performance of the human rights audit of Irish mental health law is performed.

Chapter 1 provides an account of the legal structure of the provision of mental health care in Ireland, including an outline of the health system and a description of the evolution of mental health regulation culminating in a detailed explanation of the mental health law regime as established under the MHA 2001.

In Chapter 2, an explanation of the structure of the major international human rights protection bodies, and a detailed evaluation of the human rights standards established at an international level that are of importance to people who have mental health disabilities, is provided.

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[31] *See* generally O'Neill, Anne-Marie., *Irish Mental Health Law* (Dublin: Firstlaw, 2005); Whelan, Darius, *Mental Health Law and Practice: Civil and Criminal Aspects* (Dublin: Thomson Round Hall, 2009); Kennedy, Harry, *The Annotated Mental Health Acts* (Dublin: Blackhall Publishing, 2007); Casey, Patricia, Brady, Paul, Craven, Ciaran, and Dillon, Aisling, *Psychiatry and the Law*, 2nd ed. (Dublin: Blackhall Publishing, 2009); Dwyer, Padraig, "Law of Insanity" (1996) 1 (1) *Bar Review* 9; Trager, P., "The Insanity Defence Revisited" (1998) 4 *Medico-Legal Journal of Ireland* 15; Kennedy, Harry, "Human Rights Standards and Mental Health in Prisons" (2002) 8 *Medico-Legal Journal of Ireland* 58; Barnacle, Deirdre, "Reform Of The Defence Of Insanity – The Criminal Law (Insanity) Bill 2002" (2003) 3 *University College Dublin Law Review* 153; Byrne, M., and Irwin, J., "The Added Value of A Human Rights Based Approach to Mental Health in Irish Prisons" (2010) 16(1) *Medico-Legal Journal of Ireland* 34; Whelan, Darius, "Fitness to Plead and Insanity in the District Court" (2001) 11 (2) *Irish Criminal Law Journal* 2; Whelan, Darius, "Some Procedural Aspects of Insanity Cases" (2001) 11 (3) *Irish Criminal Law Journal* 2; Yeo, Stanley, "Rethinking the incapacities of insanity" (2001) 36 *Irish Jurist* 275; Robinson, Dara, "Crazy situation" (2003) 97 (1) *Law Society Gazette* 12; Mills, Simon, "Criminal Law (Insanity) Bill 2002: Putting the sanity back into insanity" (2003) 8 (3) *Bar Review* 101; Conway, Gerard, "Fitness to Plead in Light of the Criminal Law (Insanity) Bill 2002" (2003) 13 (4) *Irish Criminal Law Journal* 2; McGillicuddy, Tony, "The Criminal Law (Insanity) Act 2006" (2006) 11 (3) *Bar Review* 95; Kennedy, Harry, "Limits Of Psychatric Evidence In Criminal Courts(2005) 11 (1) *Medico-Legal Journal of Ireland* 1; Ní Raifeartaigh, Úna, "The European Convention on Human Rights and the Criminal Justice System" (2007) 7(2) *Judicial Studies Institute Journal* 18; Duggan, Diane, "Diminished Responsibility and the Insanity Defence" (2007) 12 (6) *Bar Review* 248; Marry, Clodagh, "The Law of Insanity and Diminished Responsibility in Criminal Law versus the Meaning of Insanity within the Medical Profession: an Inevitable Conflict?" (2007) 7(1) *Hibernian Law Journal* 169; and McAuley, Finbar, "The Civilian Experience of the Insanity Defence" (1989) 24 (2) *Irish Jurist* 227.

In Chapter 3, the human rights protections provided by the Irish Constitution to people who engage with the mental health law regime are assessed, including an analysis of the impact of the European Convention on Human Rights Act 2003 on the constitutional jurisprudence in the area of mental health.

Chapter 4 contains an account of the mental health law systems in England (with which Ireland shares a common legal heritage and a shared membership of the Council of Europe) and in South Africa (which has unique constitutional provisions providing protection for a socio-economic right to health, and a mental health law regime that differs to the Irish system in a number of interesting respects).

Finally, in Chapter 5, the extent to which Irish constitutional, legislative, and common law provisions succeed in meeting the standards established by the international human rights provisions, and whether those international human rights provisions have in legal outcomes provided for meaningful substantive protections for mental health patients in Ireland, is evaluated. The conclusions drawn are summarised at the end of the work, together with recommendations for the reform of Irish mental health law to improve the level of protection of the international human rights 'mental health claims' provided.

1. THE EVOLUTION OF MENTAL HEALTH REGULATION IN IRELAND: STATUTE AND COMMON LAW

Introduction

This Chapter describes the legislative and common law framework governing mental health issues in Ireland. A brief description is first given of the legal structure regulating the provision of services to people with disabilities, and of the legal mechanisms which serve to protect the interests of people who by reason of incapacity are unable to manage their own affairs. This is then followed by a short account of the structure of the health system in Ireland and of the legal mechanisms governing the delivery of mental health care. Thereafter, an historical background to the legal regulation of mental health care in Ireland is outlined, followed by an analysis of Irish mental health regulation since the mid point of the 20th century, with the focus being on the impact of the human rights movement on the area.

The Mental Health Act 2001 (MHA 2001) was introduced specifically to make Irish law compliant with the European Convention on Human Rights (ECHR). It replaced the Mental Treatment Act 1945 (the 1945 Act) and in doing so sought to place Irish mental health law onto a human rights footing, and to ensure that the human rights of mental health service users would be maximised under the new regime. However, one of the arguments made out in this thesis is that the paternalist approach to mental health law that informed the 1945 Act has been carried over into the interpretation of the MHA 2001. The survival of the older mentality of paternalism in the judicial pronouncements on the MHA 2001 undermines the ability of the new regime to fully protect the human rights of mental health patients. For this reason it is important to understand the background to the paternalist approach that continues to exert so much influence in the jurisprudence on mental health in Ireland, and to place the new mental health law regime within the broader context of legislation introduced in the last decade aimed at protecting and promoting the human rights of people with disabilities.

1.1 The Disability and Employment Law Regimes

A number of legislative provisions in Ireland are aimed at promoting the inclusion in society of people with disabilities and at eliminating discrimination against people with disabilities, and of most interest to this discussion are those provisions aimed at securing access to mental health services and at targeting discrimination on the basis of a mental health disability.

The legal regime surrounding disability traditionally focussed only on regulation of areas where people were considered unable to engage in particular activities or to make particular decisions by virtue of a disability. The introduction of the Disability Strategy in 2004 represented a fundamental change in approach in the area of disability. From a focus on what people with disabilities were unable to do, and legislating to do these things for them, the legal regime changed to a focus on what people could do, and legislating to maximise people's access to and participation in society. This new philosophy is frequently referred to as the 'social model of disability' and at its core is the premise that a person with a disability is not excluded from participation in society by virtue of their disability, rather they are excluded by virtue of society's failure to accommodate difference and to make accommodations where necessary.[1] This approach is endorsed by the National Disability Authority, the independent state agency established in 2000[2] to advise the government on policy and practice in the area of disability:

> Starting from the early 1970s, this way of thinking about disability was increasingly challenged and rejected by people with a disability, in favour of

[1] See generally Barnes, Colin and Mercer, Geof, *The Social Model of Disability: Europe and the Majority World* (Leeds: Disability Press, 2005). In respect of the impact of the social model of disability on legal reform and on the impact of human rights philosophies to disability issues, see Traustadóttir, Rannveig, "Disability Studies, the Social Model, and Legal Developments" *in* Quinn, Gerard and Arnardóttir, Oddný Mjöll, eds, *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Leiden: Brill, 2008), 3-16; Walker, Penelope, "Lost in Translation: Human Rights and Mental Health Law" *in* McSherry, Bernadette and Walker, Penelope, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), 51-72, and Flynn, Ellionóir, "Ireland's Compliance with the Convention on the Rights of Persons with Disabilities: Towards a Rights-Based Approach for Legal Reform?" (2009) 16 (1) *Dublin University Law Journal* 357.

[2] National Disability Authority Act 1999 (No.14 of 1999).

> what has been termed the social model of disability. The central shift in thinking was that disablement arose from the environment and organisation of society rather than from the individual and their impairment. Disability is seen as a consequence of social, attitudinal and environmental barriers that prevent people from participating in society. The focus is then on the need to change societal conditions to accommodate the needs of the disabled person. Those with disabilities should be able to participate in such activities as education, employment and leisure along with everyone else.[3]

In this vein, in 2004 the government introduced the National Disability Strategy, made up of a package of legislative measures intended to mainstream service provision and thereby improve access to services for people with disabilities[4] and ensure their equal participation in society.[5] The National Disability Strategy comprises three significant pieces of legislation: the Education for Persons with Special Educational Needs Act 2004; the Disability Act 2005; and the Citizens Information Act 2007.

The Disability Act 2005 is described in its Long Title as an Act intended to make provision for the assessment of the health and educational needs of people with disabilities, to enable government to then make provision for services sufficient to meet those needs, and to make provision for public buildings to be more accessible.[6] The Act defines a disability as:

> a substantial restriction in the capacity of the person to carry on a profession, business or occupation in the State or to participate in social or cultural life in the State by reason of an enduring physical, sensory, mental health or intellectual impairment.[7]

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[3] Gannon, Brenda and Nolan, Brian, *Disability and Social Inclusion in Ireland* (Dublin: Economic and Social Research Institute, National Disability Authority, and Equality Authority, 2005) <http://www.nda.ie/Website/NDA/CntMgmtNew.nsf/0/D7A08E2E2A388B85802570660054EC15?OpenDocument> accessed 13 October 2010.

[4] Department of Justice, *Announcement on the Launch of the National Disability Strategy* (Dublin: Government Publications, 2004) <http://www.justice.ie/en/JELR/Pages/National_Disability_Strategy> accessed 20 September 2010.

[5] Department of Health, *Towards 2016 Strategic Document: National Disability Strategy Vision Mission and Strategic Objectives* (Dublin: Government Publications, 2009) <http://www.dohc.ie/publications/pdf/nds_towards_2016.pdf?direct=1> accessed 20 September 2010.

[6] Disability Act 2005, Long Title. The aspects of the Act pertaining to the accessibility of public buildings will not be addressed in this work.

[7] Disability Act 2005, s 2.

The most significant provision of the Act is the introduction of independent assessments of need.[8] These assessments are to be conducted by the HSE and must evaluate:

> whether the applicant has a disability,
>
> in case the determination is that the applicant has a disability—
>
> > a statement of the nature and extent of the disability,
> >
> > a statement of the health and education needs (if any) occasioned to the person by the disability,
> >
> > a statement of the services considered appropriate by the person or persons referred to in subsection (2) to meet the needs of the applicant and the period of time ideally required by the person or persons for the provision of those services and the order of such provision,
> >
> > a statement of the period within which a review of the assessment should be carried out.[9]

The completion of an assessment is triggered either by application from the person with a disability or by an application from another person who believes that a person with a disability may require assessment but lacks the capacity to apply themselves.[10] Consequent upon the completion of the service plan, the Act provides that the HSE shall provide a service statement specifying the health or education services (or both) that will be provided, and the time period within which they will be provided.[11] A complaints and appeals structure is provided, with the ultimate appeal being to the High Court on a point of law only.[12] Part 2 of the Act – dealing with the provision of assessments and service plans – has been in force since 1 June 2007 for persons under the age of five years.[13]

The Education for Persons with Special Educational Needs Act 2004 is intended to provide for an inclusive approach to the provision of education for children with disabilities, maximising access to mainstream education and ensuring equality of

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[8] Disability Act 2005, s 8.
[9] Disability Act 2005, s 8(7).
[10] Disability Act 2005, s 9.
[11] Disability Act 2005, s 11.
[12] Disability Act 2005, ss 14 to 22.
[13] Disability Act (Commencement) Order 2007, S.I. No.234 of 2007.

access to education with children without disabilities.[14] The Act provides for a presumption that a child with a disability will be educated in mainstream schooling so long as that is in the best interests of the child and that the child's presence would not prevent the effective education of other children,[15] for assessments of a child's special educational needs[16] and for the provision of educational plans.[17]

The Minister for Education is obligated to provide the monies and services necessary for the implementation of special educational plans, albeit with a caveat in section 13(3) that the Minister must take account of the resources available in the State and of the need to provide for education on an equitable basis to all children in the State.[18]

The Act also establishes a National Council for Special Education to coordinate the provision of special educational assessments and plans, to liaise with parents and schools, and to conduct research and advise the government on special educational needs.[19] The Council may request assistance from the local health service where it believes that health care assistance is needed to implement a special educational plan.[20]

The Citizens Information Act 2007 aims to improve access to public services for people with disabilities. Section 5 of the Act provides for the appointment of 'personal advocates' for people with disabilities who would by reason of their disability be unable to obtain a particular social service or who would have difficulty in obtaining it without the assistance of a personal advocate, and who risks harm to their health, welfare or safety if the service is not provided.[21]

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[14] Education for Persons with Special Educational Needs Act 2004, Long Title.
[15] Education for Persons with Special Educational Needs Act 2004, s 2.
[16] Education for Persons with Special Educational Needs Act 2004, s 4.
[17] Education for Persons with Special Educational Needs Act 2004, s 8.
[18] Education for Persons with Special Educational Needs Act 2004, s 13. In this regard, *see* the discussion at § 3.10.1 below of the Supreme Court decisions in *Sinnott (a minor suing by his mother and next friend) v Minister for Education, Ireland and the Attorney General* [2000] IEHC 21; [2001] IESC 63; [2001] 2 IR 545; *O'Donoghue v Minister for Health* [1996] 2 IR 20; and *T.D. (a minor suing by his mother and next friend M.D.) v Minister for Education, Ireland and the Attorney General, the Eastern Health Board and by Order of the Minister for Health and Children* [2001] IESC 101; [2001] 4 IR 259.
[19] Education for Persons with Special Educational Needs Act 2004, s 20.
[20] Education for Persons with Special Educational Needs Act 2004, s 39.
[21] Citizens Information Act 2007, s 5(3).

In addition to the disability legislation, there is also a significant body of legislation and case law dealing with the area of discrimination in the context of employment[22] or in the provision of services generally available to the public.[23] The Equal Status Act 2000 and the Employment Equality Act 1998 both prohibit discrimination on the grounds of disability.[24] The Equality Act 2004 consolidates and updates many of the provisions in the Equal Status Act 2000 and the Employment Equality Act 1998.

Ireland also provides a significant body of legislation pertaining to employment that aims to promote the participation of people with disabilities in work, and targets discrimination against people with disabilities in the workplace. These employment law statutes tackling discrimination in the workplace remain the most significant and far-reaching measures aimed at maximising the participation of people with disabilities in society applicable to adults in Ireland. The Equal Status Act 2000 and the Employment Equality Act 1998 are discussed here.

The Equal Status Act 2000 prohibits discrimination between a person with a disability and a person without a disability[25] and requires that the provider of a service make reasonable accommodation for the needs of a person with a disability if it would be impossible or unduly difficult for that person to access the service without the special treatment.[26] This applies to all services made generally available to the public (with some exceptions for private clubs and other circumstances);[27] to the disposal of premises and the provision of accommodation to the public;[28] to the provision of education[29] and to certain clubs.[30] Under Part III of the Act, a person who believes they have been discriminated against may complain to the Equality Authority and the Director of Equality Investigations may conduct an investigation into the alleged discrimination.[31]

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[22] Employment Equality Act 1998, s 16, as amended by the Equality Act 2004, s 9.
[23] Equal Status Act 2000, s 3.
[24] Employment Equality Act 1998, s 16, as amended by the Equality Act 2004, s 9; and Equal Status Act 2000, s 3(2)(g) and s 4.
[25] Equal Status Act 2000, s 3(2)(g), as amended by the Equality Act 2004.
[26] Equal Status Act 2000, s 4, as amended by the Equality Act 2004.
[27] Equal Status Act 2000, s 5, as amended by the Equality Act 2004.
[28] Equal Status Act 2000, s 6, as amended by the Equality Act 2004.
[29] Equal Status Act 2000, s 7, as amended by the Equality Act 2004.
[30] Equal Status Act 2000, ss 8 and 9, as amended by the Equality Act 2004.
[31] Equal Status Act 2000, pt III, as amended by the Equality Act 2004 – *see* particularly ss 21, 23, 25, and 27.

The Employment Equality Act 1998 prohibits discrimination between a person with a disability and a person without a disability in the context of access to employment; conditions of employment; training or experience for or in relation to employment; promotion or re-grading; and classification of posts.[32] Employers are also required to make reasonable accommodation for the needs of an employee with a disability.[33] Under Part V of the Act, a person who believes they have been discriminated against may complain to the Employment Equality Authority and the Authority may conduct an inquiry into the alleged discrimination.[34]

Significant academic work has been done on these provisions and on the legal principles established by the legislation and the precedents that have followed in the decisions of the Equality Tribunal, the Employment Appeals Tribunal and the courts.[35] Further discussion of these provisions is considered to be outside the scope of this work. The employment and disability legislation provides important protection to people with mental health disabilities by prohibiting discrimination and promoting inclusion in broader society. The influence of rights will be mentioned again in the context of the discussion of equality rights.

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[32] Employment Equality Act 1998, s 6(1)(g) and s 8, as amended by the Equality Act 2004.
[33] Employment Equality Act 1998, s 16(3), as amended by the Equality Act 2004.
[34] Employment Equality Act 1998, pt V, as amended by the Equality Act 2004 – *see* particularly ss 58 and 62.
[35] *See* for example Cox, Neville, Corbett, Val, and Ryan, Desmond, *Employment Law in Ireland* (Dublin: Clarus Press, 2009); Mooney Cotter, Anne-Marie and Moffatt, Jane, (eds.), *Discrimination Law* (London: Cavendish, 2005); Byrne, Rosemary and Duncan, William, (eds.), *Developments in Discrimination Law in Ireland and Europe* (Dublin: Irish Centre for European Law, 1997); Kilcommins, Shane, et al, *Extending the scope of employment equality legislation : comparative perspectives on the prohibited grounds of discrimination* (Dublin : Stationery Office, 2004); Kimber, Cliona, "Equality Disability (Part II)" (2001) 7 (2) *Bar Review* 66; Kimber, Cliona, "Equality Disability (Part I)" (2001) 6 (9) *Bar Review* 494; Dowling, Marcus, "Disability Discrimination under the Employment Equality Act, 1998" (1999) 5 (3) *Bar Review* 121; Smith, Olivia, "Disability, Discrimination and Employment: A Never-ending Legal Story?" (2001) 23 *Dublin University Law Journal* 148; Murdoch, Henry, "As good as it gets?" (2001) 95 (8) *Law Society Gazette* 12; O'Halloran, Barry, "Another brick in the wall?" (2000) 94 (9) *Law Society Gazette* 14; Duane, Eilean, "Children with Disabilities and the Law" (2004) 2 *Irish Journal of Family Law* 8; McCrann, Terence and Kelleher, Mary, "Disability discrimination under the Employment Equality Act 1998 and the Equality Bill 2004" (2004) 1(2) *Irish Employment Law Journal* 42; Middlemiss, Sam, "The Right to Dignity at Work? Recent Developments in Harassment Law in the United Kingdom - Part 2" (2007) 25 *Irish Law Times* 111; Smith, Olivia, "Side-Stepping Equality? Disability Discrimination and "Generally Accepted Qualifications" (2008) 30(1) *Dublin University Law Journal* 279; Morgan, Sinead, "Disability Discrimination - How Far Does it Extend?" (2009) 6(3) *Irish Employment Law Journal* 70; and Flynn, Ellionóir, "Ireland's Compliance with the Convention on the Rights of Persons with Disabilities: Towards a Rights-Based Approach for Legal Reform?" (2009) 16 (1) *Dublin University Law Journal* 357.

At this juncture attention will now turn to the regulation of capacity, and most particularly, to the legal mechanisms by which compulsory mental health treatment is regulated. These are the legal provisions that form the bedrock of Irish mental health law. In Chapter 5 of this work they are measured against the international human rights framework, in order to assess the success or failure of the effort to introduce a human rights mental health law regime in Ireland.

1.2 Wardship and Guardianship

As a general rule people are presumed to have the capacity to manage their affairs and make decisions concerning their care and welfare, and no-one else is entitled to make decisions on their behalf. Where a person suffers from a loss of their capacity to take care of their financial or legal affairs or their personal welfare, there are only two options open to their families or carers to enable someone else to take decisions for them: to execute an enduring power of attorney prior to the loss of capacity; or to avail of the wardship procedure subsequent to the loss of capacity. The Law Reform Commission in 2006 reported on the protections available to vulnerable adults and concluded that these options were insufficient to safeguard human rights and that a modern guardianship regime should be adopted in replacement of the outdated wardship mechanism.[36]

[36] Law Reform Commission, *Report: Vulnerable Adults and the Law (LRC 83 – 2006)* (Dublin: Law Reform Commission, 2006) <http://www.lawreform.ie/_fileupload/Reports/Report%20Vulnerable%20Adults.pdf> accessed 23 January 2011. *See* also Donnelly, Mary, "Legislating for Incapacity: Developing a Rights-Based Framework" (2008) 30 *Dublin University Law Journal* 395; Murray, Claire, "Safeguarding the Right to Liberty of Incapable Compliant Patients with a Mental Disorder in Ireland" (2007) 29 *Dublin University Law Journal* 279, and Flynn, Ellionóir, "Ireland's Compliance with the Convention on the Rights of Persons with Disabilities: Towards a Rights-Based Approach for Legal Reform?" (2009) 16 (1) *Dublin University Law Journal* 357.

1.2.1 Wardship

Wardship in Ireland[37] derives from the *parens patriae* jurisdiction of the High Court[38] and is regulated by the Lunacy Regulation (Ireland) Act 1871 (hereafter 'the 1871 Act'). Wardship is also closely connected with the constitutional protection in Article 40.3.2° for the personal and property rights of the citizen.[39] The wardship mechanism under the 1871 Act is regulated by the Rules of the Superior Courts, Order 67 which specifies in detail the steps to be taken in making an application to take a person into wardship and the proofs that will be required by the High Court.[40] The 1871 Act provides details on the approach to be adopted by the Court when dealing with the property of the ward, but is silent on the approach to be adopted in making decisions on the care, welfare, or treatment of the ward. In *Re a Ward of Court (No. 2)* Hamilton CJ stated that in making these decisions the Court must exercise its *parens patriae* jurisdiction within the inherent jurisdiction of the Court, and at all times act in the best interests of the ward.[41]

In order to be made a ward of court a person must be found to be of unsound mind and to be incapable of managing his or her person and/or property. Where a person is incapable of managing their affairs but does not meet the test to be declared a person

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[37] On wardship generally *see* O'Neill, Anne-Marie, *Wards of Court in Ireland* (Dublin: Firstlaw, 2004); Mc Loughlin, N., "Wardship: A Legal and Medical Perspective" (1999) 4 (4) *Medico-Legal Journal of Ireland* 61; O'Neill, Anne-Marie, Irish Mental Health Law (Dublin: Firstlaw, 2005), 645-680; Ní Chulachain, S., "Wardship: Time for Reform" (2000) 3 *Bar Review* 239; and Harris, Lesley G.E., *A Treatise on the Law and Practice in Lunacy in Ireland* (Dublin: Corrigan and Wilson Limited, 1930).

[38] Courts (Supplemental Provisions) Act 1961, s 9; Courts of Justice Act 1924, s 19. *See In Re a Ward of Court (No. 2)* [1996] 2 I.R. 96, 102-103 (Hamilton CJ). The survival of the *parens patriae* jurisdiction after the adoption of the Constitution of the Irish Free State in 1922 is a matter of some controversy and has been the subject of some debate elsewhere (*see* for example *Byrne v Ireland* [1972] IR 241 and *Webb v Ireland* [1988] IR 353) but it is a settled principle in both wardship and in mental health cases that even if it did not survive the enactment of the 1922 Constitution, it remains a legitimate basis for the consideration by the courts of protection of the property and person of vulnerable people, either by virtue of the 1924 and 1961 legislation, or as part of the inherent jurisdiction of the High Court as a court of full original jurisdiction under Article 34.3.1° of the Constitution. *See* Tomkin, D. and McAuley, A., "Re a Ward of Court: Legal Analysis" (1995) 1 *Medico-Legal Journal of Ireland* 45.

[39] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 40.3.2°.

[40] Rules of the Superior Courts, Order 67, as amended by Rules of the Superior Courts (No.2) 1989 (S.I. No.20 of 1989) and Rules of the Superior Courts (No. 1) (Remuneration of Committees of Wards of Court) 2002 (S.I. No.208 of 2002).

[41] *In Re a Ward of Court (No. 2)* [1996] 2 I.R. 96, 106 (Hamilton CJ).

of unsound mind they may not be taken into wardship.[42] Additionally, there must be some benefit to the ward of the utilisation of the wardship procedure.[43] The definition of a 'person of unsound mind' is vague. The 1871 Act merely provides that where a person is 'found' to be a person of unsound mind that they may be admitted into wardship.[44] In practice the High Court relies on the evidence of the petitioner and the proposed ward where an objection is raised, together with the reports of medical assessors (known as 'medical visitors') appointed by the Registrar of Wards of Court to assess the person it is proposed to take into wardship.[45] The vagueness of the concept of a 'person of unsound mind' and the potential for variations in its interpretation by the medical visitors is a matter of concern in respect of the international human rights obligations to ensure fair procedures and protection of the rights to liberty, autonomy, and privacy. This is discussed in more detail at §§ 5.2 and 5.3 below.

When a person is taken into wardship a Committee of the Ward is appointed to supervise the management of the ward's personal and property affairs. An annual account of all monies received and disbursed on behalf of the ward must be furnished to the Office of Wards of Court.[46]

A declaration of wardship effectively terminates a person's ability to make any decisions regarding their personal or financial affairs. It is described by O'Neill as "one of the most intrusive encroachments that a democratic society can impose on any of its members."[47] A ward of court can no longer decide how to spend their money, whether or not to dispose of their property, where they live, or what medical treatment they will or will not undergo. Wardship affects all matters relating to the ward's

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[42] *In the matter of Catherine Keogh*, Unreported, High Court, 15 October 2002 (Finnegan P).
[43] O'Neill, Anne-Marie, "Wardship Law and Procedure" *Irish Women Lawyers Association Seminar on Law and the Elderly* 22 January 2005 (2005)
<http://www.iwla.ie/docs/elderly%20seminar/Wardship_law_procedure.pdf> accessed 23 January 2011.
[44] The Lunacy Regulation (Ireland) Act 1871, s 3 originally provided that wardship would be utilised where a person was "found by inquisition an idiot, lunatic, or of unsound mind, and incapable of managing himself or his affairs." The 1961 Act introduced the phrase 'person of unsound mind' but the language of the wardship legislation continues to be considered offensive. *See* for example *Dolan v Register of Wards of Court,* Unreported High Court, 19th March 2004 (Kelly J).
[45] Rules of the Superior Courts, Order 67, Rule 4(3).
[46] Rules of the Superior Courts, Order 67, Rule 57(62).
[47] O'Neill, Anne-Marie, *Wards of Court in Ireland* (Dublin: Bloomsbury Professional, 2005), 184.

person and their estate.[48] All decisions in relation to these matters must be directed to the Court and the Committee is then charged with carrying out the specific aspects of the decisions as are directed by the Court.[49]

The 1945 Act did not provide for any particular protections for persons resident in mental hospitals who are declared wards of court, and the MHA 2001 makes no mention of wardship whatsoever. In practice, declarations of wardship in respect of persons residing in a mental hospital generally require that the ward continue to reside in the mental hospital. It is feasible then that a situation could arise whereby a person enters a mental hospital as a voluntary patient; subsequently loses capacity but is compliant with their stay in the hospital and does not seek to leave and as such is not formally detained under the involuntary patient provisions of the MHA 2001; and is thereafter declared a ward of court. This chain of events could result in a situation whereby an ostensibly voluntary patient, presumed to have capacity to consent to their admission and to any mental health treatment being received, is concurrently a ward of court with no capacity to make any decisions in respect of their personal or property affairs.[50]

The Mental Health Commission Annual Reports including the Report of the Inspector of Mental Health Services from 2004 to 2007 provided figures for the number of wards of court resident in mental hospitals in each of those years. The figures remained virtually constant throughout that time:

- In 2007, there were 81 wards of court resident in mental hospitals, representing 2.4% of the total resident population;[51]
- In 2006, there were 82 wards of court resident in mental hospitals, representing 2.5% of the total resident population;[52]

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[48] *In Re a Ward of Court (No. 2)* [1996] 2 I.R. 96, 106 (Hamilton CJ).

[49] Rules of the Superior Court, Order 67 Rule 3. All petitions to the Court in respect of decisions to be taken concerning the person or property of the ward are required to be accompanied by an unsworn statement setting out the reasons the decision in question is required.

[50] *See* the discussion at §§ 2.4.2 (a); 3.6; 4.1.2; and 5.2.1 below.

[51] Mental Health Commission, Mental Health Commission Annual Report 2007 including the Report of the Inspector of Mental Health Services (Dublin: Mental Health Commission, 2008), 58, Figure 2 <http://www.mhcirl.ie/Publications/Annual_Reports/MHC_2007_Annual_Report.zip> accessed 23 January 2011.

- In 2005, there were 87 wards of court resident in mental hospitals, representing 2.5% of the total resident population;[53] and
- In 2004, there were 88 wards of court resident in mental hospitals, representing 2.5% of the total resident population.[54]

It is unknown how many of these patients entered hospital as a ward of court, or for those who were declared wards of court while in hospital, it is unknown whether they were voluntary patients or involuntary patients (or 'temporary' or 'person of unsound mind' patients under the 1945 Act) prior to their being taken into wardship. While the overwhelming majority of patients residing in mental hospitals are voluntary patients, it would not be surprising to find that the percentage of involuntary patients among wards of court residents is higher than the percentage in the overall population. The Mental Health Commission Annual Reports since 2007 have not provided figures for the numbers of wards of court residing in mental hospitals.[55]

1.2.2 Powers of Attorney

The only other mechanism under Irish law whereby a person may make decisions on behalf of another person in respect of personal and property affairs is under an enduring power of attorney executed under the Powers of Attorney Act 1996.

The Powers of Attorney Act 1996 (hereafter 'the 1996 Act') provides a mechanism whereby a person who has full capacity, but who anticipates that they may in the

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[52] Mental Health Commission, Mental Health Commission Annual Report 2006 including the Report of the Inspector of Mental Health Services (Dublin: Mental Health Commission, 2007), 51, Table 4.9 <http://www.mhcirl.ie/Publications/Annual_Reports/MHC_Annual_Report_2006.pdf> accessed 23 January 2011.

[53] Mental Health Commission, Mental Health Commission Annual Report 2005 including the Report of the Inspector of Mental Health Services (Dublin: Mental Health Commission, 2006), 35, Table 4.4 <http://www.mhcirl.ie/Publications/Annual_Reports/MHC_2005_Annual_Report.pdf> accessed 23 January 2011.

[54] Mental Health Commission, Mental Health Commission Annual Report 2004 including the Report of the Inspector of Mental Health Services (Dublin: Mental Health Commission, 2005), 31-32, Table 2 <http://www.mhcirl.ie/Publications/Annual_Reports/MHC_Annual_Report_2004.pdf> accessed 23 January 2011.

[55] On the use of wardship in psychiatry generally, *see* McCarthy, G., and Wrigley, M., "Wards of Court – A Review of Utilisation in a Psychiatry of Old Age Service" (1999) 4(2) *Medico-Legal Journal of Ireland* 75.

future suffer a loss of capacity, may appoint another person to make decisions in respect of their property and finance affairs, and certain personal care decisions.

Decisions in respect of health care are excluded from the remit of matters over which an enduring power of attorney may be executed.[56] This is an issue the Law Reform Commission has addressed, with a recommendation that the enduring power of attorney mechanism be extended to encompass health care decisions.[57]

1.2.3 Reform: The Proposed Guardianship Regime

The Law Reform Commission in 2006 proposed the implementation of a guardianship regime to replace the wardship procedure and better reflect the human rights ethos of Irish law in the modern era.[58] A Mental Capacity and Guardianship Bill was placed before the Dáil in February 2008 but it has not to date been enacted.

The key recommendations of the Law Reform Commission's Report in respect of guardianship were:

1. That the current law on capacity be amended to move away from the current restrictive approach in the wardship regime, to an enabling approach more in keeping with the requirements of constitutional and human rights law;[59]
2. That specialist mental capacity legislation be enacted to provide for a modern definition of legal capacity; provisions for assisted decision-making; and regulatory mechanisms;[60]

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[56] Powers of Attorney Act 1996, s 4(1).
[57] Law Reform Commission, *Report: Vulnerable Adults and the Law (LRC 83 – 2006)* (Dublin: Law Reform Commission, 2006), para 4.32 <http://www.lawreform.ie/_fileupload/Reports/Report%20Vulnerable%20Adults.pdf> accessed 23 January 2011.
[58] Law Reform Commission, *Report: Vulnerable Adults and the Law (LRC 83 – 2006)* (Dublin: Law Reform Commission, 2006) <http://www.lawreform.ie/_fileupload/Reports/Report%20Vulnerable%20Adults.pdf> accessed 23 January 2011.
[59] Law Reform Commission, *Report: Vulnerable Adults and the Law (LRC 83 – 2006)* (Dublin: Law Reform Commission, 2006), para 2.11 <http://www.lawreform.ie/_fileupload/Reports/Report%20Vulnerable%20Adults.pdf> accessed 23 January 2011.
[60] Law Reform Commission, *Report: Vulnerable Adults and the Law (LRC 83 – 2006)* (Dublin: Law Reform Commission, 2006), para 2.20

3. That the proposed mental capacity legislation should include health care decisions within its remit;[61]
4. That a functional approach to capacity be adopted, whereby an assessment of capacity relates to the particular decision to be made at the time it is to be made, rather than the current status approach to capacity whereby capacity is assessed for all decisions to be made at any time into the future;[62]
5. That inappropriate terminology such as the language in the 1871 Act be repealed and replaced;[63]
6. That a rebuttable presumption of capacity should apply in law;[64]
7. That an Office of the Public Guardian and a Guardianship Board should be established to monitor the application of the new capacity and guardianship regime and to publish standards and codes of practice for its operation;[65]
8. That enduring powers of attorney should be permitted in respect of health care decisions.[66]

It is generally considered that the proposed reforms would represent a significant improvement over the existing mechanisms for protecting vulnerable adults who lack

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<http://www.lawreform.ie/_fileupload/Reports/Report%20Vulnerable%20Adults.pdf> accessed 23 January 2011.

[61] Law Reform Commission, *Report: Vulnerable Adults and the Law (LRC 83 – 2006)* (Dublin: Law Reform Commission, 2006), para 2.23 <http://www.lawreform.ie/_fileupload/Reports/Report%20Vulnerable%20Adults.pdf> accessed 23 January 2011.

[62] Law Reform Commission, *Report: Vulnerable Adults and the Law (LRC 83 – 2006)* (Dublin: Law Reform Commission, 2006), para 2.30 <http://www.lawreform.ie/_fileupload/Reports/Report%20Vulnerable%20Adults.pdf> accessed 23 January 2011.

[63] Law Reform Commission, *Report: Vulnerable Adults and the Law (LRC 83 – 2006)* (Dublin: Law Reform Commission, 2006), para 2.33 <http://www.lawreform.ie/_fileupload/Reports/Report%20Vulnerable%20Adults.pdf> accessed 23 January 2011.

[64] Law Reform Commission, *Report: Vulnerable Adults and the Law (LRC 83 – 2006)* (Dublin: Law Reform Commission, 2006), para 2.39 <http://www.lawreform.ie/_fileupload/Reports/Report%20Vulnerable%20Adults.pdf> accessed 23 January 2011.

[65] Law Reform Commission, *Report: Vulnerable Adults and the Law (LRC 83 – 2006)* (Dublin: Law Reform Commission, 2006), paras 4.46; 6.40; and 7.14 <http://www.lawreform.ie/_fileupload/Reports/Report%20Vulnerable%20Adults.pdf> accessed 23 January 2011.

[66] Law Reform Commission, *Report: Vulnerable Adults and the Law (LRC 83 – 2006)* (Dublin: Law Reform Commission, 2006), para 4.32 <http://www.lawreform.ie/_fileupload/Reports/Report%20Vulnerable%20Adults.pdf> accessed 23 January 2011.

capacity,[67] although other commentators have questioned the wisdom of abandoning the wardship regime entirely rather than amending it to reflect the requirements of the modern human rights focused era.[68] Capacity and guardianship measures similar to those proposed by the Law Reform Commission have already been enacted in England, and the benefits of the English regime are discussed in detail at § 4.1.2 below. The scheme of proposed new mental capacity legislation was published in September 2008.[69] It proposes the replacement of the wardship regime with a guardianship system that functions on a presumption of capacity and utilises a functional test of capacity, and the recognition of Enduring Powers of Attorney which would apply in respect of health care decisions. It also proposes the establishment of an Office of the Public Guardian, and a special jurisdiction of the High Court sitting as the 'High Court for Care and Protection' when dealing with matters arising under the Act. To date the proposed capacity legislation has not been laid before the Dáil.[70] The proposed Bill has attracted submissions from the Law Society,[71] the College of Psychiatry in Ireland,[72] the Irish Human Rights Commission[73] and the National

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[67] Rubotham, Noel, "From Wardship to Guardianship: Preparing for Change" *Annual Conference of the Law Reform Commission*, December 2005. *See* also Donnelly, Mary, "Legislating for Incapacity: Developing a Rights-Based Framework" (2008) 30 *Dublin University Law Journal* 395; Murray, Claire, "Safeguarding the Right to Liberty of Incapable Compliant Patients with a Mental Disorder in Ireland" (2007) 29 *Dublin University Law Journal* 279, and Flynn, Ellionóir, "Ireland's Compliance with the Convention on the Rights of Persons with Disabilities: Towards a Rights-Based Approach for Legal Reform?" (2009) 16 (1) *Dublin University Law Journal* 357.

[68] O'Neill is critical of the Law Reform Commission's reform proposals and sees them as a wholesale abandonment of a regime that may be outdated but that could be modernised through amendment, and does not necessitate abolition. *See* O'Neill, Anne-Marie, *Wards of Court in Ireland* (Dublin: Bloomsbury Professional, 2005), 206-208.

[69] Department of Justice and Law Reform, *Scheme of the Mental Capacity Bill 2008* (Dublin: Stationery Office, 2008) <http://www.justice.ie/en/JELR/Pages/Scheme_of_Mental_Capacity_Bill_2008/> accessed 24 January 2011) It was indicated on 6 October 2010 that the Mental Capacity Bill would be introduced during the Winter 2010 session of the Dáil, however this did not materialise. *See* Cowen, Brian, Debates of the Houses of the Oireachtas (Dáil Debates) Vol. 717 No. 3, *Order of Business* (3 October 2010), at 578 <http://debates.oireachtas.ie/dail/2010/10/06/00008.asp> accessed 24 January 2011. As of 12 January 2011 the proposed capacity legislation was promised to be put before the Dáil in mid-February 2011. *See* Moloney, John, Houses of the Oireachtas (Seanad Debates) Vol. 207 No. 1 *Mental Capacity and Guardianship Legislation* 25 June 2008, 8 <http://debates.oireachtas.ie/seanad/2011/01/12/00008.asp#N2> accessed 24 January 2011.

[70] College of Psychiatry of Ireland, *The College of Psychiatry of Ireland Disappointed at the Delay in Publishing the Mental Capacity Bill*, Press Statement 3 July 2009 <http://www.inclusionireland.ie/documents/CPsychIPressstatementProposedCapacityLegislationSubmissionPaper03July09.pdf> accessed 24 January 2011.

[71] Law Society of Ireland, *Submission to the Department of Justice Equality and Law Reform on the Proposed Scheme of the Mental Capacity Bill 2008* (Dublin: Law Society, 2009) <http://www.lawsociety.ie/documents/committees/lawreform/Submission_Mental_Capacity_Bill_260109.pdf> accessed 24 January 2011.

[72] College of Psychiatry of Ireland, *The College of Psychiatry of Ireland Disappointed at the Delay in Publishing the Mental Capacity Bill*, Press Statement 3 July 2009

Disability Authority.[74] While calling for some minor changes (e.g. to make explicit provision for incapacitated patients detained under the MHA 2001, and ensuring that Enduring Powers of Attorney in respect of medical treatment decisions are not restricted), the response to the legislation has been mostly positive.

1.3 The Mental Health System in Ireland

Ireland, at least in theory, has a system of universal public health care.[75] An independent public body, the Health Service Executive (HSE) established under the Health Act 2004 (hereafter the 2004 Act),[76] administers the public health system. The HSE provides primary mental health care through General Practice (GP) clinics,[77] and the vast majority of people experiencing mental illness receive their medical care from their GP. A GP can refer a patient to counselling or other therapeutic services; prescribe psychiatric medication; refer a patient to a consultant psychiatrist; and in the most serious cases recommend admission to a mental hospital as either a voluntary or involuntary patient.[78] The HSE also provides a range of specialised psychiatric services, both in the community and in mental hospitals. A patient receiving treatment in the community may continue to live in their own home, and attend at outpatient psychiatric clinics or at day centres or sheltered workshops for treatment or support. The HSE also operates a variety of inpatient services, from day hospitals and group homes to acute admission wards and continuing care wards. Depending on the

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<http://www.inclusionireland.ie/documents/CPsychIPressstatementProposedCapacityLegislationSubmissionPaper03July09.pdf> accessed 24 January 2011.

[73] Irish Human Rights Commission, *Observations on the General Scheme of the Mental Capacity Bill 2008* (Dublin: Irish Human Rights Commission, December 2008) <http://www.ihrc.ie/publications/list/observations-on-the-scheme-of-the-mental-capacity/> accessed 24 January 2011.

[74] National Disability Authority, *NDA Submission on Mental Capacity Scheme of Bill* (Dublin: National Disability Authority, May 2009) <http://www.nda.ie/Website/NDA/CntMgmtNew.nsf/0/66292BBCC27B2914802575B7003D5E83?OpenDocument> accessed 24 January 2011.

[75] For a critical account of the division between public and private health care in Ireland, *see* Burke, Sara, *Irish Apartheid: Healthcare Inequality in Ireland* (Dublin: New Island Press, 2009).

[76] Health Act 2004 (No. 42 of 2004).

[77] Health Act 1970, s 58(1) as amended by Health (Amendment) Act 2005, s 5.

[78] General Medical Services Regulations 1954, S.I. No.102 of 1954. *See* also Mental Health Act 2001, s 10(1).

locality, acute admission wards and continuing care wards may be housed in a general hospital facility or in a specialised psychiatric facility.[79]

The legislative framework for the regulation of mental health care underwent fundamental reform with the passing of the Mental Health Act 2001 (hereafter 'MHA 2001').[80] The MHA 2001 was introduced with the intention of bringing Irish law in the area of mental health regulation into compliance with the requirements of the European Convention on Human Rights (hereafter 'ECHR').[81] It represents a shift in focus in Irish mental health law, with a new emphasis on the human rights of the patient, and a move away from the medical paternalism favoured in the Mental Treatment Act 1945 (hereafter 'the 1945 Act'). The MHA 2001 is grounded on two pillars of reform:

(a) Reform of the procedures used in respect of involuntary admissions to treatment centres, and involuntary detentions;[82] and

(b) The introduction of new measures for the monitoring, inspection, and regulation of standards of care and treatment in mental health services.[83]

The monitoring and regulation features of the Act were introduced almost immediately upon the passing of the Act, on 5 April 2001,[84] while the introduction of

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[79] For detailed information on the facilities and services provided by the HSE in the area of mental health, *see* the Mental Health Commission, *Annual Reports of the Inspectorate of Mental Health Services* (Dublin: Mental Health Commission, 2003-2009) <http://www.mhcirl.ie/Publications/Annual_Reports/> accessed 20 January 2011.

[80] For historical accounts of the regulation of mental health in Ireland, *see* Kirkpatrick, T.P.C., *A Note on the History of the Care of the Insane in Ireland: Up to the End of the Nineteenth Century* (Dublin: University Press, Ponsonby and Gibbs, 1931); Malcolm, E., *Swift's Hospital: A History of St. Patricks' Hospital, Dublin: 1746-1989* (Dublin: Gill and Macmillan, 1989); Reynolds, J., *Grangegorman: Psychiatric Care in Dublin Since 1815* (Dublin: Institute of Public Administration in association with the Eastern Health Board, 1992); Robins, Joseph, *Fools and Mad: A History of the Insane in Ireland* (Dublin: Institute of Public Administration, 1986) and Finnane, M., *Insanity and the insane in post-famine Ireland* (London: Croom Helm, 1981).

[81] "Tánaiste announces the full implementation of the Mental Health Act 2001" *Press Release, 6 July, 2006* (Dublin: Government Publications, 2006) <http://www.dohc.ie/press/releases/2006/20060706.html> accessed 6 September 2006.

[82] Mental Health Act 2001, pts 2 and 3.

[83] Mental Health Act 2001, pt 3, ss 50 to 55.

[84] Mental Health Act, 2001 (ss 1 to 5, 7, 31 to 55) (Commencement) Order 2002 (S.I. No.90 of 2002) and Mental Health Act 2001 (Establishment Day) Order 2002 (S.I. No.91 of 2002).

the review mechanisms for involuntary admissions and detentions decisions was delayed until 1 November 2006.[85]

1.4 Legal Regulation of Mental Health Care in Ireland

The human rights movement has had an enormous impact on the area of mental health regulation in Ireland. The human rights standards established by the United Nations and the Council of Europe have resulted in significant changes in the administration of the provision and regulation of mental health services, and it is the degree of success of Irish mental health law in adapting to these new human rights based standards that is the subject of evaluation in this thesis.

The earliest regulation of mental health focussed on warehousing people with mental illness to prevent them causing harm to others, or more latterly, to prevent them causing harm to themselves. As such, these systems facilitated a complete and totalitarian control over the lives of the people who came within them and were permeated by a paternalist ethos in which it was believed that the physician knew best the needs of the patient – and that the physician's view should accordingly take precedence over that of the patient.

By contrast, the modern mental health regime founded on a human rights ethos seeks to minimise interference with people's freedom to control their own lives when the mental health regime is deployed, by limiting the circumstances in which mental health treatment can be compulsorily provided, and by providing for mechanisms for independent review of decisions taken under the regime.

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[85] Mental Health Act 2001 (Commencement) Order 2006 (S.I. No.411 of 2006). *See* also "Tánaiste announces the full implementation of the Mental Health Act 2001" *Press Release, 6 July, 2006* (Dublin: Government Publications, 2006) <http://www.dohc.ie/press/releases/2006/20060706.html> accessed 6 September 2006. Part of the reason for the delay in the implementation of Part 2 of the MHA 2001 was due to protracted negotiations with professional bodies prior to the establishment of the Mental Health Tribunals. *See* Mental Health Commission, *Mental Health Commission Annual Report 2005: Book 1* (Dublin: Mental Health Commission, 2006), 23 <http://www.mhcirl.ie/Publications/Annual_Reports/MHC_2005_Annual_Report.pdf> accessed 20 January 2011.

The paternalist philosophy continues to influence the jurisprudence on the interpretation of mental health law in Ireland, even since the enactment of the new human rights based mental health law regime under the MHA 2001. In this section the evolution of mental health law in Ireland is first traced, in order to provide a context for the paternalist philosophy that continues to predominate the case law in the area. Thereafter, the MHA 2001 provisions are described. The departures from the earlier regime under the 1945 Act are highlighted, along with the instances where the vestiges of the historical totalitarian approach to mental health regulation may be said to survive in the interpretations being given to the new provisions. This discussion establishes the foundations of Irish mental health law, and provides a detailed description of the structure and key provisions of the regime which will be utilised in the audit of Irish mental health law for compliance with international human rights standards in Chapter 5 of this thesis.

1.4.1 The Evolution of Mental Health Regulation in Ireland: Containment, Asylum, and Cure

This section will trace the evolution of the legal regulation of mental health treatment and care provision in Ireland. Legal regulation of mental health, or mental illness, stretches back as far as records of law exist – indeed Peter Bartlett and Ralph Sandland describe mental health law as being 'as old as law itself'.[86] This evolution may be traced across three broad phases which are here referred to as 'containment'; 'asylum'; and 'cure.' This historical account of mental health regulation in Ireland provides a counterpoint to the description of the new human rights based mental health regime that was ushered in by the MHA 2001. In Chapter 5 of this work, a critique is provided of the extent to which the MHA 2001 has succeeded in importing a human rights culture into mental health law in Ireland. One of the criticisms that is made in the human rights audit performed in Chapter 5 is that the case law interpreting and applying the MHA 2001 has too closely adhered to the strongly paternalist approach adopted to mental health regulation prior to the 2001 reforms. A

[86] Bartlett, Peter, and Sandland, Ralph, *Mental Health Law: Policy and Practice*, 1st ed. (Oxford: Oxford University Press, 2003), 21.

description of the evolution and character of the earlier mental health regime is of importance to that analysis.

The earliest approach to mental illness, utilised in early history when fewer treatments for mental illness were available, and when systems for provision of healthcare were more localised within individual communities, was to attempt to contain people with mental illness either within the home or within correctional facilities.[87] The very earliest accounts of the treatment of people with mental illness show a policy of containment, frequently at home, or of simply allowing people to wander the countryside and rely on the kindness of strangers for food, shelter, and care.[88] Under the ancient Irish Brehon law,[89] a strictly hierarchical legal system in which sanctions for breaches of legal rules were based on the status of the victims and perpetrators within the kinship system,[90] people with mental illness featured on the lower rungs of the kin's hierarchy of status. O'Neill points out that there was a division in Brehon law between the intellectually disabled (who were referred to as '*drúth*') and the mentally ill (who were referred to as '*mer*' or '*dásachtach*'), with the law placing an emphasis on the ability of a person either to work or to amuse others, which could increase the mentally disabled person's standing in the kin hierarchy.[91]

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[87] *See* generally Robins, Joseph *Fools and Mad: A History of the Insane in Ireland* (Dublin: Institute of Public Administration, 1986).

[88] *See* generally Robins, Joseph *Fools and Mad: A History of the Insane in Ireland* (Dublin: Institute of Public Administration, 1986).

[89] *See* generally, Kelly, F., *A Guide to Early Irish Law* (Dublin: Dundalgan Press, 2003); Robins, Joseph, *Fools and Mad: A History of the Insane in Ireland* (Dublin: Institute of Public Administration, 1986); Anderson, J., "Brehon Law" (Limerick, Hunt Museum, 24th February 1999); Hyde, "The Brehon Laws" *Catholic Encyclopaedia* <http://www.newadvent.org/cathen/02753a.htm> accessed 1 December 2005; Salafia, Vincent "Law, Literature and Legend" <http://ua_tuathal.tripod.com/lawpref.htm> accessed 29 November 2005; and "Theme Summary" of the *Brehon Law Project Symposium 2001* "Moving Forward into Our Brehon Past" <http://www.ucc.ie/ucc/depts/law/irishlaw/events/brehonlaw_jan12142001.shtml> accessed 16 December 2005.

[90] Kelly, F., *A Guide to Early Irish Law* (Dublin: Dundalgan Press, 2003), 222-224.

[91] O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005), 4. The unfortunate effect of this emphasis on an ability to work or to amuse was that the more severe a person's disability or illness, and the less their ability to work or to amuse, then the lower their standing in the kin hierarchy. A low status in the kin hierarchy had numerous implications for people with a mental disability. Dependant on their particular legal status, a person with a mental disability might not be capable of entering into a contractual relationship or of being held responsible for their crimes - responsibility for the legal burden, or punishment for the crime, would be imposed on their guardian in their stead (*see* Robins, Joseph *Fools and Mad: A History of the Insane in Ireland* (Dublin: Institute of Public Administration, 1986), 5). A fine could be imposed for leading a person with a mental illness or an intellectual disability into the commission of a wrong (*see* O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005), 5).

Under Brehon law hospitality was a legal duty, and where a person was considered to have a mental disability a legal responsibility existed on their family to provide care for them – in fact, the Brehon courts could impose a duty on a kin or an individual to care for a person with a mental disability, and a fine could be imposed for failing to provide care.[92] Where the mentally disabled person did not have a family to care for them or their family were unable to care for them, or if they had wandered far from their clan and were thus without family nearby, alternative provision was made. Shelter was traditionally available for wanderers at convents and monasteries, and this shelter was also made available to people with mental disabilities. Indeed, it is believed that many of these religious institutions kept separate accommodation specifically for the care of the mentally ill, in the form of hospitals and hospices specifically established for the provision of care to wayfarers: Robins cites twelfth century texts as indicating a practice on the part of Irish monasteries of keeping people with mental illness in fetters and chains – evidence that a practice of keeping specific facilities for the insane was in place by that time.[93] Despite the fact that these hospitals were generally very small, they nonetheless provided the main source of shelter for the sick and the poor. After the Norman invasion of Ireland in 1169, and the invasion of Henry II in 1171, the Brehon law initially remained in operation alongside the English common law system, but ultimately fell into decline in the 17th century.[94] With the introduction of the Penal Laws (1558-1759) the convents and

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[92] Anderson, Jack, "Brehon Law" (Limerick, Hunt Museum, 24th February 1999).

[93] Robins, Joseph, *Fools and Mad: A History of the Insane in Ireland* (Dublin: Institute of Public Administration, 1986), 17.

[94] In the twelfth century, Brehon law was formally abolished in Ireland by the Statute of Kilkenny 1366. However, although English settlers were now expected to use the common law exclusively, and failure to do so amounted to treason, in the areas of the country that remained relatively untouched by British rule, the native Irish continued to use their indigenous legal system (*see* Anderson, Jack, "Brehon Law" (Limerick, Hunt Museum, 24th February 1999)). In the seventeenth century, after the abolition of the federal clan system on which Brehon law was based (after the Treaty of Mellifont 1603), Brehon law began to decline. The indigenous legal system was officially abolished in the *Case of Tanistry* 80 Eng. Rep. 516 (K.B. 1608) and shortly thereafter the Cromwellian invasion effected total English control over Ireland. In *The Case of Tanistry* 80 Eng. Rep. 516 (K.B. 1608), the validity of the native Irish customary law of inheritance was challenged. The court invented a rule of recognition for pre-colonial indigenous law. The rule provided that the native laws of a country can only trump British rule "if they are reasonable, certain, or immemorial usage and compatible with Crown sovereignty" (at 520). The Irish law failed to meet these criteria. *See* also *Calvin's Case* 77 Eng. Rep. 377, 398 *per* Lord Coke; *Omichund* v *Barker* 125 Eng. Rep. 1310, 1312 (Ch. 1744); Dorsett, S., "Since Time Immemorial: Native Title, Common Law and the Case of Tanistry", *Brehon Law Project Symposium 2002*, 12 January 2002 and (2002) 26 *Melbourne University Law Review* 32; Salafia, Vincent, "The Birth of the Irish Law" <http://ua_tuathal.tripod.com/lllaw.htm> accessed 29 November 2005. While some vestiges of the Brehon law certainly lingered on despite the forceful assertion of the common law, ultimately, the Act of Union in 1801 formally ended any enduring currency the traditional system may have enjoyed in Ireland up to that date. Post independence, there was a revival

monasteries which had provided shelter to wayfarers – many of them people with mental illness – were gradually shut down, depriving many needy people of their only places of shelter. With a resultant increase in vagrancy, legislation was introduced to provide for the establishment in every county in Ireland of a House of Correction, in which many people with mental illness were incarcerated.[95]

A consequence of the prevailing attitude towards insanity in this period – that it was a product of some kind of moral failing in the afflicted person[96] – was reflected in the treatment methods of the day. It was thought that a mentally ill person was bereft of all reason and thus was closer to an animal than to a human state of being. Treatment focused on attempting to frighten or to punish the patient back to insanity. Restraints were frequently used, often resulting in loss of circulation to the limbs, with the consequence that gangrene in the hands and feet was a common problem in the earlier part of the century. Alongside restraint and physical intimidation, attendants utilised blood-letting; blistering of the skin; starvation; purging and the administration of drugs (including large doses of opium for those suffering from mania) to attempt to alleviate symptoms.[97] These were time-honoured methods for dealing with the mentally ill and many of them had been practised since pre-Christian times. By the end of the eighteenth century, however, the worst of these would have been abandoned as the new philosophy of 'humane treatment' or 'moral treatment' – using gentle treatments to nurse the patient back to health – was developed.

After the fifteenth century people with mental illness continued to be separated from society and kept in specialised institutions, but the philosophy underpinning the containment changed markedly. A new focus on humane treatment and on the utilisation of a gentle regime brought about the re-conceptualisation of mental health institutions as 'asylums' – places where ill people could retreat from the stresses of

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of interest in Brehon law. Today it is rarely adverted to in the Irish courts although in certain cases it has been pleaded with some success – *see* for example in relation to ancient fishing rights in *Moore* v *Attorney-General* [1934] I.R. 44 and in relation to the law of treasure trove in *Webb v Ireland* [1988] IR 353.

[95] 10 & 11 Car. 1, c4.

[96] According to Robins, under this ethic insanity was perceived as "a matter of deliberate and perverse choice rather than the inescapable consequence of an ill mind" and as such was interpreted as a rejection of the established social order – *see* Robins, Joseph, *Fools and Mad: A History of the Insane in Ireland* (Dublin: Institute of Public Administration, 1986), 24.

[97] Jones, Kathleen, *A History of the Mental Health Services* (London and Boston: Routledge & Kegan Paul, 1972), 44.

participation in society in the hopes of achieving a cure for their symptoms through rest. Of course, the asylums also served the purpose of protecting society from those people with mental illness who might pose a danger, and the warehousing of people without any real hope of effecting a cure continued. The change in approach, however, is significant, as it represents the germination of a new philosophy that would ultimately lead to the human rights model that is applied to mental health regulation today.[98]

Two cases heard before the courts in the 1760s in England influenced the introduction of reforms for the regulation of private madhouses. In *R v Turlington*[99] the writ of *habeas corpus* was successfully utilised to secure the release from a private madhouse of a woman wrongly detained there at the instance of her husband; whereas in similar circumstances in *R v Clarke*[100] the *habeas corpus* application was unsuccessful. These proceedings served to arouse the interest of the public, and following some media attention to the conditions within private madhouses, there was considerable agitation for reform.[101] A House of Commons Committee investigation was conducted,[102] and new legislation was introduced with the aim of preventing unwarranted detentions in private madhouses.[103] In 1788 the public acknowledgment of the sufferings of King George III challenged existing public perceptions of mental illness as being the result of sin, or of possession by the Devil, and began the move towards the acceptance of mental illness as capable of afflicting any person, regardless of character, which led to renewed agitation for reform of the insanity laws.[104]

In the meantime, reform was also apace in Ireland, with the introduction of standards for the care and accommodation of people with mental illness incarcerated in houses

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[98] *See* generally Jones, Kathleen, *A History of the Mental Health Services* (London and Boston: Routledge & Kegan Paul, 1972).
[99] *R v Turlington* [1761] ER 741.
[100] *R v Clarke* [1762] ER 875.
[101] *See* the extract from a January 1763 edition of *Gentleman's Magazine*, reprinted in Jones, Kathleen, *A History of the Mental Health Services* (London and Boston: Routledge & Kegan Paul, 1972), 29-30.
[102] This investigation was cursory at best, and left many questions unanswered. *See* Jones, Kathleen, *A History of the Mental Health Services* (London and Boston: Routledge & Kegan Paul, 1972), 30-31.
[103] 14 Geo. III, c 9. *See* Jones, Kathleen, *A History of the Mental Health Services* (London and Boston: Routledge & Kegan Paul, 1972), 31-33 for a description of the content of this legislation and an analysis of how it ultimately failed to secure its aim of preventing unwarranted detentions in private madhouses.
[104] *See* Jones, Kathleen, *A History of the Mental Health Services* (London and Boston: Routledge & Kegan Paul, 1972), 33-39.

of correction;[105] the creation of supplementary houses of industry[106] and an administrative county system of special wards;[107] and the establishment of an Office of Inspector General of Prisons to oversee standards.[108] Finally, the estate of Jonathan Swift made provision in 1745 for the establishment of the first private mental hospital in Ireland – St. Patrick's Hospital for the Mentally Ill.[109] The practice of incarcerating people with mental illness continued into the 18th century and ultimately incarceration could be effected in one of three ways:

1. Under the poor laws for penury;
2. Under the vagrancy laws for destitution; or
3. Under the penal laws for criminal acts.

Additionally, a mentally ill person who did not fall into one of these three regimes could be confined in their own home as a 'single lunatic' (with or without medical care); or in a private madhouse.[110]

The late eighteenth century had seen some notable advances in care and treatment for people with mental illness. The new focus on 'moral' or 'humane' treatment emphasised patients' 'good' behaviour, rather than punishing 'bad' behaviour. Patients were encouraged to engage in social activities; to work (caring for livestock; tending a garden; knitting or sewing); to study and to join in religious worship. Drugs were administered but a greater emphasis was placed on the creation of a calming atmosphere and the provision of a wholesome diet. These methods achieved greater

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[105] Geo. III c 5 and c 28.
[106] 11 & 12 Geo. III c 30 Ir. stat.
[107] 27 Geo. III c 39 Ir. stat.
[108] 26 Geo. III c 27.
[109] Swift also composed his own obituary, which included the following lines on his bequeathal: "He gave the little Wealth he had / To build a House for Fools and Mad / And shew'd by one satiric Touch / No nation wanted it so much" – Swift, Jonathan, "On the Death of Dr. Swift" *In* Browning, W., *The Poems of Jonathan Swift, D.D. Vol. 1 (of 2)* (London: G. Bell and Sons Ltd., 1910).
[110] A further possibility existed in England: a person living near London might be confined in Bethlem Hospital, which was the only public madhouse. The Bethlem Royal Hospital was founded in London in 1247, and operated under the auspices of the Order of St. Mary of Bethlehem. It came under State control from 1375 onwards, and was granted a charter on 13 January 1547 thus ceding control to the City of London. From 1557 onwards management of Bethlem was vested with the Blackfriars Bridewell, until the establishment of the National Health Service in 1948. It is from the name of this hospital that the English language developed the word 'bedlam', meaning mayhem or chaos. There was no public madhouse in Ireland until 1745. *See* Jones, Kathleen, *A History of the Mental Health Services* (London and Boston: Routledge & Kegan Paul, 1972), 11-12.

success than the traditional castigatory measures, and soon came to replace the older ways – many of the principles of moral treatment of the insane worked out in the late eighteenth and early nineteenth centuries still inform mental health treatment today.[111]

The first mention of 'curing' people with mental illness, rather than simply 'containing' them, had been in the late 16th century when the vagrancy laws were revised to include for the first time, alongside the traditional policies of 'detaining', 'restraining', and 'managing' vagrants, the new object of 'curing' lunatics.[112] Mark Finnane characterises this change as an attempt to 'rebrand' the existing administrative regime for the incarceration of lunatics as a beneficent form of social hygiene rather than a system for managing the destitute and the criminal[113] - the reality was that more often than not the places of detention for lunatics continued to be gaols or bridewells, and curative treatment was generally non-existent.[114]

By the late 18th century however, reform efforts were focussed on the provision of "a new type of institution where pauper and criminal lunatics could be treated as insane persons, and not primarily as paupers or criminals."[115] Finnane states that "...in the decades following the Union and preceding the Famine, the country's character was transformed by new social institutions."[116] In 1821 the myriad of various mental health laws were consolidated into one document, the Lunacy (Ireland) Act 1821,[117] which divided Ireland into districts and empowered the Lord Lieutenant to establish district asylums. The proliferation of private asylums in the first half of the century led to the enactment of the Private Lunatic Asylums (Ireland) Act 1842 to regulate the standards in the private sector. The 1842 Act was detailed in its regulation of admission and detention to a private asylum:

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[111] *See* Jones, Kathleen, *A History of the Mental Health Services* (London and Boston: Routledge & Kegan Paul, 1972), 25-39.
[112] 17 Geo. II, c.5.
[113] Finnane, Mark, *Insanity and the insane in post-famine Ireland* (London: Croom Helm, 1981), 22.
[114] Jones, Kathleen, *A History of the Mental Health Services* (London and Boston: Routledge & Kegan Paul, 1972), 26. Thus in the early 19th century large district lunatic asylums were constructed throughout the country (*see* Jones, Kathleen, *A History of the Mental Health Services* (London and Boston: Routledge & Kegan Paul, 1972), 57) and by the turn of the century the population of these lunatic asylums had more than doubled and 0.05% of the population was in a district lunatic asylum (*see* Walsh, Dermot, "Mental Health Policy Developments in Ireland" (1987) 33 (2) *International Journal of Social Psychiatry* 111, 111).
[115] Jones, Kathleen, *A History of the Mental Health Services* (London and Boston: Routledge & Kegan Paul, 1972), 57.
[116] Finnane, Mark, *Insanity and the insane in post-famine Ireland* (London: Croom Helm, 1981), 14.
[117] Lunacy (Ireland) Act 1821 (1 & 2 Geo. IV, c 33).

1. A person could only be admitted on the making of an order by a relative or friend, which was supported by a certificate signed by two physicians, surgeons or apothecaries, who had independently examined the patient;
2. The patient could be detained on an ongoing basis, on foot of a second certificate signed by two physicians, surgeons or apothecaries; and
3. Record keeping on patients was compulsory.[118]

The requirement of two medical certificates for admission to a private asylum, in contrast to the single certificate required for admission to the public lunatic asylum, was intended to combat abuse of the mentally ill. However, O'Neill describes these private lunatic asylums as places with "an infamous reputation" for facilitating unscrupulous relatives in profiting out of the mental illness of a wealthy person, which reputation continued notwithstanding the new requirements.[119]

The Central Criminal Lunatic Asylum Act 1845,[120] enacted as part of the comprehensive reform of the criminal law on insanity following the controversial *M'Naghten Case*,[121] extended the licensing powers of the Lord Chancellor to public asylums, and empowered the Lord Lieutenant to appoint Inspectors of Lunatics to take over the functions of the Inspectors General of Prisons with respect to lunatic asylums. However, O'Neill cites inspectors' reports of the time as showing evidence of continued abuse, with a lack of diligence evident on the part of those signing the

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[118] *See* Kelly, Brendan D., "Mental Health Law in Ireland, 1821 to 1902: Building the Asylums" (2008) 76 *Medico-Legal Journal* 18, 22 <http://www.medico-legalsociety.org.uk/articles/mental_health_ireland_1.pdf> accessed 20 January 2011.

[119] O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005), 11. O'Neill attributes the poor reputation of the private lunatic asylums to the fact that the Lord Chancellor's licenses were easily obtained and inspectors were notoriously lenient (*see* O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005), 9).

[120] The Central Criminal Lunatic Asylum Act 1945 had the primary aim of establishing a special asylum specifically for the detention of the criminally insane. The hospital opened in 1850 and continues in existence today, under the new title of the Central Mental Hospital, Dundrum (hereafter 'the CMH'). While the CMH still provides a predominantly forensic psychiatry service, it also provides some general psychiatry services for the most seriously ill mental patients.

[121] *M'Naghten* (1843) 8 E.R. 718. The facts of the case were that Daniel M'Naghten murdered the Prime Minister's secretary Edward Drummond, having mistaken him for the Prime Minister Edward Peel. Claiming to have acted on the instructions of the Tory party, and to have been followed by Catholic spies, M'Naghten was found guilty but insane. The House of Lords judgment in the case formed the substance of the criminal law defence of insanity in England until the 1960s (Criminal Procedure (Insanity) Act 1964, now replaced by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991) and in Ireland until 2006 (Criminal Law (Insanity) Act 2006).

committals of dangerous lunatics.[122] From this time on, annual reports of the Inspector of Mental Hospitals were published, describing the general state and utilisation of the asylums and the psychiatric care provided therein.[123] Further reform was undertaken in the Lunacy Act 1867, which required the signing by a dispensary medical officer of a certificate evidencing a person's derangement and dangerousness prior to that person's indictment as a dangerous lunatic, and simplifying the system in place for the discharge of dangerous lunatics.

There followed several housekeeping provisions in mental health law in the late 1800s[124] but while further lunacy care reform legislation was passed in England in 1890 these reforms were not enacted in Ireland.[125] In 1891 a commission established by the Lord Lieutenant reviewed the English legislation and made recommendations for change in Ireland, including the introduction of the concept of voluntary admission; stricter rules on the medical certificates;[126] and stricter regulation of admissions on the grounds of dangerousness, but these recommendations were never implemented.[127] Essentially, the system, as it stood after the 1867 reforms, formed the

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[122] O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005), 11.

[123] Brennan, Damien, "A consideration of the social trajectory of psychiatric nursing in Ireland" (2004) 11 *Journal of Psychiatric and Mental Health Nursing* 497, 498.

[124] The Lunacy Asylums (Ireland) Act 1875 authorised the admission of private paying patients to the district asylums for the first time, and between 1875 and 1884 several further provisions were enacted to permit the movement of prisoners between prisons and asylums and to legislative for the special verdict of 'guilty but insane' developed by the common law (*see* 38 & 39 Vic., c.67; 46 & 47 Vic., c.38; 47 & 48 Vic., c.64). In 1885 the General Rules for the Government of District Asylums stipulated and prescribed procedures for most aspects of the asylums (including management structures; admission procedures; and daily routines) (*see* Lord Lieutenant, *General Rules for the Government of District Asylums*, 1885). The 1885 General Rules informed psychiatric nursing training in Ireland up until the 1980s (*see* Brennan, Damien, "A consideration of the social trajectory of psychiatric nursing in Ireland" (2004) 11 *Journal of Psychiatric and Mental Health Nursing* 497, 498). Finally, the Local Government Act 1898 introduced a new administrative system enabling county councils to make regulations regarding the government and management of asylums, as well as the admission, detention and discharge of patients, and conditions as to the payment and accommodation for private patients (county councils were made responsible for local asylums).

[125] Jones, Kathleen, *A History of the Mental Health Services* (London and Boston: Routledge & Kegan Paul, 1972), 181.

[126] It was recommended that the medical practitioner should clearly distinguish in the certificate between information told to him by the patient's family and information gleaned from his own observations of the patient.

[127] O'Neill, Anne-Marie., *Irish Mental Health Law* (Dublin: Firstlaw, 2005), 12. There were also three reports on mental health services between 1906 and 1910. The Royal Commission on the Care and Control of the Feeble Minded (1908) recommended the abandonment of the terms 'lunatic' and 'asylum' – the new terms 'patient' and 'hospital' were to be adopted although the titles of official offices etc. continued to contain the old language (e.g. Inspectors of Lunacy); the Vice-Regal Commission on Poor Law Reform in Ireland (1906) recommended the transfer of all insane persons in the workhouse system into public asylums (motivated by financial reasons); and the Royal

structure which was to remain in force until the enactment of the Mental Treatment Act 1945.

From the mid-point of the nineteenth century onwards, the focus of mental health regulation had shifted more firmly towards the provision of cures for mental illness and the focus of mental health regulation had been incorporating this medicalisation of mental health care into the legal regime. From here onward, mental health became the realm of the hospital rather than the asylum. This development became even more pronounced in the second half of the twentieth century, with significant advances in medical understanding of mental illness as a result of new diagnostic technologies, and the development of new medications capable of lessening and even curing symptoms. Whereas previous systems for the care of people with mental illness – whether focussed on containment exclusively, or on humane care within an asylum model – could in reality offer little more than attentive nursing care, the new approach promised a scientific model that aimed to treat and to cure mental illness. This new medical model was most firmly established after the invention of powerful diagnostic tools that enabled scientists to study the operation of the brain in ways that were previously impossible, and the development of anti-psychotic and anti-depressant medications.[128]

With the establishment of the Irish Free State in 1922, the powers vested in the Lord Lieutenant with respect to the trial and custody of offenders with mental illness were transferred to the Minister for Justice while the Minister for Local Government assumed responsibility for public health services and poor relief and a restructuring of the systems of general hospitals and workhouses was undertaken. County homes; county hospitals; district hospitals; and fever hospitals were established. The Local Government Act 1925 provided that lunatic asylums were to be renamed 'mental hospitals', the name that continues to be applied today.[129] The institutions themselves, however, were not reformed, although a single Inspector of Mental Hospitals was appointed. In 1927 the Report of the Commission on the Relief of the Sick and

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Commission on the Poor Law and Relief of Distress (1909) reiterated the findings of the 1906 Commission.

[128] *See* generally O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005), Chapter 1, *and* Bartlett, Peter, and Sandland, Ralph, *Mental Health Law: Policy and Practice* 3rd ed. (Oxford: Oxford University Press, 2007), Chapter 1.

[129] Local Government Act 1925, s 79.

Destitute Poor including the Insane Poor attempted to highlight overcrowding and lack of appropriate facilities for children with intellectual disabilities who were being cared for in the 'county homes' (an informal title which had come to be used for the former workhouses).[130] The Commission recommended the establishment of auxiliary mental hospitals and specialised institutions for children with intellectual disabilities; outpatient services for mental health treatment; the cessation of the practice of admitting people as 'dangerous lunatics' in inappropriate circumstances; and the introduction of a new legislative regime for mental health treatment, but these recommendations languished thanks to pressing concerns in other sectors of the health service (particularly the ongoing battle with tuberculosis infections) and severe economic depression exacerbated by the isolationist economic policy of the time.[131] In the latter half of the 1930s however, plans to introduce a system of universal health care in part bolstered by the success of the Hospitals Sweepstakes led to reforms in mental health law also.[132] Concerns about the standards of treatment provided within the asylum system, and about the lack of more formal mechanisms for the provision of treatment to patients on a voluntary basis (which it was felt was leading to an explosion in the numbers of involuntary patients, many of whom did not require to be formally committed), became increasingly pressing after the turn of the century.[133]

The Mental Treatment Act 1945 "aimed to address legislative deficiencies in Irish mental health law and to strengthen the delivery of appropriate care to individuals with mental illness".[134] The 1945 Act established 'mental treatment centres',[135] and regulated the admission and detention of patients either as 'voluntary' or 'involuntary' (classified as 'temporary' or 'person of unsound mind') patients, and their medical treatment while they were detained.[136] A voluntary patient was a patient who had

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[130] Commission for the Relief of the Sick and Destitute Poor including the Insane Poor, *Report of the Commission on the Relief of the Sick and Destitute Poor including the Insane Poor* (Dublin: Stationery Office, 1927).

[131] *See* O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005), Chapter 1.

[132] Kelly, Brendan D., "The Mental Treatment Act 1945 in Ireland: An Historical Enquiry" (2008) 19 *History of Psychiatry* 47, 49.

[133] *See* the detailed account of the various calls for reform from 1827 to the late 1930s in Kelly, Brendan D., "The Mental Treatment Act 1945 in Ireland: An Historical Enquiry" (2008) 19 *History of Psychiatry* 47, 52-56.

[134] Kelly, Brendan D., "The Mental Treatment Act 1945 in Ireland: An Historical Enquiry" (2008) 19 *History of Psychiatry* 47, 55.

[135] Mental Treatment Act 1945, pt V.

[136] Mental Treatment Act 1945, pt XIV. A patient could be admitted on a voluntary basis where they consented to the admission (s 190); on a temporary basis where the admission was involuntary and the

consented to their admission and was not compulsorily detained.[137] An involuntary patient was a patient admitted against their will following the making of an application for a 'recommendation for reception'. The application for the recommendation was usually made by a concerned relative. The recommendation for reception was then made to the mental hospital by an authorised medical offer, usually a GP.[138] There was no requirement to certify the existence of a specified mental illness or a specified diagnosis; all that was required was a certification the person was 'of unsound mind' and was in need of admission. An admission (whether voluntary or involuntary) would last for as long as it was deemed necessary, and the existence of a continuing need for the admission was to be monitored by the treating psychiatrist.[139] The Act contained only spare provisions dealing with the administration of treatment – there was a general duty on mental hospitals to provide treatment and to refrain from ill treatment or neglect of patients;[140] the necessity of treatment was a component of the requirement for involuntary admissions;[141] and seclusion and restraint were only to be administered where necessary in order to provide treatment or to prevent harm.[142]

The 1945 Act provided for very limited mechanisms for the review of admission, detention and treatment decisions. Under s 240 the Inspector of Mental Hospitals was required to review any involuntary detentions where he had reason to doubt their propriety.[143] A third party could initiate a procedure whereby the Minister for Health could appoint two medical practitioners to review a patient and report on the necessity for their detention.[144] The patient themselves, and the original application for the recommendation for reception, could complain to the Inspector of Mental Hospitals,

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detention was expected to be of less than six months' duration (s 163); or as a 'person of unsound mind' where the admission was involuntary and the detention was expected to be of greater than six months' duration (s 185).

[137] Mental Treatment Act 1945, s 3.

[138] Mental Treatment Act 1945, ss 162, 184, and 185.

[139] Mental Treatment Act 1945, s 189.

[140] Mental Treatment Act 1945, s19. See also ss 253.

[141] The Mental Treatment Act 1945, ss 184, 185, and 208. Ss 184 and 185 made it a requirement for admission as a temporary chargeable or private patients that the patient requires "at least six months' preventive and curative treatment." Finally, s 208 provided for the removal of a patient to another hospital for specialised treatment that is not available in the hospital in which they are currently receiving treatment. In respect of voluntary patients, s 192 provided that a person "may" be received as a voluntary patient in a mental hospital and "treated therein."

[142] Mental Treatment Act 1945, s263.

[143] Mental Treatment Act 1945, ss 222 and 240.

[144] Mental Treatment Act 1945, s 222.

the relevant Health Board (now the HSE), or the President of the High Court upon the extension of a patient's detention.[145] Finally, patients could correspond with the Minister for Health and Children; the President of the High Court; the relevant Health Board; or, if applicable, the Registrar of Wards of Court, and this correspondence was to be forwarded unopened.[146] None of these provisions, however, provide for an independent and automatic review of detention by a forum with the power to order the release of an improperly detained patient. In reality the most powerful means by which a patient could challenge admission, detention, or treatment decisions made by the medical professionals with responsibility for them was for him to institute *habeas corpus* proceedings under Article 40 of the Constitution, or to take administrative judicial review proceedings seeking to quash those decisions on illegality or unreasonableness grounds.[147] The most influential litigation taken in respect of the 1945 Act – the cases of *In Re Philip Clarke*[148] and *Croke v Smith*[149] – were both *habeus corpus* applications challenging compulsory detentions under the Act. In these cases the courts adopted a conservative paternalist approach to the interpretation of patients' constitutional and human rights when they come into contact with the mental health law regime. This approach operated as a brake on any kind of sustained judicial scrutiny of the impact of the coercive powers contained in the legislation on patients' rights.[150] As a result, while the 1945 Act's provisions were considered forward thinking at the time of its enactment, they had by the mid-1990s come to be regarded as outmoded and no longer in keeping with contemporary European human rights ideologies. Webb has described criticism of the 1945 Act as focussing on two areas in particular:

> [t]he existing laws have for many years been seen to be inadequate, particularly in relation to protection of the individual's rights to freedom, and in recourse to judicial-type review of mental treatment orders which restrict that freedom.[151]

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[145] Mental Treatment Act 1945, s 189.
[146] Mental Treatment Act 1945, s 241.
[147] Keys, Mary "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 24 *Dublin University Law Journal* 26.
[148] *In Re Philip Clarke* [1950] IR 235.
[149] *Croke* v *Smith* [1998] 1 IR 101 (Supreme Court); (1995) IEHC 6 (31 July 1995), Budd J.
[150] See the discussion below at §§ 3.6; 2.7; 3.8 and at §§ 5.2 and 5.3.
[151] Webb, M., et al, "Comments from an Adult Psychiatric Service on the Mental Health Bill 1999" (2000) 6 *Medico-Legal Journal of Ireland* 14.

The trajectory of mental health law provisions to this point had seen the ethos of mental health law move from containment, to asylum, to cure; but it had at all times maintained a core policy of incarceration of people with mental illness. The changing perceptions of the nature of mental illness, together with a growing awareness of the potential for abuses within the mental health system, had led first to the reconceptualisation of mental health institutions as 'asylums' rather than as places of confinement for the morally deficient or the dangerous, and later to the medicalisation of the asylums so that they became 'hospitals'. Legal regulation of mental health accordingly had progressed from a model focussed on the organisation and administrative aspects of incarceration prior to the 17th century; to the monitoring of standards within institutions in the 17th, 18th, and 19th centuries; to the introduction of a legal framework for the provision of mental health treatment in the 20th century. By the mid-point of the 20th century, with the advent of the United Nations and the Council of Europe and the extensive human rights protections these institutions promoted, a new approach to mental health regulation was adopted. The new philosophy emphasised minimising interference with a person's freedom of action, and as such clashed significantly with the previous policies. The admission and treatment provisions in the mental health law came to be seen as heavy-handed and overly invasive, and in the new human rights era the 1945 Act seemed an outmoded product of older, now disfavoured, philosophies.

The process of reforming the 1945 Act, however, proved to be a protracted one. A number of reports and inquiries from the mid 1960s onwards called for a move to a community-based approach to the provision of mental health care, and reform of the mental health law regime to encourage a move away from the institutional model of mental health care, but progress in that direction was painstakingly slow.[152] Walsh has suggested that the reluctance to close the large institutions that had traditionally provided the bulk of mental health services was attributable to a desire to preserve the employment they contributed to their local economies.[153]

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[152] *See* for example the *Commission of Inquiry into Mental Illness 1966* (Dublin: The Stationery Office, 1966); Department of Health, *The Psychiatric Services – Planning For The Future* (Dublin: The Stationery Office, 1984); Department of Health, *Shaping A Healthier Future: A Strategy for Effective Healthcare in the 1990s* (Dublin: The Stationery Office, 1987) and Department of Health, *Equality and Fairness: A Health System for You* (Dublin: The Stationery Office, 2001).

[153] Walsh, Dermot, "Mental Health Policy Developments in Ireland" (1987) 33 (2) *International Journal of Social Psychiatry* 111.

The Mental Treatment Act 1961 amended and extended the 1945 Act. It made certain changes to the manner in which the various categories of patient (chargeable, temporary, and voluntary) were to be funded within the health service and also made various housekeeping amendments in respect of budgeting and remuneration aspects of the 1945 Act. Additionally, the 1961 Act made the following changes of interest to the 1945 Act:

1. The power to extend the period of detention of a temporary patient was transferred from the Minister for Health to the Chief Medical Officer of the institution in which the patient was detained;[154]
2. Certain functions regarding the discharge of patients were transferred to the resident medical superintendent of the mental hospital, whereas under the 1945 Act these functions had resided in the mental hospital authority (meaning the relevant health board);[155]
3. The voluntary patient provisions in s 160(3) of the 1945 Act were restricted in application to children only;[156]
4. Arrangements for the after-care of patients could now be made with the consent of the Minister for Health,[157] and the Minister could authorise the payment of patients for work done within mental hospitals;[158] and
5. The title of the State's forensic mental hospital, 'the Central Criminal Lunatic Asylum, Dundrum' was changed to 'the Central Mental Hospital', the name by which it continues to be known today.[159]

By the mid-1990s the failures of the 1945 Act had come to be widely accepted, particularly in terms of compliance with Ireland's obligations under the European Convention on Human Rights, which had been ratified in 1953.[160] In April 1992 a

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[154] Mental Treatment Act, 1961, s 17.
[155] Mental Treatment Act, 1961, ss 26, 28, 29 and 30.
[156] Mental Treatment Act, 1961, s 19.
[157] Mental Treatment Act, 1961, s31.
[158] Mental Treatment Act, 1961, s3.
[159] Mental Treatment Act, 1961, s39.
[160] In 1981 the Health (Mental Services) Bill 1981 was proposed to adopt a new focus on the human rights of patients and to introduce review tribunals and limited provisions on consent to treatment. Many of the provisions that would ultimately be introduced in the MHA 2001 were foreshadowed in this legislation, but while the bill was passed as the Health (Mental Services) Act 1981 no ministerial

private member's bill was placed before the Oireachtas by introducing a proposed new mental health law framework. Containing many similar provisions to the abandoned 1981 legislation, the Mental Treatment (Amendment) Bill 1992 proposed to introduce review tribunals and to abolish the provisions in the 1945 Act restricting the circumstances in which patients could take civil action challenging decisions made under the mental health regime. The bill was defeated in the Dáil in May 1992[161] with Ivor Callely TD commenting that:

> The Bill really addresses only two issues, medical certification for temporary reception orders and the establishment of mental health review bodies. Any new legislation must go a great deal further. I already covered the changing trends in psychiatric services, particularly since the introduction of Planning for the Future, and we must now introduce the necessary legislation which will cover the providers of services and the patients as well as many other proposed developments and the changing trends in the psychiatric services.[162]

In a similar vein, Brian Lenihan TD commented that:

> The Government are determined to avoid a repetition of the failed attempt to bring into operation new mental treatment legislation which occurred following the enactment of the Health (Mental Services) Act, 1981. They are also conscious of the need to achieve broad consensus on safeguarding the rights of detained patients and future development of the psychiatric services. In relation to the former, it is important to ensure that proposed legislation will fully comply with this country's obligations under the European Convention

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commencement order was ever signed to bring the act into force, and the Act was ultimately repealed by the MHA 2001. The full text of the Health (Mental Services) Act 1981 (No. 17 of 1981) <http://www.irishstatutebook.ie/1981/en/act/pub/0017/index.html> accessed 23 January 2011.

[161] For the passage of the Mental Treatment (Amendment) Bill 1992, and the Dáil debates on its contents, *see* Debates of the Houses of the Oireachtas (Dáil Debates) Vol. 418 No. 6, *Mental Treatment (Amendment) Bill, 1992: First Stage* (9 April 1992) <http://debates.oireachtas.ie/dail/1992/04/09/00004.asp> accessed 23 January 2011; Debates of the Houses of the Oireachtas (Dáil Debates) Vol. 418 No. 7, *Private Members' Business. - Mental Treatment (Amendment) Bill, 1992: Second Stage* (28 April 1992) <http://debates.oireachtas.ie/dail/1992/04/28/00015.asp> accessed 23 January 2011; Debates of the Houses of the Oireachtas (Dáil Debates) Vol. 418 No. 8, *Private Members' Business. - Mental Treatment (Amendment) Bill, 1992: Second Stage Resumed* (29 April 1992) <http://debates.oireachtas.ie/dail/1992/04/29/00016.asp> accessed 23 January 2011; Debates of the Houses of the Oireachtas (Dáil Debates) Vol. 419 No. 1, *Private Members' Business. - Mental Treatment (Amendment) Bill, 1992: Second Stage Resumed* (5 May 1992) <http://debates.oireachtas.ie/dail/1992/04/29/00018.asp> accessed 23 January 2011; and Debates of the Houses of the Oireachtas (Dáil Debates) Vol. 419 No. 2, *Private Members' Business. - Mental Treatment (Amendment) Bill, 1992: Second Stage Resumed* (6 May 1992) <http://debates.oireachtas.ie/dail/1992/04/29/00019.asp> accessed 23 January 2011.

[162] Callely, Ivor, Debates of the Houses of the Oireachtas (Dáil Debates) Vol. 419 No. 2, *Private Members' Business. - Mental Treatment (Amendment) Bill, 1992: Second Stage Resumed* (6 May 1992), 526-527 <http://debates.oireachtas.ie/dail/1992/04/29/00019.asp> accessed 23 January 2011.

> for Protection of Human Rights and Fundamental Freedoms and the International Covenant on Civil and Political Rights under the auspices of the United Nations. While the provisions of the proposed Mental Treatment (Amendment) Bill, 1992, mark an improvement in the rights of detained patients, they would not in fact completely satisfy this country's international obligations under international law. It is clear therefore that the approach agreed by Government to introduce new mental health legislation offers the most practical and open method to ensure our psychiatric services are developed to meet the needs of the mentally ill into the next century.[163]

Following the debates on the Mental Treatment (Amendment) Bill 1992 a Green Paper on Mental Health was published in June 1992.[164] The Green Paper on Mental Health formally acknowledged that the provisions of the 1945 Act did not comply with Ireland's obligations under the ECHR.[165] Many specific areas of the 1945 Act had come to be identified as problematic in respect of the State's obligations under the ECHR, the most pressing among them being the provisions dealing with compulsory detention of a person in a mental hospital. Specifically, the following areas were of most concern:

(a) There was no provision for independent review of a decision to detain a person;
(b) The provisions on compulsory civil commitment did not provide any automatic independent review of the appropriateness of a patient's continued detention once a retention order had been made; and
(c) The provisions which outlined the criteria for the detention of mentally disordered persons were too broad and vague in their scope to be compliant with the strict requirements of ECtHR jurisprudence.[166]

The purpose of the Green Paper was twofold: to review progress on the implementation of the Planning for the Future Report from 1984,[167] and to invite

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[163] Lenihan, Brian, Debates of the Houses of the Oireachtas (Dáil Debates) Vol. 419 No. 2, *Private Members' Business. - Mental Treatment (Amendment) Bill, 1992: Second Stage Resumed* (6 May 1992), 531 <http://debates.oireachtas.ie/dail/1992/04/29/00019.asp> accessed 23 January 2011.

[164] Department of Health, *Green Paper on Mental Health* (Dublin: Government Publications Office,1992) Pn. 8918.

[165] Department of Health, *Green Paper on Mental Health* (Dublin: Government Publications Office, 1992) Pn. 8918.

[166] These are the problematic areas of the 1945 Act as identified in *Croke* v *Smith* [1994] 3 IR 529; Unreported, Supreme Court, 31 July 1996.

submissions on reform of the Mental Treatment Act 1945. In particular, submissions on a new regime for the involuntary detention of mental patients were sought, specifically on:

(a) A new definition of the criteria for detention which would accord with the United Nations (UN) Mental Illness Principles;[168]
(b) A new definition of mental disorder;
(c) Appropriate places for detention;
(d) Systems for the regulation of consent to mental health treatments and of treatment without consent; and
(e) A system of review of the decision to detain.[169]

One hundred submissions were received, and agreement was unanimous that a human rights approach to mental health regulation was the correct approach to adopt.[170]

Two years after the publication of the Green Paper on Mental Health, the shortcomings of the 1945 Act were the subject of constitutional challenge in *Croke* v *Smith*.[171] Along with a *habeas corpus* application, the applicant argued that the provisions of the 1945 Act violated his constitutional rights under Article 40.4.1 (the right to liberty); Article 40.3.1 (personal rights); and Article 38 (due process of law) of the Irish Constitution. The *habeas corpus* application was dismissed as no violations of the 1945 Act were found, and, while no violations of the Constitution were found on the facts, the case was subsequently deemed admissible before the ECtHR and a friendly settlement was reached in November 2000.[172] This is not surprising given the Green Paper on Mental Health's earlier acknowledgment of the

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[167] Department of Health Report of the Study Group on the Development of the Psychiatric Services, *Planning for the Future* (Dublin: Government Publications Office, 1984) Pn. 3001.
[168] United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (New York: United Nations Secretariat Centre for Human Rights, 1991); (1991) G.A. Res. 119, U.N. GAOR, 46th Sess., U.N. Doc. A/46/49, Supp. No. 49, Annex, 188-92.
[169] Department of Health, *Green Paper on Mental Health* (Dublin: Government Publications Office, 1992) Pn. 8918.
[170] Department of Health, *White Paper: A New Mental Health Act* (Dublin: Government Publications Office, 1995) Pn. 1824, at 6.
[171] *Croke* v *Smith* [1998] 1 IR 101 (Supreme Court); (1995) IEHC 6 (31 July 1995), Budd J. See more detailed discussed at § 3.6 below.
[172] *Croke v Ireland* Application No. 3326/96, Judgment (Striking Out) Strasbourg, December 21, 2000. *See* Keys, Mary "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 24 *Dublin University Law Journal* 26 and O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: FirstLaw, 2005) at 141.

1945 Act's non-compliance with the ECHR. At this point however, the reform process had stalled somewhat, and the *Croke* case served as an impetus to jump start the reform process once again.

In the same year, s 207 of the 1945 Act was the subject of a constitutional challenge in *RT v The Director of the Central Mental Hospital.*[173] The applicant argued (a) that his detention in the Central Mental Hospital was unlawful; and alternatively, (b) that s 207 of the 1945 Act was unconstitutional having regard to the provisions of Article 40.4.1 (the right to liberty) of the Constitution. Costello P in the High Court found against the applicant on the first argument, and held that his detention had been effected in accordance with the procedure proscribed by the 1945 Act and was accordingly lawful. The applicant was however successful in respect of his second argument. Costello P adopted the concerns of the Green Paper on Mental Health in respect of s 207 and additionally expressed further criticisms of the potential for the use of s 207 to circumvent the protections inherent in the criminal process and the lack of safeguards providing for review of s 207 detentions.[174] The Court ultimately found that:

> The defects in this section are such that there are no adequate safeguards against abuse or error both in the making of the transfer order, and in the continuance of the indefinite detention which is permitted by the section. These defects, not only mean that the section falls far short of internationally accepted standards but, in my opinion, render the section unconstitutional because they mean that the State has failed adequately to protect the right to liberty of temporary patients.[175]

An additional concern in relation to the constitutionality of the 1945 Act is demonstrated in the decision in *Blehein v Minister for Health.*[176] In that case, Denham J in the Supreme Court upheld the decision of Carroll J in the High Court that s 260 of the 1945 Act was unconstitutional. S 260 placed restrictions on the right of a patient detained under the 1945 Act to litigate civil proceedings in relation to any act done under the Act. The patient was required to seek the leave of the High Court to litigate

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[173] *RT v Director of the Central Mental Hospital* [1995] 2 ILRM 354; [1995] 2 IR 65.
[174] *RT v Director of the Central Mental Hospital* [1995] 2 ILRM 354; [1995] 2 IR 65, at 79-80.
[175] *RT v Director of the Central Mental Hospital* [1995] 2 ILRM 354; [1995] 2 IR 65, at 81.
[176] *Blehein v Minister for Health and Children* [2004] IEHC 374; [2004] 3 IR 610 (High Court, Carroll J), and *Blehein v Minister for Health and Children* [2008] IESC 40; [2009] 1 IR 275; [2008] 2 ILRM 401 (Supreme Court, Denham J).

proceedings, and leave could only be granted where the Court was satisfied that there were "substantial grounds" for contending that the person against whom the proceedings were to be brought had acted in bad faith or without reasonable care. Denham J approved of the High Court's finding that while a restriction on the right to litigate could be justified in certain circumstances, that in this instance the limitation of the High Court's assessment of the application for leave to litigate to the two grounds of 'bad faith' or 'without reasonable care' amounted to an unreasonable and disproportionate interference with the applicant's rights under Articles 6 and 34 of the Constitution.[177]

The year after *RT v The Director of the Central Mental Hospital*, and the first *Croke* case, the government published the White Paper: A New Mental Health Act[178] detailing its proposed reforms of the mental health law. These included new criteria for involuntary admission, detention and treatment; the establishment of a Mental Health Review Board; reform of the system of inspection of mental health facilities; reform of the law on consent to mental health treatment; reform of the law on seclusion and restraint; and most significantly a system of review of detentions under mental health law. The White Paper ultimately evolved into the MHA 2001 which forms the backbone of the current mental health law regime in Ireland.

1.4.2 Contemporary Mental Health Regulation in Ireland: A Human Rights Approach

The contemporary legislation providing for compulsory civil committal and treatment frameworks, and mechanisms for review of detention and treatment decisions made within that framework, is contained in the MHA 2001. There is also a significant body of common law precedent underpinning, interpreting, and supplementing the

[177] *Blehein v Minister for Health and Children* [2008] IESC 40 (Supreme Court, Denham J); [2008] 2 ILRM 401; [2009] 1 IR 275, at 279.
[178] Department of Health, *White Paper: A New Mental Health Act* (Dublin: Government Publications Office, 1995) Pn. 1824.

legislative regime pertaining to mental health care.[179] In this section the contemporary legal regulation of mental health care is discussed under three broad headings:

(a) Regulation of admission to a mental hospital;
(b) Regulation of detention in a mental hospital (including review of detention); and
(c) Regulation of the administration of mental health treatments.

These three issues form the core of the contemporary regulation of mental health in Ireland, and are at the heart of the human rights approach to mental health law, with its concern for the preservation of freedom of action and the minimisation of interference with individual choices. Highlighting the importance of the new human rights ideology to the MHA 2001, these categories are also reflected in the titles chosen for the three core parts of that Act: 'Part 2 - Involuntary admission of persons to approved centres'; 'Part 3 - Independent Review of Detention'; and 'Part 4 – Consent to Treatment.'

The Mental Health Act 2001 ('the MHA 2001') represented a fundamental reform of Irish mental health regulation.[180] It constitutes a shift in focus in Irish mental health law, with a new emphasis on the human rights of the patient, and a move away from the medical paternalism favoured in the 1945 Act. The MHA 2001 is grounded on two pillars of reform: (a) reform of the procedures used in respect of involuntary admissions to treatment centres, and involuntary detentions;[181] and (b) introduction of new measures for the monitoring, inspection, and regulation of standards of care and

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[179] For a broad overview of cases brought challenging aspects of the 2001 Act, *see* generally Mental Health Commission, *Summary of Judgments delivered by the Superior Courts on the Interpretation of the Mental Health Act 2001* (Dublin: Mental Health Commission, 2009).

[180] For historical accounts of the regulation of mental health in Ireland, *see* Kirkpatrick, T.P.C., *A Note on the History of the Care of the Insane in Ireland: Up to the End of the Nineteenth Century* (Dublin: University Press, Ponsonby and Gibbs, 1931); Malcolm, E., *Swift's Hospital: A History of St. Patricks' Hospital, Dublin: 1746-1989* (Dublin: Gill and Macmillan, 1989); Reynolds, J., *Grangegorman: Psychiatric Care in Dublin Since 1815* (Dublin: Institute of Public Administration in association with the Eastern Health Board, 1992); Robins, J., *Fools and Mad: A History of the Insane in Ireland* (Dublin: Institute of Public Administration, 1986) and Finnane, M., *Insanity and the insane in post-famine Ireland* (London: Croom Helm, 1981). For commentary on the extent of the reform from the time of the enactment of the MHA 2001, *see* "Tánaiste announces the full implementation of the Mental Health Act 2001" *Press Release, 6 July, 2006* (Dublin: Government Publications, 2006) <http://www.dohc.ie/press/releases/2006/20060706.html> accessed 6 September 2006.

[181] Mental Health Act 2001, pts 2 and 3.

treatment in mental health services.[182] As was noted earlier, the monitoring and regulation features of the Act were introduced almost straight away upon the passing of the Act, on 5 April 2001,[183] while the introduction of the review mechanisms for involuntary admissions and detentions decisions was delayed until 1 November 2006.[184]

The consensus from the reform efforts in the 1980s and 1990s was that the 1945 Act was problematic (a) in respect of the tests to be applied for the utilisation of the compulsory powers of admission, detention and treatment as these tests did not contain any requirement that the decision-maker certify the patient's suffering from a mental illness of a nature and degree warranting confinement; and (b) in that the regime did not provide for any mechanism by which compulsory admission, detention and treatment decisions would be subject to automatic review by an independent forum.[185] Both of these concerns were deeply rooted in the right to liberty as enshrined in Article 5 of the ECHR, with the first also being concerned with the right to freedom from torture and degrading treatment and punishment as enunciated in Article 3 of the Convention. The Mental Health Act 2001 attempts to address these concerns.

1.4.2 (a) MHA 2001 Part 2: Admission to a Mental Hospital

Part 2 of the MHA 2001 governs involuntary admission to a mental hospital, but the Act provides for both voluntary and involuntary admissions.

The 1945 Act had provided a mechanism whereby a person could apply to become a voluntary patient in a mental hospital, after which they could be admitted if the

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[182] Mental Health Act 2001, pt 3, ss 50 to 55.

[183] Mental Health Act 2001 (ss 1 to 5, 7, 31 to 55) (Commencement) Order 2002 (S.I. No. 90 of 2002) and Mental Health Act 2001 (Establishment Day) Order 2002 (S.I. No. 91 of 2002).

[184] Mental Health Act 2001 (Commencement) Order 2006 (S.I. No. 411 of 2006). *See* also "Tánaiste announces the full implementation of the Mental Health Act 2001" *Press Release, 6 July, 2006* (Dublin: Government Publications, 2006) <http://www.dohc.ie/press/releases/2006/20060706.html> accessed 6 September 2006.

[185] *See* Department of Health, *Green Paper on Mental Health* (Dublin: Government Publications Office, 1992) Pn. 8918; *Croke v Smith* [1998] 1 IR 101; *Croke v Ireland* Application No. 3326/96, Judgment (Striking Out) Strasbourg, December 21, 2000; and Department of Health, *White Paper: A New Mental Health Act* (Dublin: Government Publications Office, 1995) Pn. 1824.

admission was considered by a medical professional to be likely to be of benefit to them[186] and provided they did not occupy a place required for a 'person of unsound mind' (the equivalent of an involuntary patient under the MHA 2001). A voluntary patient was defined as a person who "acting by himself or, in the case of a person less than sixteen years of age, by his parent or guardian, submits himself voluntarily for treatment for illness of a mental or kindred nature."[187] Voluntary patients under the 1945 Act did not have any greater protections in terms of consent to treatment, or in respect of leaving the hospital, than did involuntary patients. Once a patient was admitted on voluntary status, they could be discharged only "on recovery" or if they had given 72 hours' written notice to the hospital of their intention to leave and then awaited the expiry of the notice period (which gave the hospital ample time to effect an involuntary committal, in keeping with the paternalist character of the 1945 Act). In the new ethos of minimising interference with patients' human rights, this stance was indefensible.

The MHA 2001 defines a 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.[188] Section 29 of the MHA 2001 deals with the admission and detention of voluntary patients:

> 29.— Nothing in this Act shall be construed as preventing a person from being admitted voluntarily to an approved centre for treatment without any application, recommendation or admission order rendering him or her liable to be detained under this Act, or from remaining in an approved centre after he or she has ceased to be so liable to be detained.[189]

These provisions operate as 'definition by exclusion' from the involuntary patients regime. In effect, the definition of a voluntary patient is that they are not an involuntary patient. A number of problems arise in terms of the human rights standards compliance of these provisions. These include the lack of a requirement to

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[186] Mental Treatment Act 1945, s 190(3): "An application under this section shall be accompanied by a recommendation by the authorised medical officer stating that such officer has examined the person whose reception is sought on a specified date not earlier than seven days before the date of the application and is of opinion that he will benefit by the proposed reception." This section would subsequently amended to apply to children only – Mental Treatment Act, 1961, s19.
[187] Mental Treatment Act 1945, s 3.
[188] Mental Health Act 2001, s 2(1).
[189] Mental Health Act 2001, s 29.

assess whether a proposed voluntary patient has sufficient capacity to consent to their admission to the mental hospital; or to check that the decision to seek admission is truly voluntary; and the lack of any requirement to certify that they are suffering from a mental disorder as defined under the Act, or, as had been required under the 1945 Act,[190] that their admission is likely to benefit them. The implications of these potential shortcomings are discussed in more detail in Chapter 5.

A voluntary patient may be prevented from leaving a mental hospital under section 23(1) of the MHA 2001, and detained for a period of 24 hours, where the medical staff present believe that they are suffering from a mental disorder as defined under the Act.[191] Where a person who for whatever reason is not involuntarily detained under the formal involuntary patient mechanisms but nonetheless requires inpatient care attempts to leave hospital, section 23 gives the medical staff sufficient time to hold them in the hospital while an involuntary admission is effected. The 24 hour period specified is significantly shorter than the 72 hour period provided under the 1945 Act, and there is no requirement to provide an indication of the intention to leave in writing. These amendments represent significant improvements from a human rights perspective, as they reduce the impact of the regime on the patient's right to liberty. However, section 23 is capable of being used to 'paper over' inappropriate admissions on an ostensibly voluntary patient basis of the so-called 'compliant incapacitated patient', who is in need of mental health treatment but has not been formally admitted and detained under the involuntary patient provisions. Discussion of this phenomenon is provided at § 5.2.1 below.

The admission of involuntary patients is dealt with in section 8(1) of the MHA 2001:

> 8.— (1) A person may be involuntarily admitted to an approved centre pursuant to an application under *section 9* or *12* and detained there on the grounds that he or she is suffering from a mental disorder.
>
> (2) Nothing in *subsection (1)* shall be construed as authorising the involuntary admission of a person to an approved centre by reason only of the fact that the person—

[190] Mental Treatment Act 1945, s 190(3). See the critique of s 2 in Irish Human Rights Commission, *Policy Paper concerning the Definition of a "voluntary patient" under s.2 of the Mental Health Act 2001* (Dublin: Irish Human Rights Commission, February 2010).
[191] Mental Health Act 2001, s 23(1).

(*a*) is suffering from a personality disorder,

(*b*) is socially deviant, or

(*c*) is addicted to drugs or intoxicants.[192]

Section 3 provides the definition of a mental disorder, which is the fundamental prerequisite for an involuntary admission under section 8:

> 3.— (1) In this Act "mental disorder" means mental illness, severe dementia or significant intellectual disability where—
>
> (*a*) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or
>
> (*b*) (i) because of the severity of the illness, disability or dementia, 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, and
>
> (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.[193]

Section 3 is a significant improvement on the 1945 Act, which had not provided definitions of 'mental illness', 'unsound mind' or 'treatment'. The provision of clear definitions for all of these concepts which may be used to justify a deprivation of liberty is an important cornerstone of the human rights jurisprudence of the European Court of Human Rights[194] and in this respect the MHA 2001 is a significant improvement on the previous regime. These provisions are discussed in detail at § 5.2.2 below.

The 2001 Act in section 4(1) also requires that the person making the decision to compulsorily admit a patient under section 8 must make that decision with the patient's best interests in mind, while also considering the interests of other persons

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[192] Mental Health Act 2001, s 8.
[193] Mental Health Act 2001, s 3(1).
[194] *See* the seminal case of *Winterwerp v The Netherlands* (1979) EHRR 387.

who might be at risk if the admission was not made.[195] This provision has the potential to be a strong human rights protection if it were to be utilised by the courts in a manner that seeks to minimise intrusions on human rights while still providing the necessary protection for vulnerable people. Regrettably, however, section 4(1) has been interpreted by the courts in a conservative and paternalist fashion that draws on case law precedents pertaining to the 1945 Act. The default position adopted by the Irish courts in interpreting section 4(1) has been to deploy it as a paternalist measure first and foremost.[196] This is a product of the long history of this type of approach to mental health regulation in Ireland, and a clear demonstration of the continuation of the old philosophies even after the implementation of the new regime.

1.4.2 (b) MHA 2001 Part 3: Review of Detention in a Mental Hospital

The 1945 Act provided for no mechanism of automatic review of involuntary detention, and in the *Croke v Ireland* case the Irish government pointed to the availability of the writ of *habeas corpus* as a potential means to satisfy the State's obligations under the ECHR to provide for a right to a review of one's detention.[197]

The shortcomings of relying on the writ of *habeas corpus* as a means of review of involuntary mental health detentions are addressed in detail below at § 3.8.2. A limited form of administrative review of detention was provided in section 240 of the 1945 Act whereby the Inspector of Mental Hospitals was required to review the detention of an involuntary patient if he had reason to doubt the propriety of their detention.[198]

There were also provisions whereby 'any person' (which could be the patient, a relative, or a friend) may apply to the Minister for Health for an examination of the

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[195] Mental Health Act 2001, s 4(1).
[196] For academic criticism of the courts' approach *see* Murray, Claire, "Reinforcing Paternalism within Irish Mental Health Law – Contrasting the Decisions in *EH v St. Vincent's Hospital and Others* and *SM v The Mental Health Commission and Others*" (2010) 32 *Dublin University Law Journal* 273.
[197] *Croke v Ireland* Application No. 3326/96, Judgment (Striking Out) Strasbourg, December 21, 2000.
[198] Mental Treatment Act 1945, ss 222 and 240.

patient by two medical practitioners, however, the Minister retained a discretion whether or not to order the release of the patient.[199]

Where a temporary patient's detention was extended, the patient's treating psychiatrist was under an obligation to inform the patient and the original applicant for the reception order that objections to the extension could be addressed to the Inspector of Mental Hospitals, the relevant Health Board (now the HSE), or the President of the High Court.[200]

Finally, all patients under the Act had the right to have any correspondence addressed to the Minister for Health and Children; the President of the High Court; the relevant Health Board; or, if applicable, the Registrar of Wards of Court, forwarded unopened.[201]

None of these measures could be said to provide for an independent, automatically triggered, review of detention by a body with the power to order the release of the patient in circumstances where the detention was found to be improper. This was the most serious shortcoming of the 1945 Act in terms of the protection of the human rights of patients, and the introduction of independent review was the primary impetus for the introduction of the MHA 2001.

S 17 of the MHA 2001 provides that all involuntary admissions and detentions must be notified to the Mental Health Commission within 24 hours, and that the Commission will direct the matter to the Mental Health Tribunal (MHT) for review; appoint a legal representative for the patient (unless the patient intends to appoint their own); and appoint an independent consultant psychiatrist from the Commission's panel of consultant psychiatrists to report in writing on the patient's detention within 14 days.[202] The MHT, on review of the patient's detention, will assess the appropriateness and lawfulness of the patient's detention. The test the MHT will apply is set out in s 18(1)(a) of the MHA 2001. The MHT must be satisfied that the patient is suffering from a mental disorder, and that the provisions of the Act in

[199] Mental Treatment Act 1945, s 222.
[200] Mental Treatment Act 1945, s 189.
[201] Mental Treatment Act 1945, s 241.
[202] Mental Health Act 2001, s 17.

respect of the admission, renewal and review procedures have been complied with. The review mechanisms set down in s 18 apply to all admission orders and renewal orders made under the MHA 2001.[203]

Should the MHT find that the admission or renewal was not in accordance with the requirements of the Act, the Tribunal has the power to order the discharge of the patient.[204] Alternatively, if the Tribunal finds that the admission was lawful, and that detention is still necessary, it can authorise the continued detention of the patient.[205] The reviews are required to occur within 21 days of the making of the admission order, or the renewal order, subject to the MHT having the power to delay the hearing of the review for a 14 day period at the Tribunal or the patient's application, and again for a further 14 day period at the patient's application only, if the adjournment is in the patient's interests.[206] In these circumstances the admission or renewal order in respect of the patient will continue to be in force during the period of the adjournment.[207] The time periods for which involuntary patients' detentions may be authorised are set out by section 15. On admission, the initial period of detention is 21 days (subject to the adjournment mechanism provided for in section 18(4)).[208] During this period the admission order will be forwarded to the Mental Health Commission, and the independent second consultant psychiatrist will report in writing on the patient's need for detention.[209] After the initial 21 day period, the treating consultant psychiatrist may renew the admission for a further period of up to three months – this is known as a renewal order.[210] At the expiration of the three month renewal order, a second renewal order may be made renewing the admission for a further period of up to six months.[211] On the expiration of the six month renewal order, each further renewal order thereafter may be for a period up of to 12 months.[212] All renewals are

[203] Mental Health Act 2001, s 18 (1).
[204] Mental Health Act 2001, s 18(1)(b).
[205] Mental Health Act 2001, s 18(1)(a).
[206] Mental Health Act 2001, s 18(2) and s 18(4).
[207] Mental Health Act 2001, s 18(4).
[208] Mental Health Act 2001, s 15(1).
[209] Mental Heath Act 2001, s 17.
[210] Mental Health Act 2001, s 15(2).
[211] Mental Health Act 2001, s 15(3).
[212] Mental Health Act 2001, s 15(3).

subject to the patient being reviewed by the treating psychiatrist and certified as continuing to suffer from a mental disorder under s 3.[213]

S 18(a)(ii) provides that where the MHT finds that the patient's detention is not in accordance with some of the provisions of the MHA 2001, but that the flaw does not effect the substance of the admission or renewal order, the MHT may affirm the order.[214] A patient who is aggrieved by a decision to affirm an admission or renewal order under s 18(a)(ii) may attempt to judicially review the decision of the MHT. Indeed, judicial review proceedings challenging the decision of a MHT to affirm an admission or renewal order – alleging that the MHT acted outside its powers; or that it did not follow the formal or procedural requirements; or that it showed bias; or that it failed to give reasons for its decisions – have been taken in thirteen cases on the MHA 2001 to date. This jurisprudence is discussed in detail at § 3.8.2 below.

Finally, where a patient is unhappy with the decision of a MHT, and is not raising an issue more properly raised in judicial review proceedings, s 19 of the MHA 2001 provides for appeal to the Circuit Court (on the basis that the patient is not in fact suffering from a mental disorder).[215] However, in a Circuit Court appeal the court may not overturn the decision of the MHT unless it is satisfied that the patient does not suffer from a mental disorder as defined in the MHA 2001, and the onus of proving this rests on the patient. This is contrary to the jurisprudence of the European Court of Human Rights[216] (see § 5.2.2 below) and is perhaps the reason the Circuit Court appeals procedure has been infrequently adopted to date, with patients preferring to go the route of judicially reviewing the decision of the MHT in the High Court.[217]

These provisions ensure that every patient has access to a review of their detention at a minimum twice yearly; and that review occurs automatically and does not have to be triggered by the patient. However, the tribunal mechanism has only been operative

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[213] Mental Health Act 2001, s 15(4).
[214] Mental Health Act 2001, s 18(a)(ii).
[215] Mental Health Act 2001, s 19.
[216] *Hutchison Reid v United Kingdom,* Application No. 50272/99 [2003] ECHR 94 (20 February 2003).
[217] Walsh, Keith "Circuit Court Appeals and other reviews of Mental Health Tribunal decisions" *Dublin Solicitors' Bar Association Seminar: Mental Health Law – The Need for Change*, 9 October 2010.

since 2006 and is still finding its feet. Concerns continue about the appeals mechanism under the Act.[218] Further, the MHT procedure is only available to involuntary patients. Voluntary patients' admissions are not subject to review by any independent body, and of even greater concern the position of compliant incapacitated patients is also not subject to review, as these patients are classified as voluntary.[219] The extension of the full machinery of MHT reviews to voluntary patients would be an enormous administrative burden that would in reality be disproportionate to need. However, an almost complete lack of review is indefensible. In § 4.2.2 below a description is provided of the mechanism utilised in South Africa whereby the admission and continued treatment of each voluntary patient is brought to the attention of the Inspector of Mental Hospitals on an annual basis in the form of institutional reports, and the introduction of a similar mechanism here is recommended.

1.4.2 (c) MHA 2001 Part 3: Regulation of the Administration of Mental Health Treatments

It is a general proposition at common law that no medical treatment may be administered without the consent of the patient[220] and a valid consent at common law requires three elements: (a) it must be voluntary; (b) it must be given by a patient with capacity to understand the nature and effects of the proposed treatment; and (c) it

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[218] Walsh, Keith "Circuit Court Appeals and other reviews of Mental Health Tribunal decisions" *Dublin Solicitors' Bar Association Seminar: Mental Health Law – The Need for Change*, 9 October 2010.

[219] While the Inspector of Mental Hospitals may inspect 'any person' residing in a mental hospital during the annual inspection reports, he is not obliged to monitor the admissions and detentions of voluntary patients, and the remit of the Mental Health Commission is curtailed in respect of involuntary patients. In respect of standard setting, however, and in monitoring the provision of services in approved centres, the Mental Health Commission's remit does extend to all 'residents' in a mental hospital. *See* Mental Health Act 2001, Part V, and Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No. 551 of 2006). Additionally, the Mental Health Commission has established Codes of Practice and Rules in respect of the administration of electro-convulsive therapy; on the use of physical restraint; and on the notification of deaths and incident reporting which apply to all residents in approved centres (*see* <http://www.mhcirl.ie/Standards_Quality_Assurance/> accessed 9 May 2011).

[220] *Schloendorff v Society of New York Hospital* 211 NY 125, 105 NE 92 (1914).

must be given by a patient who has received appropriate information about the details of the treatment including about its risks.[221]

The 1945 Act's three different sets of provisions on the admission and detention of both voluntary and involuntary (whether 'temporary' or as a 'person of unsound mind') patients all provided for the 'treatment' of patients. In the case of voluntary patients, section 192 provided that a voluntary patient could be received in a mental hospital and "may be treated therein, and on his recovery, may be discharged."[222] The provisions on temporary patients provided as a prerequisite for the admission that the patient "requires, for his recovery, not more than six months suitable treatment."[223] Section 163(2)(b) in respect of the admission of 'persons of unsound mind' required that the patient "is a proper person to be taken charge of and detained under care and treatment, and is unlikely to recover within six months".[224] There were no specialised provisions in respect of more invasive treatments beyond the section 208 provision providing that a patient could be removed to another hospital for treatment, including surgical treatment, that would not be available otherwise (i.e. that would not be available in the institution in which the patient was currently detained)[225] and the obligation under section 19 to provide "any treatment" required by the patient.[226]

None of these provisions made any mention whatsoever of obtaining the consent of the patient prior to the administration of any treatment. In effect, consent to treatment was dispensed with for all mental health treatment provided in the hospital, irrespective of the nature of the treatment, and of whether the patient was voluntary or involuntary. While no express provision in the 1945 Act authorised the administration of treatment without consent, the presumption was that it was unnecessary to obtain consent from any patient admitted under the Act, in whatever capacity.[227] This aspect

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[221] *Walsh v Family Planning Service* [1992] 1 IR 496; *Geoghegan v Harris* [2000] 3 IR 536; *Fitzpatrick and Ryan v FK and the AG* [2008] IEHC 104, [2009] 2 IR 7 (Laffoy J).
[222] Mental Treatment Act 1945, s 192.
[223] Mental Treatment Act 1945, ss 184 and 185.
[224] Mental Treatment Act 1945, s 163(2)(b).
[225] Mental Treatment Act 1945, s 208.
[226] Mental Treatment Act 1945, s 19.
[227] The validity of this presumption was critiqued in respect of the similar presumption operative in England under the Mental Health Act 1959 by Jacob, J., "The Right of the Mental Patient to his Psychosis" (1976) 39 *Modern Law Review* 17. It was never challenged before the Irish courts, as perhaps the attempt would have been futile given the characterisation in 1950 of the 1945 Act as a

of the 1945 Act regime jarred uncomfortably with the human rights philosophy of maximising autonomy and freedom of action and of minimising interference with a person's ability to make decisions for themselves. It also jarred with the growing preference within psychiatry for a collaborative approach to mental health treatment, whereby patients would engage actively with treatment and thus become more involved with the management of their health, which it was believed led to better recovery outcomes.[228]

The MHA 2001 does not set out principles regarding the administration of mental health treatment to voluntary patients. As a result, the common law principles are the only provisions applicable to voluntary patients in receipt of treatment within a mental hospital. The significant problems that arise in the utilisation of the common law rules on consent – which require an assessment of capacity to give consent – to voluntary mental patients or compliant incapacitated patients – in respect of whom large gaps exist in the Irish legislative framework concerning assessments and regulation of capacity – are discussed in detail at §§ 5.3.3(b) and 5.3.3(c).

Under the 1945 Act there was no legal requirement that treating physicians be able to demonstrate a clinical purpose for the treatments administered to mental patients, an omission that was contrary to the human rights philosophy that deprivations of liberty must be justified by the reciprocal provision of some good (in the criminal context, reparation for a crime, and in the context of mental health, by the provision of treatment intended to ameliorate the patient's suffering).[229] By contrast, the MHA 2001 requires treatments to be aimed at amelioration of the patient's mental disorder where the patient has been admitted under s 3(1)(b) of the Act (where an admission is made under s 3(1)(a) of the MHA 2001, there is no treatability requirement as these admissions are made on the basis of the likelihood of serious harm to self or

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piece of paternalist legislation intended to provide for the 'prevention and treatment of mental disorders' – *see In Re Philip Clarke* [1950] IR 235.

[228] *See* for example Bartlett, Peter, and Sandland, Ralph, *Mental Health Law: Policy and Practice*, 2nd ed. (Oxford: Oxford University Press, 2003), Chapter 1, and Brennan, D., "A consideration of the social trajectory of psychiatric nursing in Ireland" (2004) 11 *Journal of Psychiatric and Mental Health Nursing* 497.

[229] *See* Keys, Mary "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 24 *Dublin University Law Journal* 26.

others).[230] The MHA 2001 also requires the development and regular updating of treatment plans for each individual patient.[231]

The MHA 2001 contains detailed provisions in respect of obtaining consent from involuntary patients where possible and on the administration of treatment without consent where it is not possible to obtain it. Before administering a treatment without an involuntary patient's consent, the treating psychiatrist must perform an assessment of the patient's capacity to give or refuse consent.[232] In respect of general mental health treatments, treatment may be administered without consent where it is necessary to safeguard the patient's life; to restore his health; to alleviate his condition; or to relieve suffering, provided that the treating consultant psychiatrist believes that the patient's refusal of consent or inability to give consent is a result of his mental disorder.[233] Section 60(1) provides for the continuation of the administration of psychiatric medication beyond a period of three months only with the written consent of the patient, or where an involuntary patient is 'unable or unwilling' to give consent, and then only with the certification of two consultant psychiatrists.[234]

Psycho-surgery (defined by the MHA 2001 as "any surgical operation that destroys brain tissue or the functioning of brain tissue and which is performed for the purposes of ameliorating a mental disorder"[235] – it is also commonly referred to as 'lobotomy') is subject to more stringent provisions, requiring either the consent in writing of the patient or the authorisation of a Mental Health Tribunal, and the waiting out of a Circuit Court appeal period before the administration of the treatment.[236]

One area in which the provision of treatment has been controversial is in the administration of electro-convulsive therapy (also known as electro-shock therapy or 'ECT'). ECT is described by the Mental Health Commission as follows:

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[230] Mental Health Act 2001, s 3(1)(b)(ii).
[231] Mental Health Act 2001, s 66(1)(g).
[232] Mental Health Act 2001, s 56(a).
[233] Mental Health Act 2001, s 57.
[234] Mental Health Act 2001, s 60.
[235] Mental Health Act 2001, s 59(6).
[236] Mental Health Act 2001, s 59.

> ECT is a medical procedure in which an electric current is passed briefly through the brain via electrodes applied to the scalp to induce generalised seizure activity. The person receiving treatment is placed under general anaesthetic and muscle relaxants are given to prevent body spasms. Its purpose is to treat specific types of major mental illnesses.[237]

ECT is a controversial treatment and its use has been the subject of numerous media reports – it could be said that in recent years ECT has become the poster child treatment for alleged human rights abuses of mental patients.[238] ECT has been

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[237] The Mental Health Commission, *Rules Governing the Use of Electro-Convulsive Therapy, issued Pursuant to Section 59(2) of the Mental Health Act, 2001* (Dublin: Mental Health Commission, 2009), 15 <http://www.mhcirl.ie/Mental_Health_Act_2001/Mental_Health_Commission_Rules/Electro-Convulsive_Therapy/Revised_-_Rules_Governing_the_Use_of_Electro-Convulsive_Therapy.pdf> accessed 23 January 2011.

[238] *See* for example the reports at Balfe, CM, "ECT without consent" *Irish Times Letters to the Editor* 22 January 2010; Bartlett, Darius, "ECT without consent" *Irish Times Letters to the Editor* 19 December 2009; Barton, Richard "Electroshock is a barbaric therapy" *Irish Independent Letters to the Editor*, (Dublin, 23 June 2008) <http://www.independent.ie/opinion/letters/electroshock-is-a-barbaric-therapy-1418816.html> accessed 23 January 2011; Bates, Tony, "A Doctor's Perspective: ECT" *Headstrong*, 2 February 2010 <http://www.headstrong.ie/content/doctors-perspective-ect> accessed 23 January 2011; Bates, Tony, "A Doctor's Perspective: Patients' Rights" *Irish Times* 2 February 2010; Bracken, Pat, "Side effects of ECT" *Irish Times Letters to the Editor* 30 August 2010; Browne, Ivor, "Side effects of ECT" *Irish Times Letters to the Editor* 2 September 2010; Carroll, Stephen, "Mental health on the edge" *Irish Times* 6 April 2010; Carroll, Steven, "Group calls for ECT ban" *Irish Times* 3 October 2008; Cash, Tom, "Ireland can lead the way on ECT ban" *Irish Independent Letters to the Editor*, (Dublin, 23 June 2008) <http://www.independent.ie/opinion/letters/ireland-can-lead-way-on-ect-ban-1419244.html> accessed 23 January 2011; Corry, Michael, "Barbaric age of electric shock 'cure' must vanish" *Irish Times* 25 June 2008; Corry, Michael, "ECT without consent" *Irish Times Letters to the Editor* 10 December 2009; Culliton, Gary, "ECT debate continues in the Seanad" *Irish Medical Times* 16 October 2008 <http://www.imt.ie/clinical/mental-health-cns/2008/10/ect-debate-continues-in-the-seanad.html> accessed 23 January 2011; Donnelly, Mary, "Patients' Rights and ECT" *Irish Times Letters to the Editor* 2 July 2008; Giller, Joan, "ECT without consent" *Irish Times Letters to the Editor* 8 February 2010; Hanley, Ruairi, "ECT without consent" *Irish Times Letters to the Editor* 9 December 2010; Horan, Niamh, "'Inhumane' shock therapy is on the rise" *Irish Independent* (Dublin, 29 October 2006) <http://www.independent.ie/national-news/inhumane-shock-therapy-is-on-rise-136388.html> accessed 23 January 2010; Hough, Jennifer, "Electric shock therapy for mental illness 'should be banished to history'" *Irish Examiner* (Cork, 6 December 2010) <http://www.examiner.ie/ireland/electric-shock-therapy-for-mental-illness-should-be-banished-to-history-138574.html> accessed 23 January 2011; Maddock, Mary and Jim, "ECT without consent" *Irish Times Letters to the Editor* 19 January 2010; McDonagh, Michelle, "Call for law to help voluntary patients" *Irish Times* 26 October 2007; McDonagh, Michelle, "Mental illness needs range of treatments, says expert" *Irish Times* 8 May 2007; Miller, Basil and Walsh, Consilia, "Head to Head: Should electric shock treatment be banned?" *Irish Times* 7 July 2008; O'Brien, Carl, "A shock to the system of care" *Headline: The National Media Monitoring Agency* 3 February 2010 <http://www.headline.ie/news/headline/2010/feb/03/shock-system-care/> accessed 23 January 2011; O'Brien, Carl, "Advocates for change: lobbying for choices in psychiatric treatment: 'A big chunk of your life taken away'" *Irish Times* 7 December 2009; O'Brien, Carl, "Psychiatric patients still given ECT without consent" *Irish Times* 7 December 2009; O'Brien, Carl, "Psychiatrist says rules for ECT need to change" *Irish Times* 16 March 2010; O'Brien, Carl, "Risks of ECT outweigh benefits, review finds" *Irish Times HealthPlus* 7 December 2010; O'Connell, Claire "ECT side effects may be short term" *Irish Times HealthPlus* 24 August 2010; O'Connell, Paul, "ECT still a valuable psychiatric treatment" *Irish Times Letters to the Editor* 28 June 2008; O'Connell, Paul, "The case for retaining ECT treatment" *Irish Medical Times* 30 July 2008 <http://www.imt.ie/clinical/mental-health-cns/2008/07/the-case-for-retaining-ect-treatment.html> accessed 23 January 2011; O'Connor, John, "ECT without consent" *Irish Times Letters to the Editor* 25 January 2010; Rowley, Rosemary, "ECT

described as one of the most "emotive and divisive" topics in the area of mental health[239] and its effectiveness continues to be hotly debated.[240] Proponents of ECT refer to its benefits and argue that it can relieve the symptoms of severe depression that has proved resistant to treatment with medication, and that in cases of catatonia it can be life-saving.[241] Opponents point to reports of permanent impairment of brain function and long-term memory loss.[242] In Ireland and in the United Kingdom ECT is used only when other treatments have proven ineffective,[243] but in the United States it is not recommended to be reserved for 'last resort' use:

> ECT is a major treatment in psychiatry, with well defined indications. It should not be reserved for use only as a "last resort." Such practice may deprive patients of an effective treatment, delay response and prolong suffering, and may possibly contribute to treatment resistance.[244]

According to data compiled by the Mental Health Commission, there were 407 programmes of ECT (meaning a course of 12 treatments or less) administered in

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without consent" *Irish Times Letters to the Editor* 8 December 2010; RTÉ News, "Use of electroconvulsive therapy defended" *RTÉ News* 28 September 2010 <http://www.rte.ie/news/2010/0831/health.html> accessed 23 January 2011; Ryan, Susan, "Electro-shock therapy defended by psychiatric group" *The Journal* 31 August 2010 <http://www.thejournal.ie/electro-shock-therapy-defended-by-psychiatric-group-2010-08/> accessed 23 January 2011; Shannon, June, "Call to support retention of ECT treatment: 2010 Irish Medical Organisation AGM" *Medical Independent* 15 April 2010 <http://www.medicalindependent.ie/page.aspx?title=call_to_support_retention_of_ect_treatment> accessed 23 January 2011; Walsh, Dermot, "Opinion: Shock therapy must remain available to some" *Irish Times* 28 December 2009; Walsh, M.C., "ECT still a valuable psychiatric treatment" *Irish Times Letters to the Editor* 28 June 2008.

[239] Bates, Tony, "A Doctor's Perspective: ECT" *Headstrong*, 2 February 2010 <http://www.headstrong.ie/content/doctors-perspective-ect> accessed 23 January 2011.

[240] *See* Miller, Basil and Walsh, Consilia, "Head to Head: Should electric shock treatment be banned?" *Irish Times* 7 July 2008.

[241] College of Psychiatry of Ireland, *ECT Information Pack: Seanad All Party Briefing 3 March 2010* (Dublin: College of Psychiatry of Ireland, 2010), 5 (para '1. Electroconvulsive Therapy: ECT, Background') <http://www.dohc.ie/issues/ect/ECT_information_pack.pdf?direct=1> accessed 23 January 2011.

[242] *See* Horan, Niamh, "'Inhumane' shock therapy is on the rise" *Irish Independent* (Dublin, 29 October 2006) <http://www.independent.ie/national-news/inhumane-shock-therapy-is-on-rise-136388.html> accessed 23 January 2010.

[243] The Mental Health Commission, *Rules Governing the Use of Electro-Convulsive Therapy, issued Pursuant to Section 59(2) of the Mental Health Act, 2001* (Dublin: Mental Health Commission, 2009), 21 <http://www.mhcirl.ie/Mental_Health_Act_2001/Mental_Health_Commission_Rules/Electro-Convulsive_Therapy/Revised_-_Rules_Governing_the_Use_of_Electro-Convulsive_Therapy.pdf> accessed 23 January 2011 and National Institute for Health and Clinical Excellent, *Guidance on the Use of Electroconvulsive Therapy* (London: National Institute for Health and Clinical Excellence, 2003), 5 <http://www.nice.org.uk/nicemedia/live/11494/32597/32597.pdf> accessed 23 January 2011.

[244] Weiner, Richard D., *The Practice of Electroconvulsive Therapy:* 3rd edn. (Oxford: Oxford University Press, 1997); *Recommendations for Treatment, Training and Privileging: A Task Force Report of the American Psychiatric Association* 2nd edn. (completely revised) (Arlington: American Psychiatric Publishing, Inc., 2001), § 2.2.1 <http://www.ect.org/resources/apa/2.html> accessed 23 January 2011.

approved centres in 2008.[245] A large variation in the use of ECT was reported across the country, with the highest numbers of programmes being administered by private hospitals.[246] St. Patrick's Hospital in Dublin had the highest rate of administration of ECT in the country.[247] Over 80% of the patients receiving ECT are voluntary patients.[248]

The provisions in the MHA 2001 on ECT are less strict than those for psycho-surgery, but more so than for medication and general mental health treatment. Section 59(1) of the MHA 2001 requires that for the administration of ECT either the patient must consent in writing, or two consultant psychiatrists must approve and authorise the treatment.[249] There is no requirement that the treatment be 'necessary' or 'appropriate' (beyond the general 'best interests' requirement in section 4, which we have seen is interpreted according to a paternalist, rather than a human rights, philosophy), and no requirement that the consultant psychiatrists reach their conclusion to approve of the treatment independently of one another.[250]

The Mental Health Commission was required under section 59(2) to make rules concerning the use of ECT, and the administration of ECT must at all times accord with the Commission's rules.[251] The Rules Governing the Use of Electro-Convulsive Therapy[252] are detailed and stringent in the requirements placed on mental hospitals to

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[245] Mental Health Commission, *Report on the Use of Electroconvulsive Therapy in Approved Centres in 2008* (Dublin: Mental Health Commission, 2009), 8 <http://www.mhcirl.ie/Publications/Report_on_the_use_of_ECT_in_Approved_Centres_in_2008.pdf> accessed 23 January 2011.

[246] Mental Health Commission, *Report on the Use of Electroconvulsive Therapy in Approved Centres in 2008* (Dublin: Mental Health Commission, 2009), 8 <http://www.mhcirl.ie/Publications/Report_on_the_use_of_ECT_in_Approved_Centres_in_2008.pdf> accessed 23 January 2011.

[247] Mental Health Commission, *Report on the Use of Electroconvulsive Therapy in Approved Centres in 2008* (Dublin: Mental Health Commission, 2009), 8, Table 3 <http://www.mhcirl.ie/Publications/Report_on_the_use_of_ECT_in_Approved_Centres_in_2008.pdf> accessed 23 January 2011.

[248] Mental Health Commission, *Report on the Use of Electroconvulsive Therapy in Approved Centres in 2008* (Dublin: Mental Health Commission, 2009), 10 <http://www.mhcirl.ie/Publications/Report_on_the_use_of_ECT_in_Approved_Centres_in_2008.pdf> accessed 23 January 2011.

[249] Mental Health Act 2001, s 59(1).

[250] *See* discussion of Mental Health Act 2001, s 59, at § 5.3.2 below.

[251] Mental Health Act 2001, s 59(2).

[252] The Mental Health Commission, *Rules Governing the Use of Electro-Convulsive Therapy, issued Pursuant to Section 59(2) of the Mental Health Act, 2001* (Dublin: Mental Health Commission, 2009) <http://www.mhcirl.ie/Mental_Health_Act_2001/Mental_Health_Commission_Rules/Electro-

assess capacity to consent to ECT. They state a presumption of capacity to give informed consent to ECT and anaesthesia unless there is evidence to the contrary; and impose an obligation on the treating consultant psychiatrist to assess capacity to consent prior to obtaining consent. To be considered capable of consenting to a programme of ECT the patient must: (a) understand the nature of ECT; (b) understand why ECT is being proposed; (c) understand the benefits, risks and alternatives to receiving ECT; (d) understand and believe the broad consequences of not receiving ECT; (e) retain the information long enough to make a decision to receive or not receive ECT; (f) make a free choice to receive or refuse ECT; and (g) communicate the decision to consent to ECT. Written consent is required from the patient (a carer, relative or guardian cannot consent on their behalf) for every programme of ECT and must include consent to the use of anaesthesia during the treatment.[253]

It is important to note that in the provisions in Part 6 of the MHA 2001 relating to bodily restraint and seclusion in section 69 the provisions are stated to apply to voluntary patients as well as involuntary patients:

> 69.— (1) A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.
>
> (2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.
>
> (3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1,500.
>
> (4) In this section "patient" includes—

Convulsive_Therapy/Revised_-_Rules_Governing_the_Use_of_Electro-Convulsive_Therapy.pdf> accessed 23 January 2011.

[253] The Mental Health Commission, *Rules Governing the Use of Electro-Convulsive Therapy, issued Pursuant to Section 59(2) of the Mental Health Act, 2001* (Dublin: Mental Health Commission, 2009), 17-18 <http://www.mhcirl.ie/Mental_Health_Act_2001/Mental_Health_Commission_Rules/Electro-Convulsive_Therapy/Revised_-_Rules_Governing_the_Use_of_Electro-Convulsive_Therapy.pdf> accessed 23 January 2011.

(a) a child in respect of whom an order under section 25 is in force, and

(b) a voluntary patient.[254]

This is a marked difference from the approach taken in Part 4 on medication, ECT, and psycho-surgery, and it would appear to indicate that the drafters of the MHA 2001 intended to exclude voluntary patients from the application of the consent to treatment protections under the Act. The provisions in respect of consent to treatment in Part 4 refer only to 'patients', which, according to section 1 of the MHA 2001 means a patient as defined under section 14, that is, an involuntary patient. This excludes voluntary patients from the consent to treatment protections of Part 4 of the MHA 2001 on consent to treatment. Voluntary patients who are detained under ss 23 and 24 are thereafter regarded as involuntary patients and as such are immediately entitled to the procedural protections of ss 15-11 (providing for review of the detention by a Mental Health Tribunal) and to the protections in Part 4 of the Act.

Voluntary patients then have to rely on the provisions at common law pertaining to consent. As was noted above, the requirements for a valid consent to medical treatment at common law are voluntariness; capacity; and full disclosure of the details of the treatment.[255] One of the leading cases from the United Kingdom on disclosure in the context of consent to treatment is an ECT case, *Bolam v Friern Hospital Management Committee*.[256] In that case, a patient who consented to electro-

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[254] Mental Health Act 2001, s 69.

[255] *Walsh v Family Planning Service* [1992] 1 IR 496. For an interesting account from the perspective of the medical profession of the frustrations caused by the lack of clear legislative guidelines on the treatment of patients who consented to voluntary admission to a mental hospital but subsequently lose capacity to consent to treatment, see Dunne, R., Kavanagh, A., and McLoughlin, D., "Electroconvulsive therapy, capacity and the law in Ireland" (2009) 26 (1) *Irish Journal of Psychological Medicine* 3, available online at http://www.ijpm.org/content/pdf/423/Editorial.pdf (accessed 20 September 2010). On consent to medical treatment in Irish law, see Donnelly, M., *Consent: Bridging the Gap between Doctor and Patient* (Cork: Cork University Press, 2002); O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005), Chapter 10, and Whelan, Darius, *Mental Health Law and Practice: Civil and Criminal Aspects* (Dublin: Thomson Round Hall, 2009), Chapter 10.There is also a sizeable body of academic literature on the question of consent to treatment in England. *See* for example, Bartlett, Peter, and Sandland, Ralph, *Mental Health Law: Policy and Practice*, 2nd ed. (Oxford: Oxford University Press, 2003), Chapter 7; Hoggett, Brenda M., *Mental Health Law* (London: Sweet and Maxwell, 1996), Chapter 5; Mason, Kenyon and Laurie, Graeme, *Mason & McCall Smith's Law and Medical Ethics* 7th edn (Oxford: Oxford University Press, 2005), Chapter 10; Fenwick, Helen, *Civil Liberties and Human Rights*, 3rd ed. (London: Cavendish Publishing Limited, 2004), Chapter 12; Davies, M., *Medical Law* 2nd edn (London: Blackstone, 1998), Chapter 5.

[256] *Bolam* v *Friern Hospital Management Committee* [1957] 2 All E.R. 118.

convulsive therapy was not informed of the risks associated with the use of the electro-shock therapy without the administration of a muscle relaxant and/or an anaesthetic. At the time medical opinion was divided on the benefits of the use of a muscle relaxant in the administration of ECT – while the muscle relaxant would eliminate any risk of fractures entirely, the risk of fractures occurring was small and the administration of the muscle relaxant in conjunction with anaesthesia also posed risks to the patient.[257] The plaintiff patient received neither a muscle relaxant nor an anaesthetic and suffered numerous injuries including a fractured pelvis during the seizures induced by the treatment. McNair J in the Queen's Bench Division ruled that the test for the standard of care in respect of negligence in this context was that of 'acting in accordance with the standards of reasonably competent medical men at the time':

> But where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. I do not think that I quarrel much with any of the submissions in law which have been put before you by counsel. Mr. Fox-Andrews put it in this way, that in the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if he conforms with one of those proper standards, then he is not negligent.[258]

The question of the administration of ECT to voluntary patients is therefore not without its controversies in terms of the assessment of ability to consent and liability for negligence where a patient suffers an injury after consenting to the treatment when the treating psychiatrist did not disclose information about its risks which might have dissuaded them from consenting. Indeed in *Bolam*, the court referred with approval to expert evidence that the category of patients most likely to benefit from ECT are also a category of patients likely to suffer from delusions and a distortion of judgement about the state of their health, to the extent that a decision not to disclose certain of

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[257] *Bolam* v *Friern Hospital Management Committee* [1957] 2 All E.R. 118, [1957] 1 WLR 582, 591.
[258] *Bolam* v *Friern Hospital Management Committee* [1957] 2 All E.R. 118, [1957] 1 WLR 582, 586-587.

the risks of ECT might be justifiable if the disclosure would leave to a refusal to consent to the treatment.[259]

In 2008 a private members bill was introduced in the Seanad seeking to amend the MHA 2001 in respect of consent to treatment. The Mental Health (Involuntary Procedures) (Amendment) Bill 2008[260] proposed a complete reform of the MHA 2001 Part 4 provisions in respect of involuntary procedures. The first of these sought the deletion of section 58 in respect of psycho-surgery[261] and the proposal of a prohibition on its use.[262] The second amendment would have amended the wording of the MHA 2001, s 59, to require the 'informed consent in writing' of the patient for every administration of ECT and the removal of the provisions facilitating the administration of ECT in circumstances where a patient is 'unable or unwilling to consent due to their mental illness.'[263]

These amendments focus on issues that have been raised by Mary Donnelly, who has argued for at least the deletion of the word 'unwilling' from section 59 in order to limit its scope, and for the insertion of a requirement that the second consultant psychiatrist who certifies the use of ECT be independent of the treating consultant psychiatrist.[264] The deletion of the word 'unwilling' from section 59(1) is also supported by the College of Psychiatry in Ireland, who additionally also propose that the second opinion psychiatrist be appointed from a panel established by the Mental Health Commission, and that the degree of regulation of ECT by the Commission be increased through the introduction of more detailed audit procedures.[265]

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[259] *Bolam* v *Friern Hospital Management Committee* [1957] 2 All E.R. 118, [1957] 1 WLR 582, 589.
[260] Mental Health (Involuntary Procedures) (Amendment) Bill 2008 (Seanad) (Private Members Bill) (No. 36 of 2008).
[261] Mental Health (Involuntary Procedures) (Amendment) Bill 2008 (Seanad) (Private Members Bill) (No. 36 of 2008), section 1.
[262] De Búrca, Déirdre, Seanad Debates Vol. 190 No. 6 *Mental Health (Involuntary Procedures) (Amendment) Bill 2008: Second Stage* 25 June 2008, 481 <http://debates.oireachtas.ie/seanad/2008/06/25/00013.asp> accessed 23 January 2011.
[263] De Búrca, Déirdre, Seanad Debates Vol. 190 No. 6 *Mental Health (Involuntary Procedures) (Amendment) Bill 2008: Second Stage* 25 June 2008, 482 <http://debates.oireachtas.ie/seanad/2008/06/25/00013.asp> accessed 23 January 2011.
[264] Donnelly, Mary, "Patients' Rights and ECT" *Irish Times Letters to the Editor* 2 July 2008.
[265] College of Psychiatry of Ireland, *ECT Information Pack* (Dublin: College of Psychiatry of Ireland, 2010), 9, 'Tuesday 9 March 2010: Seanad All-Party Briefing on the administration of Electroconvulsive Therapy: College of Psychiatry of Ireland Recommendations', §§ 1 and 2 (Dublin: Government Publications, 2010) <http://www.dohc.ie/issues/ect/ECT_information_pack.pdf?direct=1> accessed 23 January 2011.

The Mental Health (Involuntary Procedures) (Amendment) Bill 2008 currently stands adjourned at the Committee Stage in the Seanad, to facilitate the consideration by the government of the incorporation of the proposed amendments into the broader proposed amendment of the mental health law regime that is proposed to occur in tandem with the introduction of new capacity and guardianship legislation:

> Legislation is being prepared which will take into account issues that arise in this debate. The matter will not be parked or shelved because it is part of the ongoing process of arriving at legislation that will be well accepted. Any amendment of the Mental Health Act on these lines — for example, to delete the word "unwilling" from section 59 — would have to be undertaken within a supporting framework of legislation defining legal capacity. The Office for Disability and Mental Health has already raised this matter in the context of the development of new capacity legislation by the Department of Justice, Equality and Law Reform. I can assure the House that it will be considered further in that context. This aspect defines the importance of the Minister of State with responsibility for disability and mental health. It is a cross-departmental issue that requires continued action, not least under my Department's aegis.[266]

The question of the use of ECT in particular, and of consent to mental health treatment generally, under the MHA 2001 can be seen to have the potential to continue to raise human rights concerns.[267] Many of these difficulties revolve around the lack of a clear regime for dealing with incapacitated patients, and around the regime applying to voluntary patients and are the result of the lingering vestiges of the paternalist philosophy of the pre human rights era in mental health law in Ireland. The human rights issues raised are discussed in more detail below at § 5.3.

Conclusion

The reform of mental health law in Ireland has undoubtedly resulted in significant improvements on the previous regime that was in place under the 1945 Act. The new requirements on admissions and detentions represent a substantial improvement on

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[266] Moloney, John, Seanad Debates Vol. 190 No. 6 *Mental Health (Involuntary Procedures) (Amendment) Bill 2008: Second Stage* 25 June 2008, 491-492 <http://debates.oireachtas.ie/seanad/2008/06/25/00013.asp> accessed 23 January 2011.

[267] *See* also Robinson, R., "ECT and the Human Rights Act 1998" (2003) July *Journal of Mental Health Law* 66.

the old regime and are a significant enhancement in the protections of patients' human rights. Under the MHA 2001, people admitted and detained involuntarily in mental hospitals enjoy markedly greater protection of their positive right to liberty, and greatly enhanced safeguards around the circumstances of its curtailment.

However, a number of areas of difficulty still arise under the MHA 2001 in respect of patients' human rights. These difficulties may be said to cluster particularly around the issue of capacity and of assessments of capacity. The failure to address this issue has led to potential for human rights abuses in respect of voluntary admissions; regulation of voluntary patients' consent to treatment; regulation of involuntary patients' consent to treatment; and the position of the compliant incapacitated patient who is not formally detained as an involuntary patient. Some concerns remain about the new standards and tests established under the MHA 2001, in particular with respect to involuntary incapacitated patients and voluntary patients. Significant concerns also continue to be raised around the provisions on consent to treatment and in particular in respect of involuntary treatment and above all in respect of the administration of ECT.

Many of these concerns may be said to derive from the continuing paternalist approach that has been adopted by the drafters in the framing of the section 4 best interests provision and in the structure of the consent to treatment safeguards and their application to involuntary patients only. Compounding the problem, the judiciary have in cases on the MHA 2001 continued to utilise the paternalist philosophy in the interpretation of mental health legislation that was adopted in the cases that came before them under the 1945 Act. The difficulties with this approach, and its unsuitability to the human rights based regime that the MHA 2001 seeks to achieve, are outlined in detail at §§ 3.7 and 5.2.4 below.

Additionally, the continued absence of a human rights based capacity regime founded on a functional model of capacity and capable of providing protection in cases where people have suffered temporary or intermittent loss of capacity in addition to cases where the person's loss of capacity is permanent, is of significant concern.

In order to draw out in more detail the reasons why these issues are so problematic in terms of Ireland's efforts to implement a mental health law regime that is compliant with our international human rights obligations, it is necessary to understand the parameters of the international human rights protections to which Ireland is committed in this area. In Chapter 2 a description is provided of the international human rights standards against which the Irish mental health law framework will be judged in this work.

2. MENTAL HEALTH RIGHTS: THE INTERNATIONAL HUMAN RIGHTS FRAMEWORK

Introduction

International human rights have enormous importance for the lives of people suffering from mental illness. This Chapter outlines the major international human rights documents and the mechanisms by which these provisions have provided protection for people suffering from mental illness. The purpose of this is to establish the parameters of Ireland's international human rights commitments in the area of mental health, in order to develop a clear picture of the standard to which Irish mental health law will be held in the performance of the 'human rights audit' in Chapter 5 of this work.

The discussion in this Chapter first outlines the types of legal dilemmas that are frequently encountered by mental health service users, and then identifies the types of human rights claims that are engaged by those legal dilemmas. The international human rights provisions and jurisprudence dealing with those types of human rights claims are described, and the ways in which those rights claims are protected are evaluated on both the international and European levels.

In the next Chapter, the same analysis is performed in respect of the human rights protected by the Irish Constitution. In Chapter 4 a description of the mental health law regimes in England and South Africa is provided, in order to provide a comparative analysis of the degrees of protection of the international human rights standards in the mental health laws of those jurisdiction. An evaluation of the substance and effect of Irish mental health law, presented as an audit of our constitutional human rights jurisprudence and statutory and common law regulation of mental health services against the international and constitutional human rights standards described in this Chapter, is performed in Chapter 5.

In this thesis the types of rights claims put forward by mental health service users in legal challenges brought pertaining to their experiences within the mental health services, or pertaining to their claimed unsatisfactory treatment in other aspects of society as a result of their status as mental health patients, are grouped into seven categories. These seven categories are:

1. Dignity claims;
2. Liberty claims;
3. Autonomy, bodily integrity, and privacy claims;
4. Fair procedures claims;
5. Claims based in the right to freedom from torture and inhuman and degrading treatment and punishment;
6. Equality claims; and
7. Affirmative rights claims based on arguments for particular entitlements (for example, an entitlement to access to a certain standard of health or health care, or an entitlement to access to education).

The following discussion provides a detailed analysis of the substance of the rights claims made within each of these categories, assessing the meaning and application of these rights at the international human rights level in the context of mental health claims, but at this juncture it is appropriate to provide an account of the major human rights sources that will be considered in this analysis, and of the human rights bodies that promote and enforce these rights. An assessment of whether these rights have in legal outcomes provided for meaningful substantive protection for mental health patients will be undertaken in Chapter 5.

2.1 Global Human Rights Bodies

Ireland can boast membership of two international human rights bodies, both of which have generated significant human rights instruments of crucial importance to the protection of the rights of mental health patients. On the global scale, Ireland is a member of the United Nations, which is the premier international human rights standards-setting organisation. On the regional scale, Ireland is a member of the

Council of Europe, and a party to the European Convention on Human Rights, which has been incorporated into Irish law by the European Convention on Human Rights Act 2003. The human rights standards established by these organisations are the model against which Irish mental health law is compared in this work.

The primary international human rights body is the United Nations (the UN), which operates as the vanguard of international human rights law. Emerging out of the trauma of World War II, the UN was established in 1954 in an effort to build "a post-war world of safety, justice and returning prosperity."[1] The UN is a system of more than thirty affiliated organisations, which cooperate to address the most pressing problems affecting humanity. Whittaker summarises the functions of the UN in a thematic way as being threefold and interrelated:

1. To be a forum for discussion and decision;
2. To meet as a syndicate for action, employing non-forcible measures to improve the world; and
3. To be a missionary centre appealing to moral values and standards higher than those generally prevailing in international relations.[2]

The UN's extensive list of activities can be grouped into four main purposes that encapsulate the essence of the UN's work: the maintenance of international peace and security; developing friendly relations among nations; cooperation in solving international problems and in promoting respect for human rights; and acting as a centre for harmonizing the actions of nations.[3]

The UN's protection of human rights is contained in the International Bill of Rights, which is a treaty based system of safeguards for human rights; and is also contained in numerous declarations, resolutions, and guidance documents, some of which

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[1] Whittaker, D. J., *United Nations in the Contemporary World* (London and New York: Routledge, 1997), 3.

[2] Whittaker, D. J., *United Nations in the Contemporary World* (London and New York: Routledge, 1997), 6. United Nations, *U.N. IN Brief: Chapter 1 – How the U.N. Works* <http://www.un.org/Overview/uninbrief/about.shtml> accessed 1 October 2006. *See* also United Nations, *U.N. in Brief: Introduction – Not So Well Known...*, <http://www.un.org/Overview/uninbrief/> accessed 24 October 2009.

[3] *See* United Nations, *U.N. in Brief: Chapter 1 – How the U.N. Works*, <http://www.un.org/Overview/uninbrief/about.shtml> accessed 24 October 2009.

specifically address the rights of people with mental disabilities. The International Bill of Rights is comprised of the United Nations Charter;[4] the Universal Declaration of Human Rights;[5] and the two International Covenants of Human Rights – the International Covenant on Civil and Political Rights[6] and the International Covenant on Economic, Social and Cultural Rights.[7] Four further conventions up to 2006 offer protections to specific groups of people vulnerable to human rights abuses – women;[8] children;[9] racial minorities;[10] and those subjected to torture and inhuman and degrading treatment or punishment.[11] All of these conventions apply to people with mental disabilities who may fall within their realm, and in some instances the conventions provide specific protection against abuses being targeted particularly at mental disability or exacerbated in terms of their impact by the victim's mental disability. For example, the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment specifically includes discrimination on the basis of mental disability as a type of cruel, inhuman or degrading treatment.[12]

Specific monitoring bodies are established under the Conventions to oversee their enactment and compliance with each Convention's terms. Monitoring is done on the basis of visits by national and independent international bodies to places of detention, as well as states parties' self-reporting to the monitoring bodies. The monitoring mechanisms for each of the major conventions are discussed below.

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[4] United Nations Charter, 24th November 1945 <http://www.un.org/aboutun/charter/> accessed 24 October 2009.

[5] *See* United Nations, *Universal Declaration of Human Rights*, (1948) G.A. Res. 217A, U.N. GAOR, 3rd Sess. U.N. Doc. A/311, Preamble. *See* also Rosenthal, Eric, and Sundram, Clarence J., "International Human Rights in Mental Health Legislation" (2002) 21 *New York Law School Journal of International and Comparative Law* 469, 479; *and* Gostin, L.O. and Gable, L., "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health" (2004) 63 (1) *Maryland Law Review* 20, 32.

[6] United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171.

[7] United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3.

[8] United Nations, *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979, 1249 U.N.T.S. 13.

[9] United Nations, *Convention on the Rights of the Child*, 20 November 1989, 1577 U.N.T.S. 43.

[10] United Nations, *International Convention on the Elimination of All Forms of Racial Discrimination*, opened for signature 7 March 1966, 660 U.N.T.S. 211.

[11] United Nations, *Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, 10 December 1984, 1465 U.N.T.S. 113.

[12] United Nations, *Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, 10 December 1984, 1465 U.N.T.S. 113, Article 1.

The International Bill of Human Rights may be taken to lay down a foundational or base level of human rights entitlements and mechanisms to safeguard against abuses of those rights.[13] It did not, however, specifically address the rights of people with disabilities. In terms of the benefits accruing to mental health service users and to people with disabilities more generally, one commentator has described the International Bill of Rights system as a "toothless tiger".[14] In an attempt to address these shortcomings, a number of further United Nations documents – in the form of Comments,[15] Declarations,[16] Resolutions,[17] and guidance documents[18] were drafted to focus specifically on the interpretation of the International Bill of Human Rights in its application to people with mental disabilities. These provisions form part of the UN's portfolio of 'soft law'. They are not legally binding upon signatories to the International Bill of Human Rights, but they are considered authoritative interpretations of the rights enshrined in it, and as such are of significant importance in progressing an understanding of the United Nations framework as encompassing the rights of people with disabilities.

Notwithstanding the adoption of the numerous soft law provisions, particularly throughout the last decade of the 20th century, considerable disquiet remained among

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[13] Gostin, Lawrence O. and Gable, Lance, "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health" (2004) 63 (1) *Maryland Law Review* 20, 36.

[14] Degener, Theresia, "Disability as a Subject of International Human Rights Law and Comparative Discrimination Law" *In* Herr, S. S. et al (eds.), *The Human Rights of Persons with Intellectual Disabilities: Different but Equal* (Oxford and New York: Oxford University Press, 2003), 159.

[15] General information on the various UN Committees and how they operate can be found at <http://www.un.org/ga/committees.shtml> accessed 24 May 2010.

[16] The declarations that are of most importance to the area of mental health rights are the Declaration on the Rights of Mentally Retarded Persons 1971 (United Nations, *Declaration on the Rights of Mentally Retarded Persons* (New York: United Nations Secretariat Centre for Human Rights, 1971). G.A. Res. 2856, U.N. GAOR, 26th Sess., Supp. No. 29, at 99, U.N. Doc. A/8429 (1971)); the Declaration on the Rights of Disabled Persons 1975 (United Nations, *Declaration on the Rights of Disabled Persons* (New York: United Nations Secretariat Centre for Human Rights, 1975). G.A. Res. 3447, U.N. GAOR, 30th Sess., Supp. No. 34, at 92, U.N. Doc. A/10034 (1975)); and the Vienna Declaration and Programme of Action of the World Conference on Human Rights 1993. (United Nations, *Vienna Declaration and Programme of Action of the World Conference on Human Rights* (New York: United Nations Secretariat Centre for Human Rights, 1993). G.A. Res. 48/141, U.N. GAOR, U.N. Doc. A/CONF.157/23 (1993)).

[17] *See* for example the Committee on Economic, Social and Cultural Rights (CESCR) established under the United Nations Economic and Social Council (ECOSOC) Resolution 1985/17 < http://ap.ohchr.org/documents/E/ECOSOC/resolutions/E-RES-1985-17.doc> accessed 24 January 2011.

[18] United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (New York: United Nations Secretariat Centre for Human Rights, 1991); (1991) G.A. Res. 119, U.N. GAOR, 46th Sess., U.N. Doc. A/46/49, Supp. No. 49, Annex, 188-92.

human rights activists regarding the lack of adequate protection for the human rights of people with disabilities – as Oliver Lewis describes, people with mental health disabilities specifically "are among those who suffer most from the compliance gap between lofty declaration and rights reality."[19] This ultimately lead to the disability rights movement successfully lobbying the UN to draft and pass a legally binding convention that would specifically safeguard the rights of people with disabilities.[20] The convention was passed by the UN in 2006 and Ireland signed the Convention on the Rights of Persons with Disabilities in 2007. The Convention on the Rights of Persons with Disabilities (CRPD) had its genesis in the establishment of an Ad Hoc Committee to consider proposals for "a comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities."[21] Gostin describes the establishment of this committee, and the decision to draft a convention specifically on the rights of persons with disabilities, as a "potential paradigm shift".[22] The CRPD is based around eight guiding principles that permeate each of its provisions. It may be said that these principles represent a list of the types of rights claims that are of most importance to people with disabilities, and they centre on the principles of dignity; autonomy; freedom; independence; and equality:

1. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
2. Non-discrimination;
3. Full and effective participation and inclusion in society;
4. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;

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[19] Lewis, Oliver, "The Expressive, Educational and Proactive Roles of Human Rights: An Analysis of the United Nations Convention on the Rights of Persons with Disabilities" *in* McSherry, Bernadette and Walker, Penelope, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), 97-128, 97.

[20] For more information on the drafting process behind the CRPD, *see* for example Stein, Michael Ashley and Lord, Janet E., "Monitoring the Convention on the Rights of Persons with Disabilities: Innovations, Lost Opportunities, and Future Potential" (2010) 32 *Human Rights Quarterly* 689.

[21] United Nations, *Comprehensive and Integral Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities*, G.A. Res. 168, U.N. GAOR, 56th Sess., 88th plenary meeting, U.N. Doc. A/56/583/Add.2 (New York: United Nations, 2001).

[22] Gostin, Lawrence O. and Gable, Lance, "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health" (2004) 63 (1) *Maryland Law Review* 20, 45.

5. Equality of opportunity;
6. Accessibility;
7. Equality between men and women; and
8. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.[23]

The CRPD consciously attempts to reflect the changes in thinking and approach that have occurred in society with respect to people with disabilities. Unlike the earlier UN documents which adopted a paternalistic approach, the CRPD is rooted in the social model of disability approach that focuses on the person rather than their disability. The fundamental starting point of the social model of disability is that a person is never disabled as a result of their disability, rather they are disabled as a result of society's failure to accommodate that disability.[24] The CRPD therefore operates from the premise that adaptations must be made within society in order that people with disabilities can exercise their human rights effectively. The aim of the Convention is to encourage the making of these adaptations and to protect the human rights of people with disabilities from infringement. Significantly, the CRPD provides for an obligation on states to take steps to eliminate discrimination in the private in addition to the public sphere, and, in its optional protocol, contains a means of individual complaint in respect of alleged violations.[25]

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[23] United Nations Enable, *Guiding Principles of the Convention* (United Nations, 2007) <http://www.un.org/esa/socdev/enable/convinfoguide.htm> accessed 24 October 2009. *See* also United Nations, *Comprehensive and Integral Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities*, G.A. Res. 168, U.N. GAOR, 56th Sess., 88th plenary meeting, U.N. Doc. A/56/583/Add.2 (New York: United Nations, 2001).

[24] *See* generally Barnes, Colin and Mercer, Geof, *The Social Model of Disability: Europe and the Majority World* (Leeds: Disability Press, 2005). In respect of the impact of the social model of disability on legal reform and on the impact of human rights philosophies to disability issues, *see* Traustadóttir, Rannveig, "Disability Studies, the Social Model, and Legal Developments" *in* Quinn, Gerard and Arnardóttir, Oddný Mjöll, eds, *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Leiden: Brill, 2008), 3-16 and Walker, Penelope, "Lost in Translation: Human Rights and Mental Health Law" *in* McSherry, Bernadette and Walker, Penelope, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), 51-72.

[25] For detailed information on the enforcement mechanisms around the CRPD, *see* United Nations Enable, *Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities* (United Nations, U.N. Doc. A/HRC/10/48, 26th January 2009) <http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf> accessed 14 May 2011 and Stein, Michael Ashley and Lord, Janet E., "Monitoring the Convention on the Rights of Persons with Disabilities: Innovations, Lost Opportunities, and Future Potential" (2010) 32 *Human Rights Quarterly* 689.

These international human rights documents provide for both civil and political and socio-economic rights that are applicable in the area of mental health. These rights are contained both in the broad ranging international human rights principles, and also in a variety of specifically targeted documents that focus on the field of mental health. The International Covenant on Civil and Political Rights provides an avenue for the guaranteeing of procedural protections against arbitrary civil commitment to psychiatric institutions (under the rights to liberty and to fair procedures) and protection against inhumane conditions of confinement and of treatment (prohibition on torture, and inhuman and degrading treatment). Additionally, the CRPD contains a blend of both civil and political, and socio-economic rights. The Mental Illness Principles and General Comment 21 of the Human Rights Committee provide further guidance on the applicability of these international human rights norms in the sphere of mental health law. In terms of socio-economic rights, the International Covenant on Economic, Social and Cultural Rights can be utilised to argue for access to community treatment schemes; humane treatments; and educational and vocational programmes.[26]

As noted above, the CRPD recognises a number of socio-economic rights specifically in the realm of the protection of the rights of people with disabilities. Additionally, the UN has adopted the Mental Illness Principles, the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities, the Declaration on the Rights of Disabled Persons, and General Comments 5 and 12 directly pertinent to the protection of the rights of people affected by mental health law regimes. Each of these is discussed in more detail below within the thematic discussion of mental health rights claims.

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[26] *See* generally Quinn, G. and Degener, Theresia, et al, *Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments In The Context of Disability* (Geneva: United Nations, Office of the High Commission for Human Rights, 2002), 59.

2.1.1 UN Human Rights Monitoring and Enforcement

The UN is structured around six central institutions: the General Assembly;[27] the Security Council;[28] the Secretariat;[29] the Economic and Social Council;[30] the Trusteeship Council[31] and the International Court of Justice.[32] There are many more sub-committees, commissions, treaty monitoring bodies and assemblies which report back to the six central institutions.

The Office of the UN High Commissioner for Human Rights provides support to the Human Rights Council and the other core treaty bodies (such as the Committees set up to monitor the implementation of the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic Social and Cultural Rights (ICESCR) and Convention on the Rights of Persons with Disabilities (CRPD)), and works to promote human rights through human rights education and public information activities. The Office divides its workload into three streams – standard-setting; monitoring; and on the ground implementation. The first two streams support the various treaty Committees in their tasks of reviewing and monitoring treaty compliance. The third stream is achieved through the appointment of special rapporteurs, independent experts, and working groups to monitor human rights in specific countries or in relation to specific issues. The Commission also maintains field offices in areas considered to be in need of assistance in the promotion of human rights.[33]

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[27] United Nations, *Guiding Principles of the Convention* (United Nations, 2007) <http://www.un.org/esa/socdev/enable/convinfoguide.htm> accessed 24 October 2009.

[28] *See* United Nations, *U.N. in Brief: Chapter 1 – How the U.N. Works: 1B – The Security Council*, <http://www.un.org/Overview/uninbrief/sc.shtml> accessed 24 October 2009.

[29] *See* United Nations, *U.N. in Brief: Chapter 1 – How the U.N. Works: 1F – The Secretariat*, <http://www.un.org/Overview/uninbrief/secretariat.shtml> accessed 24 October 2009.

[30] *See* United Nations, *U.N. in Brief: Chapter 1 – How the U.N. Works: 1C – The Economic and Social Council*, <http://www.un.org/Overview/uninbrief/ecosoc.shtml> accessed 24 October 2009.

[31] *See* United Nations, *U.N. in Brief: Chapter 1 – How the U.N. Works: 1D – The Economic and Social Council* <http://www.un.org/Overview/uninbrief/ecosoc.shtml> accessed 24 October 2009.

[32] *See* United Nations, *U.N. in Brief: Chapter 1 – How the U.N. Works: 1E – The Economic and Social Council*, <http://www.un.org/Overview/uninbrief/ecosoc.shtml> accessed 24 October 2009.

[33] For general information on the work of the UN High Commissioner for Human Rights, *see* <http://www.ohchr.org/EN/Pages/WelcomePage.aspx> accessed 24 May 2010. *See* also United Nations Enable, *Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities* (United Nations, U.N. Doc. A/HRC/10/48, 26th January 2009)

The Human Rights Council, established in 2006, replacing the previous Commission on Human Rights, is a UN Charter body with responsibility for the promotion and protection of human rights globally. It operates on the basis of periodic reviews of the UN member states' human rights records. Ireland is scheduled for its first review in the 12th Human Rights Council Universal Periodic Review Session, to occur in late 2011. The Human Rights Council, under the First Protocol to the International Covenant on Civil and Political Rights (ICCPR) has the power to accept private complaints from individuals alleging that they have been the victim of a Convention violation. Ireland has signed up to the First Protocol, but with a derogation at Article 5(2) in respect of communications from an individual if the matter has already been considered under another procedure of international investigation or settlement.

The International Bill of Human Rights provides for the establishment of human rights committees, which publish interpretations of the content of the international human rights provisions and monitor worldwide implementation of the human rights contained in the Bill of Human Rights. These interpretations are presented in reports on specific thematic issues and are published as 'General Comments'. The Committee on Human Rights focuses on interpretations of the ICCPR, while the Committee on Economic, Social and Cultural Rights focuses on interpretations of the ICESCR. There is also a committee set up under the CRPD. The committees perform their monitoring function via a system of reporting and recommendations. States that have signed up to a treaty will be required to report to the relevant committee body on a regular basis (generally every four years). The committee will then examine the report received and compose a reply outlining any concerns and recommendations that arise. The two International Covenants on Human Rights (the ICCPR and the ICESCR) are intended to provide enforceable mechanisms to promote and protect the human rights recognised in the Universal Declaration of Human Rights (UDHR). Complaints of violations of the ICCPR and the ICESCR can be addressed to the Special Rapporteur system, and can also be brought before the Human Rights Committee, a special body that sits for eight weeks every year to monitor compliance with the UN human rights documents.

<http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf> accessed 14 May 2011.

The committees also have the power to issue General Comments, which are recommendations for the implementation of individual treaty articles. The most relevant of these for the purposes of this thesis are: the Human Rights Committee's General Comment 21 on the Humane Treatment of Persons Deprived of their Liberty; the Committee on Economic, Social and Cultural Rights' General Comment 5 on Persons with Disabilities; and the Committee on Economic, Social and Cultural Rights' General Comment 14 on The Right to the Highest Attainable Standard of Health.[34]

2.2 European Human Rights Bodies

On the regional level, human rights are given strong protection in Europe by the Council of Europe, the monitoring body that oversees the enforcement of the provisions of the European Convention for the Protection of Human Rights and Fundamental Freedoms, which is more commonly known as the European Convention on Human Rights (ECHR). The operation of the ECHR is monitored and enforced by the European Court of Human Rights (ECtHR). The ECHR has been

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[34] These interpretations are presented in reports on specific thematic issues and are published as 'General Comments'. The full text of all of the General Comments is available at <http://www2.ohchr.org/english/bodies/hrc/comments.htm> accessed 28 August 2010. The Committee on Human Rights focuses on interpretations of the ICCPR (*see* generally <http://www2.ohchr.org/english/bodies/hrc/index.htm> accessed 24 May 2010), while the Committee on Economic, Social and Cultural Rights focuses on interpretations of the ICESCR (*see* generally <http://www2.ohchr.org/english/bodies/cescr/index.htm> accessed 24 May 2010). There is also a committee set up under the CRPD (*see* generally <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDIndex.aspx> accessed 24 May 2010). *See* in particular: the Human Rights Committee's *General Comment 21 on the Humane Treatment of Persons Deprived of their Liberty* (United Nations Office of the High Commissioner for Human Rights, *General Comment 21 of the Committee on Human Rights: Replaces General Comment 9 Concerning Humane Treatment of Persons Deprived of Liberty* (Geneva: UNHCR, 1992) <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/3327552b9511fb98c12563ed004cbe59?Opendocument> accessed 24 May 2010); the Committee on Economic, Social and Cultural Rights' *General Comment 5 on Persons with Disabilities* (United Nations Office of the High Commissioner for Human Rights, *General Comment 5 of the Committee on Economic, Social and Cultural Rights: Persons with Disabilities* (Geneva: UNHCR, 1996) <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/CESCR%20General%20comment%205.En?Opendocument> accessed 1 October 2006); and the Committee on Economic, Social and Cultural Rights' *General Comment 14 on The Right to the Highest Attainable Standard of Health* (United Nations Office of the High Commissioner for Human Rights, General Comment 14 of the Committee on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health (Geneva: UNHCR, 2000) <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument> accessed 24 May 2010).

incorporated into Irish law in the form of the European Convention on Human Rights Act 2003, and is as a result the international human rights document that has had the most profound impact on domestic Irish law, and on Irish mental health law in particular. When the MHA 2001 was described at the time of its enactment as bringing Irish mental health law into compliance with international human rights standards, the ECHR was the yardstick against which this hoped for compliance had been measured. It is therefore of particular importance to the 'human rights audit' exercise in this thesis to understand the operation of the Council of Europe and the parameters of the human rights protections provided in the ECHR itself and in the jurisprudence of the ECtHR.

The Council of Europe was established in the aftermath of World War II with the aim of achieving greater harmony and unity among the countries of Europe, in order to prevent the horrors of war being revisited. The Council's endeavours ultimately led to the establishment of the European Union. Today the Council of Europe's primary function is to act as a watchdog for democracy and human rights in Europe, and as the administrating body for the ECtHR in its function of overseeing the enforcement of the ECHR.

The ECHR was signed in Rome in 1950. The Human Rights Charter of the Council of Europe, the ECHR is interpreted and guarded by the Strasbourg based European Court of Human Rights (ECtHR), to which there is an individual right of complaint where there has been a violation by a contracting party. It is a prerequisite of membership of the European Union to become a party to the Council of Europe and ratify the ECHR. Ireland ratified the ECHR in 1953 and was the first contracting party to issue a declaration under Article 46 of the Convention, thereby recognising the validity of the ECtHR.

In its jurisprudence with respect to the human rights of people with mental disabilities, the ECHR guarantees only civil and political rights. It does not protect the so-called 'affirmative' social, economic and cultural rights (although the European Social Charter is increasingly being relied upon before the ECtHR, and cited in its judgments, which is a development that may hold potential in this area for the protection of the health rights of mental health patients). As such, the protections that

have been developed under the ECHR are negative in nature, requiring the State and private actors to refrain from violating a person's rights, rather than positive in nature, entitling an individual to services which must be provided by the State.

In an echo of the guiding principles laid down for the CRPD (which were earlier posited to be centred on the principles of dignity; autonomy; freedom; independence; and equality), the provisions of the ECHR that have seen the most litigation in the area of mental health rights claims have been Article 3 (the prohibition on torture and cruel, inhuman and degrading treatment); Article 5 (the right to liberty); Article 6 (the right to due process of law); Article 8 (the right to privacy) and Article 14 (the right to non-discrimination).

The ECHR has a social and economic rights counterpart in the European Social Charter (ESC), adopted by the Council of Europe in 1961. The ESC protects rights to housing; health; education; employment; legal protection; free movement; and non-discrimination. The principles of the ESC are policy aims, rather than binding human rights obligations, and States are not required to sign up to the document in its entirety.[35] Ireland has signed up to all but three articles of the ESC: Article 8(3) (the right of nursing mothers to sufficient time off from work for this purpose); Article 21 (the right of workers to information and consultation with regard to the financial affairs of their employer); and Article 31 (promotion of the right to housing).[36]

Compliance with the ESC is monitored through a system of self-reporting to the European Committee of Social Rights, a fifteen person panel elected by the Council of Europe's Committee of Ministers. Member States submit annual reports to the Committee, which then issues annual 'Conclusions' assessing the degree of compliance with the terms of the ESC. If a State does not take action on a conclusion that it is not in compliance with the ESC the matter is passed on to the Governmental

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[35] Revised European Social Charter 1996, pt III, Article A.

[36] For a chart showing the articles ratified or not ratified by Ireland *see* Council of Europe, *Ireland and the European Social Charter* (Strasbourg: May 2010) <http://www.coe.int/t/dghl/monitoring/socialcharter/CountryFactsheets/Ireland_en.asp> accessed 24 May 2010, and for a chart showing these statistics for all signatories *see* Council of Europe, *Acceptance of Provisions of the Revised European Social Charter (1996)* (Strasbourg: 5 March 2010) <http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/ProvisionTableRev_en.pdf> accessed 24 May 2010.

Committee, which may issue 'Recommendations' requesting that the State in question make the necessary legal or policy changes to achieve compliance.

There is also a collective complaints mechanism whereby certain European trade and business organisations; certain non-governmental organisations; and domestic employers' organisations and trade unions may lodge complaints with the Committee of Social Rights. If the Committee deems the complaint admissible, it will invite written submissions and may hold a public hearing into the complaint. The Committee of Social Rights ultimately prepares a report on the validity of the complaint, which is submitted to the Committee of Ministers. The Committee of Ministers may then adopt a resolution, and may 'recommend' that the member State make changes to its laws or policies in instances where non-compliance with the ESC has been found.

Rehman describes the ESC's implementation mechanism as "weak and cumbersome."[37] He argues that the Committee of Ministers, as a political body, is an inappropriate entity to be charged with implementation of the ESC as politicians are "reluctant to criticise States for fear of generating political tensions" and highlights antagonism between the Committee of Social Rights and the Governmental Committee.[38] Rehman does acknowledge that the reforms undertaken in 1990 to clarify the relationship between the two Committees, avoiding previous duplications of workload, and to streamline the reporting procedures, represent improvements to the overall system.[39]

Many of the rights provided for in the ESC are related to employment, including protections against child labour; provisions with respect to working hours and holidays; and the right to safe and healthy working conditions including provision for maternity leave. Many of these rights also fall within the ambit of the European Union and are extensively regulated in EU Directives, which are incorporated into domestic law and can thereafter be litigated directly in the domestic courts of EU Member

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[37] Rehman, Javaid, *International Human Rights Law*, 2nd ed. (Essex: Pearson Education Limited, 2010), at 239.
[38] Rehman, Javaid, *International Human Rights Law*, 2nd ed. (Essex: Perason Education Limited, 2010), at 239.
[39] Rehman, Javaid, *International Human Rights Law*, 2nd ed. (Essex: Perason Education Limited, 2010), at 240.

States, with the further possibility of referral to the European Court of Justice. The EU protected rights accordingly have a significantly greater degree of 'bite' than the ESC rights, which are subject only to the reports-and-recommendations system of monitoring.[40]

2.2.1 European Human Rights Monitoring and Enforcement

As is noted above, the ECHR is enforced by the European Court of Human Rights (ECtHR) sitting in Strasbourg. Additionally, the strength of the rights provided for under the ECHR is significantly greater in the Irish context than the UN rights as the ECHR rights are embedded in the Irish legal system at the domestic level by the European Convention on Human Rights Act 2003. As a result, ECHR rights are justiciable before the Irish domestic courts (albeit at a sub-constitutional level).

A person who believes that their ECHR rights have been violated, and who has not had success in persuading his or her domestic courts of the alleged violation, may then take his or her grievance to the ECtHR in Strasbourg (ECtHR). In this regard, Lester, Pannick and Herberg describe the ECHR as "a revolutionary enterprise" in its conferring of enforceable rights on individuals against sovereign states.[41] The decisions of the Strasbourg court are binding in Ireland and can compel changes to Irish law. Even the threat of an adverse ECtHR ruling can prompt a review of the impugned law and result in changes, as occurred in the case of *Croke v Ireland*. That case originated in the Irish courts as *Croke v Smith*, in which the applicant alleged that certain aspects of the Mental Treatment Act 1961 were repugnant to the ECHR. The Supreme Court found against the applicant, who appealed to the ECtHR. In the knowledge that the Strasbourg court was likely to find that the Mental Treatment Act 1961 offended against the applicant's rights under the ECHR, the parties came to a

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[40] On the protection of human rights by the European human rights bodies in the disability context generally *see* Þór Bjögvinsson, Davíð, "The Protection of the Rights of Persons with Disabilities in the Case Law of the European Court of Human Rights" *in* Quinn, Gerard and Arnardóttir, Oddný Mjöll, eds, *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Leiden: Brill, 2008), 140-162.

[41] Lord Lester of Herne Hill QC, Lord Pannick QC, Javan Herberg (eds), *Human Rights Law and Practice*, 3rd ed. (London: Butterworths, 2009), at 5.

settlement out of court whereby the government undertook to reform Irish mental health law.[42]

The monitoring and enforcement mechanisms for the European Social Charter have already been outlined. To date, two complaints have been lodged with the Committee of Social Rights in respect of Ireland, dealing respectively with a lack of prohibition on the corporal punishment of children within the home, in child care settings, and in foster and residential care placements (No. 18/2003 *World Organisation against Torture (OMCT) v. Ireland*[43]) and with an allegedly discriminatory administration of the contributory old age pension (No. 42/2007, *International Federation of Human Rights (FIDH) v. Ireland*[44]). No violation was found in respect of the 2007 complaint. In respect of the 2003 complaint, a violation of Article 17 (the right of children and young people to social, legal and economic protection) was found to have occurred, and the Committee of Ministers issued a resolution noting the government's intention to take advice on the issue and to review the question of an outright ban on corporal punishment of children.[45]

2.3 Dignity Claims

As was noted in the Introduction to this thesis, dignity claims are often conceptualised as a natural continuation of another human rights claim, or of multiple human rights claims. In the mental health context, a dignity claim may be presented as an entitlement to be treated in a fashion that protects one's dignity or as an entitlement not to be required to undergo certain treatment that it is felt diminishes one's

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[42] *Croke v Smith (No 2)* (1998) 1 IR 101 (Supreme Court); *Croke v Ireland* Application No. 3326/96, Judgment (Striking Out) Strasbourg, December 21, 2000. *See* Keys, Mary "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 24 *Dublin University Law Journal* 26 and O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: FirstLaw, 2005) at 141.

[43] *World Organisation against Torture (OMCT) v. Ireland*, Application No. 18/2003, decision of the European Committee of Social Rights of 25 January 2005.

[44] *International Federation of Human Rights (FIDH) v. Ireland*, Application No. 42/2007, decision of the European Committee of Social Rights of 4 July 2008.

[45] In respect of all of the international human rights bodies' enforcement mechanisms listed above, for an overview of the impact of these mechanisms on the protection of the rights of people with mental disabilities, see generally Quinn, Gerard and Waddington, Lisa, eds, *European Yearbook of Disability Law: Volume 1* (Antwerp: Intersentia, 2009) and Quinn, Gerard and Waddington, Lisa, eds, *European Yearbook of Disability Law: Volume 2* (Antwerp: Intersentia, 2010).

dignity.[46] This encompasses challenges to compulsory detention or to compulsory treatment, and even challenges to a prevailing regime in a mental hospital where the patient objects to a particular aspect of it.[47]

In Chapter 5 the degree to which Irish mental health law succeeds in protecting the dignity of mental health patients, measured against the standards established for the protection of dignity by the international human rights framework, is evaluated. The conclusion is overall positive in terms of dignity as a stand-alone concept. However, the results of the 'human rights audit' are more mixed for the protection of dignity when it is presented as a facet of another right, for example, the right to autonomy, or the right to freedom from torture and inhuman and degrading treatment or punishment.

The concept of 'treatment with dignity' is a regular calling card in debates on the rights of people with mental health disabilities and Degener has described it as one of the four core "human rights values that underlie the transformation process of viewing disability as a human rights value."[48] Vorhaus quotes with approval from Feldman's[49] distinguishing of dignity into three spheres:

> Feldman has distinguished three spheres within international law in which human dignity operates: the dignity attaching to the whole human species, requiring rules which protect the special status and integrity of the species; the dignity of groups within the human species, requiring rules which serve to prevent discrimination between groups on irrelevant grounds, and enabling groups to assert a right to respect for their existence; and, finally, the dignity

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[46] *See* generally Feldman, David, "Human Dignity as a Legal Value – Part 1 (1999) Winter *Public Law* 683; Rabkin, Jeremy, "What We Can Learn About Human Dignity from International Law" (2003-2004) 27 *Harvard Journal of Law and Public Policy* 145; Vorhaus, John, "On Degradation Part Two: Degrading Treatment and Punishment" (2003) 32 *Common Law World Review* 65; Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.

[47] For one example of a mental health case in which dignity was argued as a component of the argument that the applicant's right to liberty had been infringed, *see* the European Court of Human Rights decision in *HL v United Kingdom* (2004) Application No. 45508/99, (2004) ECHR 471, discussed in detail below.

[48] Degener, Theresia, "Disability as a Subject of Law" *in* Herr, Stanley S., Gostin, Lawrence O., and Koh, Harold Koh (eds), *The Human Rights of Persons with Intellectual Disabilities: Different But Equal* (Oxford: Oxford University Press, 2003), at 152.

[49] Feldman, David, "Human Dignity as a Legal Value – Part 1 (1999) Winter *Public Law* 683.

> of individuals, upheld by rules of law which protect autonomy and moral integrity.[50]

The idea of 'treatment with dignity' at first blush sounds like a straightforward and commonsense proposition. However, 'dignity' is a concept that has proved elusive to legal conceptualisation. At the 1948 debates on the text of the UDHR, the General Assembly's Third Committee on Social, Humanitarian and Cultural Affairs took six days to approve the text of Article 1, which at that point read:

> All human beings are born free and equal in dignity and rights. They are endowed by nature with reason and conscience, and should act towards one another in a spirit of brotherhood.

Ultimately the text was adopted with only the deletion of the words 'by nature'; but the preservation in Article 1 of the word 'dignity' was hard fought, with debate focussing on whether the word 'dignity' should be replaced with the word 'fundamental'. In the debates, Eleanor Roosevelt argued that the word 'dignity' had been carefully chosen, and was included "in order to emphasise that every human being is worthy of respect."[51] Roosevelt then appeared to view the concept of 'dignity' as mandating the treatment of other human beings with respect in a way that the idea of 'fundamental rights' did not. Dignity, rather than being an empty concept capable of being deleted without adverse consequences for the idea of rights, added something crucial to the human rights project. Roosevelt's conceptualisation of dignity as being rooted in respect has been repeated by Degener:

> This dignity exists in each human being as a permanent and inseparable attribute. The recognition of human dignity is not dependant on social status, religion, race, gender, genetic makeup, or merit. Every human being is born with dignity and retains dignity until after death. In the context of disability it means that respect for each disabled person's dignity may not be linked to his or her medical condition, functional limitations, or economic and professional performance.[52]

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[50] Vorhaus, John, "On Degradation Part Two: Degrading Treatment and Punishment" (2003) 32 *Common Law World Review* 65, at 74.

[51] *See* Glendon, Mary Ann, *A World Made New* (New York: Random House, 2001) at 146.

[52] Degener, Theresia, "Disability as a Subject of Law" *in* Herr, Stanley S., Gostin, Lawrence O., and Koh, Harold Koh (eds), *The Human Rights of Persons with Intellectual Disabilities: Different But Equal* (Oxford: Oxford University Press, 2003), at 154.

The proposition that dignity as a human value uniquely encapsulates the idea of respect is joined by a number of other themes in the academic writings on dignity in the context of mental health rights. Rabkin notes that the UN human rights texts equate dignity with equality.[53] Luban, critical of international human rights theory's tendency towards vagueness in defining the concept of 'human dignity' roots his discussion of the concept in the idea of non-humiliation:

> What about human dignity? Evidently, it must refer to the prestige conferred simply by being human. To violate someone's human dignity means to treat them as if they were a being of lower rank – as an animal, as a handy but disposable tool, as property, as an object, as a subhuman, an as overgrown child, as nothing at all.[54]

The calling cards of human dignity then appear to be: respect, equality, and non-humiliation. The importance of these concepts in the realm of mental health is immediate. The experience of compulsory admission, detention, and treatment, if not handled with great sensitivity and care by the mental health law regime and by the service providers administering it, has the potential to cause significant damage to the compulsory patient's sense of their own dignity and self worth.[55]

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[53] Rabkin, Jeremy, "What We Can Learn About Human Dignity from International Law" (2003-2004) 27 *Harvard Journal of Law and Public Policy* 145, at 146. Rabkin's analysis then contrasts this UN equality-based conception of dignity with his analysis of the American Founders' view of dignity as being based in distinction from the ordinary, and injuries to dignity as involving a loss of that distinction.

[54] Luban, David, "Lawyers as Upholders of Human Dignity (When they aren't Busy Assaulting It)" (2005) 3 *University of Illinois Law Review* 816, at 839.

[55] The strength of the 'survivors of psychiatry' movement is testamount to the profound negative impact that improper utilisation of the coercive mental health law regime may have on patients' sense of dignity. For an indication of the concerns that are frequently raised by service users who feel that mental health systems failed to adequately respect their dignity, and of the tenor of the anti-psychiatry movement and the responses from the psychiatric profession, *see* for example Breggin, Peter, *Toxic Psychiatry: Why Therapy, Empathy and Love Must Replace the Drugs, Electroshock, and Biochemical Theories of the "New Psychiatry"* (New York: St. Martin's Griffin, 1994); Lynch, Terry, *Beyond Prozac: Healing Mental Suffering Without Drugs* (Dublin: Mercier Press, 1995); Szaz, Thomas, *The Age of Madness* (New York: Jason Aronson Inc. Publishers, 1984); Laing, R.D., *The Divided Self* (Harmondstworth: Penguin, 1972); Crossley, Nick, *Contesting psychiatry : social movements in mental health* (Oxfordshire and New York: Routledge, 2006); Ingleby, David, ed., *Critical Psychiatry: The politics of mental health* (London: Free Association Books, 2004); Boyers, Robert, *Laing and Anti-Psychiatry* (Harmondsworth: Penguin, 1972); Foucault, Michel, *Madness and Civilisation: A history of insanity in the Age of Reason* (London: Routledge, 2001); Bracken, Patrick, *Post-Psychiatry* (Oxford: Oxford University Press, 2005); Ennis, Bruce J., *Prisoners of psychiatry : mental patients, psychiatrists, and the law* (New York : Harcourt Brace Jovanovich, 1972); Cooper, David, *Psychiatry and anti-psychiatry* (London: Paladin, 1970); Kotowicz, Zbigniew, *R.D. Laing and the paths of anti-psychiatry* (London: Routledge, 1997); and Schaler, Jeffrey A., ed., *Szasz under fire : the psychiatric abolitionist faces his critics* (Chicago: Open Court, 2004).

2.3.1 Dignity Claims under the UN Human Rights Instruments

Dignity claims as a principle, appear in all of the international human rights instruments. As a standalone concept, it features prominently in Article 1 of the UDHR and is also centre stage in the Preambles to the ICCPR and ICESCR, reinforcing the message of the United Nations Charter that human dignity is the cornerstone upon which all other human rights are built:

> Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,
>
> Recognising that these rights derive from the inherent dignity of the human person...[56]

Article 22 of the UDHR expressly states that the recognition of economic, social and cultural rights is indispensable for a person's "dignity and free development of his personality."[57]

These provisions are more aspirational and guiding in nature, and are not capable of giving rise to rights claims in their own right. However, many of the provisions of the international human rights instruments specifically reference dignity as an integral component of specific human rights protected in the substantive portions of the international human rights instruments. Article 23 of the UDHR recognises a right to 'remuneration of a value sufficient to enable an existence worthy of human dignity'. Dignity features in Article 10 of the ICCPR, which provides that all persons deprived of their liberty "shall be treated with humanity and with respect for the inherent dignity of the human person."[58] The Human Rights Committee, in General Comment

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[56] United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Article 1.
[57] United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Article 22.
[58] United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Article 1.

21 described this obligation as "a fundamental and universally applicable rule."[59] General Comment 21 then continues in a similar vein to highlight that persons deprived of their liberty at law, may not be subjected to any hardship or constraint other than that resulting from the deprivation of liberty, and that their dignity must be guaranteed under the same conditions as for that of free persons.[60]

The ICESCR includes the concept of dignity in its provisions in Article 13 on education:

> The States Parties to the present Covenant recognise the right of everyone to education. They agree that education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms. They further agree that education shall enable all persons to participate effectively in a free society, promote understanding, tolerance and friendship among all nations and all racial, ethnic or religious groups, and further the activities of the United Nations for the maintenance of peace.[61]

Dignity is also enshrined in the guiding principles of the CRPD, set out in Article 3 of that convention – indeed, all but one of the eight guiding principles reference 'dignity', 'respect', or 'equality / non-discrimination'.[62] Kämpf has described dignity as "the underlying foundation for the interpretation and application of rights and freedoms" in the CRPD and has stated that the concept of dignity is linked with that of equality in the underlying rationale of non-discrimination in the Convention.[63]

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[59] United Nations Office of the High Commissioner for Human Rights, *General Comment 21 of the Committee on Human Rights: Replaces General Comment 9 Concerning Humane Treatment of Persons Deprived of Liberty* (Geneva: UNHCR, 1992) para 4 <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/3327552b9511fb98c12563ed004cbe59?Opendocument> accessed 24 May 2010.

[60] United Nations Office of the High Commissioner for Human Rights, *General Comment 21 of the Committee on Human Rights: Replaces General Comment 9 Concerning Humane Treatment of Persons Deprived of Liberty* (Geneva: UNHCR, 1992), para 3.

[61] United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3., Article 13.

[62] United Nations, *Comprehensive and Integral Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities*, G.A. Res. 168, U.N. GAOR, 56th Sess., 88th plenary meeting, U.N. Doc. A/56/583/Add.2 (New York: United Nations, 2001), Article 3.

[63] Kämpf, Annegret, "Involuntary Treatment Decisions: Using Negotiated Silence to Facilitate Change?" *in* McSherry, Bernadette and Walker, Penelope, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), 129-150, 137.

Finally, Article 22 of the UDHR provides that 'social, economic, and cultural rights' are explicitly indispensable to a person's dignity and the free development of his personality.[64]

2.3.2 Dignity Claims under the ECHR and ESC

The text of the ECHR does not mention dignity, however, the concept has been employed before the ECtHR and has been referenced frequently in its judgments. In *Pretty v United Kingdom*, in the context of a claim that the Article 2 protection of the right to life also encompassed a correlating right to death, the Court stated that the "very essence of the Convention is respect for human dignity and human freedom."[65]

Of relevance in the context of mental health rights, dignity features frequently in judgments handed down in respect of the right to freedom from torture and inhuman and degrading treatment and punishment, for example in *Pretty v United Kingdom*:

> Where treatment humiliates or debases an individual, showing a lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of Article 3…[66]

A further example occurs in *Ramirez Sanchez v France* where the ECtHR states:

> Nevertheless, Article 3 requires the State to ensure that prisoners are detained in conditions that are compatible with respect for their human dignity, that the manner and method of the execution of the measure do not subject them to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, their health and well-being are adequately secured…[67]

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[64] United Nations, *Universal Declaration of Human Rights*, (1948) G.A. Res. 217A, U.N. GAOR, 3rd Sess. U.N. Doc. A/311, Article 22. Article 22 CPRD.

[65] *Pretty v United Kingdom*, Application No. 2346 of 2002 (judgment delivered 29 April 2002), at para 65.

[66] *Pretty v United Kingdom*, Application No. 2346 of 2002 (judgment delivered 29 April 2002), at para 52.

[67] *Ramirez Sanchez v France*, Application No. 59450 of 2000 (judgment delivered 4 July 2006), at para 119.

Also relevant is *McGlinchey v United Kingdom*:

> Under this provision the State must ensure that a person is detained in conditions which are compatible with respect for her human dignity, that the manner and method of the execution of the measure do not subject her to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, her health and well-being are adequately secured by, among other things, providing her with the requisite medical assistance...[68]

Finally, in the case of *HL v United Kingdom*[69] the applicant successfully argued that his ostensibly voluntary detention was actually compulsory in character, and that not having been afforded the protections of the legal regime applicable to compulsory detentions (owing to his ostensibly voluntary patient status), his Article 5 right to liberty had been infringed. The European Court of Human Rights in its judgment quoted with approval the following passage from the judgment of Lord Steyn in the Court of Appeal:

> Given that [compliant incapacitated] patients are diagnostically indistinguishable from compulsory patients, there is no reason to withhold the specific and effective protections of [the 1983 Act] from a large class of vulnerable mentally incapacitated individuals. Their moral right to be treated with dignity requires nothing less. The only comfort is that counsel for the Secretary of State has assured the House that reform of the law is under active consideration.[70]

Dignity, as it features in mental health rights claims is therefore usually argued as an inherent feature of another right that it is sought to have upheld through litigation. Dignity is particularly pleaded in respect of claims engaging the rights to liberty; to autonomy, bodily integrity and privacy; and to freedom from torture and inhuman and degrading treatment and punishment.

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[68] *McGlinchey v United Kingdom*, Application No. 50390 of 1999 (judgment delivered 29 April 2003), at para 46.
[69] *HL v United Kingdom* (2004) Application No. 45508/99, (2004) ECHR 471.
[70] *HL v United Kingdom* (2004) Application No. 45508/99, (2004) ECHR 471, at para 49.

2.4 Liberty Claims

Liberty claims encompass the right to freedom in its most straightforward sense as a freedom from detention, and also the classical liberal right to be allowed to act as one chooses.[71] In the mental health context liberty claims may arise in challenges to the validity of compulsory admissions, treatments and detentions.[72]

In the 'human rights audit' that is performed in this work, the protection afforded to the right to liberty by Irish mental health law is measured against the yardstick of the provisions of the UN human rights framework, and, most particularly, the conditions established by the ECHR and the jurisprudence of the ECtHR for the protection of the right to liberty. The impact of the ECHR on these types of human rights claims has been of enormous significance, and it is essential to the exercise performed in this thesis to clearly outline the scope of the right to liberty protection under the ECHR, and the parameters set by the ECtHR for lawful restrictions of it in the mental health context.

The right to liberty has been described as the core common law right, encapsulated in the idea of a 'right to be left alone'.[73] It is in essence the right to live one's life free from interference from the State or others, with the ability to live in a place of one's choosing and regulate one's day and one's activities in the manner of one's choosing. The right to liberty, however, is not absolute, and can be forfeited in accordance with procedures established by law. The most obvious example of a limitation on the right to liberty is of course incarceration following conviction for a criminal offence. The right to liberty is also of vital importance in mental health law in consequence of the compulsory detention powers utilised to detain a person even against their wishes for

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[71] Glendon, Mary Ann, *Rights Talk: The Impoverishment of Political Discourse* (The Free Press: New York, 1993), *see* generally Chapter Three: 'The Lone Rights Bearer'. *See* also Murray, Claire, "Safeguarding the Right to Liberty of Incapable Compliant Patients with a Mental Disorder in Ireland" (2007) 29 *Dublin University Law Journal* 279; Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.

[72] *See* for example *Winterwerp v Netherlands* (1979) Application No. 6301/73, [1979] 2 EHRR 387, and *HL v United Kingdom* (2004) Application No. 45508/99, (2004) ECHR 471, discussed in detail below.

[73] Glendon, Mary Ann, *Rights Talk: The Impoverishment of Political Discourse* (The Free Press: New York, 1993), *see* generally Chapter Three: 'The Lone Rights Bearer'.

psychiatric treatment in a mental hospital, in circumstances defined by law and regulated by legal review procedures. The right to liberty also arises where a person is forced by law to accept treatments or regimes they do not wish to cooperate with. This latter facet of the right to liberty, significantly overlaps with the rights to autonomy, privacy and bodily integrity, discussed in detail later.

2.4.1 Liberty Claims under the UN Human Rights Instruments

Article 9(1) of the ICCPR protects the right to liberty and security:

> No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty save on such grounds and in accordance with such procedure as are established by law.[74]

This right is recognised as being of crucial importance by the UNHCR:

> [a]ll countries are confronted by the practice of arbitrary detention. It knows no boundaries, and thousands of persons are subjected to arbitrary detention each year.[75]

General Comment 8 on the Right to Liberty and Security of Persons (Art. 9) confirms that Article 9(1) applies to instances of detention on the grounds of mental illness, as well as to detentions based on vagrancy; drug addiction; educational purposes and immigration control.[76]

As well as the substantive right to liberty, Article 9 also provides a checklist of procedural guarantees that must be afforded to persons deprived of their liberty. These include the giving of reasons for the detention (Article 9(2)); the provision of a mechanism for challenging the detention (Article 9(4)); and the provision for compensation in cases of unlawful detention (Article 9(5)).

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[74] United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Article 9(1).

[75] United Nations, *The Working Group on Arbitrary Detention: Fact Sheet No. 26* <http://www.unhcr.ch/html/menu6/2/fs26.htm> accessed 19 July 2010.

[76] Human Rights Commission, *General Comment 8 on the Right to Liberty and Security of Persons (Article 9)* (Geneva: UNHCR, 1982) para 1.
<http://www2.ohchr.org/english/bodies/hrc/comments.htm> accessed 28 August 2010.

In *A v New Zealand*[77] the applicant alleged that his compulsory detention in a mental hospital had amounted to a violation of his rights under Article 9 of the ICCPR. The applicant founded his claim on the allegation that his original detention was unlawful, together with a claim that the reviews of his detention conducted thereafter were unfair.[78] The Human Rights Committee rejected his claim, holding (a) that the original committal order was issued according to law, and (b) that the applicant's deprivation of liberty was subject to periodical review. As such, the Committee held that the deprivation of liberty that occurred was not arbitrary or unlawful and as such was not in violation of Article 9 (1).[79] Furthermore, in light of the additional regular review of the applicant's detention by the New Zealand courts, the Committee was not prepared to hold that a violation of Article 9 (4) had occurred:

> The Committee refers to its constant jurisprudence, that it is for the courts of States parties concerned to review the evaluation of the facts as well as the application of the law in a particular case, and not for the Committee, unless the Courts' decisions are manifestly arbitrary or amount to a denial of justice.[80]

The CRPD contains significant protections around the right to liberty, and is unequivocal in its assertion in Article 14(1)(b) that a deprivation of liberty must never be founded solely on the existence of a disability:

> 1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
>   (a) Enjoy the right to liberty and security of person;
>   (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

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[77] *A (name withheld) v New Zealand*, Communication No. 754/1997, U.N. Doc. CCPR/C/66/D/754/1997 (3 August 1999) <http://www1.umn.edu/humanrts/undocs/session66/view754.htm> accessed 5 May 2011.
[78] *A (name withheld) v New Zealand*, Communication No. 754/1997, U.N. Doc. CCPR/C/66/D/754/1997 (3 August 1999) §§ 3.1-3.5 <http://www1.umn.edu/humanrts/undocs/session66/view754.htm> accessed 5 May 2011.
[79] *A (name withheld) v New Zealand*, Communication No. 754/1997, U.N. Doc. CCPR/C/66/D/754/1997 (3 August 1999) § 7.2 <http://www1.umn.edu/humanrts/undocs/session66/view754.htm> accessed 5 May 2011.
[80] *A (name withheld) v New Zealand*, Communication No. 754/1997, U.N. Doc. CCPR/C/66/D/754/1997 (3 August 1999) § 7.3 <http://www1.umn.edu/humanrts/undocs/session66/view754.htm> accessed 5 May 2011.

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.

The utilisation of mental disorder as a ground for compulsory civil committal and compulsory mental health treatment might be said to amount to a deprivation of liberty on the grounds of a disability, and as such might be said to fall foul of Article 14(2)(b). The CRPD itself is silent on the lawfulness or otherwise of compulsory mental health laws although some additional guidance may be gleaned from the UNHCR's Thematic Study on enhancing awareness and understanding of the CRPD, which includes the statement that "Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished."[81] This has led to significant debate in respect of its impact on states' domestic mental health law regimes.[82] In Australia, for example, ratification of the CRPD has been completed with the insertion of a declaration that it is understood that the Convention "allows for fully substituted decision-making and compulsory treatment for mental disability, if it is necessary, as a last resort and subject to safeguards."[83] It remains to be seen what approach will be taken to the

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[81] United Nations Enable, *Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities* (United Nations, U.N. Doc. A/HRC/10/48, 26th January 2009) <http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf> accessed 14 May 2011, § 49.

[82] See for example, Dhanda, Amita, "Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?" (2007) 34 (2) *Syracuse Journal of International Law and Commerce* 429; Kämpf, Annegret, "Involuntary Treatment Decisions: Using Negotiated Silence to Facilitate Change?" *in* McSherry, Bernadette and Walker, Penelope, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), 129-150; Minkowitz, Tina, "Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities" *in* McSherry, Bernadette and Walker, Penelope, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), 151-178; Stein, Michael Ashley and Lord, Janet E., "Monitoring the Convention on the Rights of Persons with Disabilities: Innovations, Lost Opportunities, and Future Potential" (2010) 32 *Human Rights Quarterly* 689; Hunt, Paul and Mesquita, Judith, "Mental Disabilities and the Human Right to the Highest Attainable Standard of Health" (2006) 28 *Human Rights Quarterly* 332; Diniz, Debora, Barbosa, Lívia, and dos Santos, Wederson Rufino, "Disability, Human Rights and Justice" (2009) 6 (11) *International Journal on Human Rights* 61; and Dhanda, Amita, "Constructing a New Human Rights Lexicon: Convention on the Rights of Persons with Disabilities" (2008) 5 (8) *International Journal on Human Rights* 43.

[83] Kämpf, Annegret, "Involuntary Treatment Decisions: Using Negotiated Silence to Facilitate Change?" *in* McSherry, Bernadette and Walker, Penelope, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), 129-150, 130. *See* further United Nations Enable, *Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities*

ratification of the CRPD in Ireland. Discussion is provided next of the requirements set down by the jurisprudence of the ECtHR in respect of ensuring that compulsion is a last resort course of action, and of the need for safeguards around its utilisation.

2.4.2 Liberty Claims under the ECHR and ESC

Article 5 of the ECHR protects the right to liberty. Fenwick makes the point that while the ECHR provides for protection for both one's liberty and one's security, the right to liberty has been interpreted in such a way as to mean a right to freedom from unlawful intrusion on one's physical liberty, rather than as meaning a right to protection of one's physical safety.[84]

Article 5 does not provide for an absolute right to liberty. Rather, Article 5(1) recognises that a person's liberty may, in a number of circumstances, be limited in accordance with a procedure set down at law. Of the circumstances listed, Article 5(1)(e) is of most interest in the area of mental health:

> Everyone has the right to liberty and security of person.
>
> No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> > (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants;

The remaining subsections of Article 5 contain protections for persons deprived of their liberty. A detained person must be informed of the reasons for their arrest (Article 5(2)); they must have access to a speedy review of their detention (Article 5(4)); and there must be an enforceable right to compensation for wrongful arrests or detentions (Article 5(5)).

(United Nations, U.N. Doc. A/HRC/10/48, 26th January 2009) <http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf> accessed 14 May 2011.

[84] Fenwick, Helen, *Civil Liberties and Human Rights*, 3rd ed. (London: Cavendish Publishing Limited, 2004), at 50.

Where the ECtHR finds that a detention within the meaning of Article 5 has occurred, it may nonetheless find that the detention is not objectionable, provided it meets the above requirements within Article 5. Within the area of mental health, in order to meet the standards mandated by the Convention, any deprivation of liberty must: (a) be in accordance with a procedure set down at law; (b) be effected because the person detained is currently suffering from a mental illness that warrants confinement for care and treatment; and (c) be subject to review by a body with the authority to order the release of the person detained.

Together with challenges to the meaning of 'detention' itself, and to the means adopted for determining whether or not a person is of 'unsound mind' under Article 5(1)(e), these requirements of 'reasons, review, and recompense', have formed the five planks of mental health service users' Article 5 human rights claims.

In the *Vagrancy Cases*,[85] the ECtHR narrowed the scope for States to argue the margin of appreciation in their decisions as to who should come within the scope of the Article 5(1)(e) exception to the guarantee of liberty. The Court refused to interpret Belgian municipal law on the definition of 'vagrant' (while accepting that the applicants were correctly defined as such under the terms of the Belgian law), but did engage in an assessment of what the meaning of 'vagrant' was for the purposes of Article 5(1)(e), and found that the applicants did not come within that meaning and accordingly their detention had been in contravention of their Convention rights.[86]

2.4.2 (a) Meaning of 'detention'

The ECtHR has given a number of judgments on the concept of 'detention' in which it has attempted to delineate the parameters of a deprivation of liberty sufficient to engage Article 5. In *Ashingdane v United Kingdom*[87] the ECtHR held that the applicant, who had been permitted on frequent occasions to leave the mental hospital in which he was being treated, had nonetheless been detained for the purposes of

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[85] *Vagrancy* Cases, Judgment of 18 June 1971, A 14.
[86] Fenwick, Helen, *Civil Liberties and Human Rights*, 3rd ed. (Cavendish Publishing Limited: London, 2004), at 53.
[87] *Ashingdane v United Kingdom* (1985) Application No. 8225/78, (1985) 7 EHRR 528.

Article 5. The court stated that the deciding factor was the fact that "his liberty, and not just his freedom of movement, has been constrained both in fact and in law".[88] Bartlett, Lewis and Thorold describe the type of restriction of liberty that the applicant in *Ashingdane* experienced as a 'long leash' deprivation of liberty.[89] Under the *Ashingdane* ruling, determinations of whether or not an Article 5 activating detention has occurred must take account of the type, duration, effects and manner of restraint employed. In *Amuur v France*[90] (a case concerning immigration law) detention was held to be a matter of degree or intensity rather than of nature or substance.

By contrast with the mental health cases, *Guenat v Switzerland*[91] concerned the detention of a suspect by police for questioning in relation to a crime. The applicant was invited to accompany police officers to a police station and it was his assertion that because he was not told he was free to resist that invitation that he was detained for the purposes of Article 5, and that the procedural safeguards mandated by the Convention were not granted to him. The ECtHR held that as no force was used, and the applicant was in reality free to leave, his detention in the police station did not violate Article 5. A greater degree of protection is thus afforded to a mental health patient as they are seen to be particularly vulnerable and therefore in need of a higher standard of protection.[92]

Some of the mental health law cases deal with the issue of patients who are 'de facto detained'. These patients are not formally detained in accordance with a civil commitment mechanism, and are ostensibly present in hospital on a voluntary basis. However, where these patients lack the capacity to understand that they are free to leave, a question arises as to whether they may in reality be detained within the meaning of Article 5, notwithstanding that a formal civil commitment mechanism has never been applied to them.

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[88] *Ashingdane v United Kingdom* (1985) Application No. 8225/78, (1985) 7 EHRR 528, para 42.
[89] Bartlett, Peter, Lewis, Oliver, and Thorold, Oliver, *Mental Disability and the European Convention on Human Rights* (Leiden: Brill, 2007), 35.
[90] *Amuur v France* (1996) Application No. 19776/92, (1996) 22 EHRR 533.
[91] *Guenat v Switzerland* (1995) Application No. 24722/94, (1995) 81-B DR 130.
[92] *Winterwerp v Netherlands* (1979) Application No. 6301/73, [1979] 2 EHRR 387 and *Herczegfalvy v Austria* (1992) Application No. 10533/83, [1992] 15 EHRR 437, both discussed in detail below.

If a person is detained within the meaning of Article 5, without a formal legal process to assess the validity of that detention having been made available to them, then a violation of Article 5 will have occurred. The landmark case in relation to de facto detained patients is *HL v United Kingdom*.[93] In that case, the ECtHR held that the detention of a non-protesting patient in a psychiatric institution amounts to a violation of Article 5, if a formal civil commitment process is not utilised. The absence of any use of force and the fact that the patient in question was at all times free to leave did not affect the court's determination that Article 5 had been breached. Under *HL*, a patient will be considered to be detained for the purposes of the Convention if he is not aware of his rights and he genuinely feels constrained.

Finally, in *L v Sweden* the applicant challenged a compulsory treatment order applied to him upon his discharge from hospital – the ECtHR held that a provisional discharge which contains a condition that the patient accept medical treatment on an outpatient basis is not a deprivation of liberty under Article 5.[94]

2.4.2 (b) Determination of 'unsound mind'

The requirement that detention be in accordance with law, requires the ECtHR to refer back to the domestic law of the respondent contracting party, and assess it against the standards mandated by the Convention.[95] As per *Aerts v Belgium*[96] the detention must be consistent with the purpose for which the person is detained. In the mental health context, this requires the detention to be of a therapeutic character and not just a 'warehousing' measure.

The second requirement, that the detained person must be currently suffering from a mental illness that warrants confinement for care and treatment, was laid down in the *Winterwerp* judgment. In that decision, the ECtHR was at pains to point out that while

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[93] *HL v United Kingdom* (2004) Application No. 45508/99, (2004) ECHR 471.
[94] *L v Sweden* (1986) Application No. 10801/84, (1986) 45 DR 18.
[95] In both *Van der Leer v Netherlands* (1990) Application No. 11509/85 (1990) 12 EHRR 567 and *DSE (Erkalo) v Netherlands* (1998) Application No. 23807/94, (1998) 28 EHRR 509 for example, where the detention challenged had failed to comply with the domestic requirements, a violation of Article 5 was found to have occurred as a result.
[96] *Aerts v Belgium* (1998) Application No. 25257/94, (1998) 29 EHRR 50.

the Convention does not define a 'person of unsound mind', the concept cannot legitimate the detention of a person because "his views or behaviour deviate from the norms prevailing in a particular society".[97] *Winterwerp* requires that any deprivation of liberty founded on the basis of the 'unsound mind' provision of Article 5(1)(e) must meet three requirements: (1) it must be grounded on objective medical expertise; (2) the mental illness involved must be of a kind or degree that warrants compulsory confinement (i.e. it is an illness that is of sufficient seriousness to justify a deprivation of liberty); and (3) the continuation of the confinement is dependant on the persistence of the illness and this is a matter that must be subject to ongoing review.

In *Kay v United Kingdom*,[98] the applicant's detention was held to have been in violation of his Article 5 rights, as there had been no consideration of current medical information when his detention was authorised.

The decision in *Johnson v United Kingdom*,[99] addressed the question of how rapidly a person must be released from detention after the illness that justified the confinement has resolved. In that case the three year delay in finding an appropriate facility to which the applicant could be discharged after it had been found that it was no longer appropriate to detain him, was not of itself a violation of Article 5, however, the lack of safeguards to prevent unwarranted delays from occurring could potentially amount to a violation. In *Johnson*, the applicant's medical team had encountered genuine difficulties in sourcing the appropriate levels of supervision required to support him after his discharge from hospital, and in those circumstances the court was not prepared to find that the delay was unwarranted.

In emergency situations a certain degree of flexibility in relation to the three *Winterwerp* criteria is considered necessary. In *X v United Kingdom*[100] the Commission stated that a wide discretion should be available to States in relation to emergency detentions and that in circumstances where the patient may pose an immediate public threat or might be at risk of suffering a serious deterioration in their health, then the requirement for an objective medical opinion may be waived.

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[97] *Winterwerp v Netherlands* (1979) Application No. 6301/73, [1979] 2 EHRR 387, § 37.
[98] *Kay v United Kingdom* (1998) 40 BMLR 20.
[99] *Johnson v United Kingdom* (1997) Application No. 22520/93, (1997) 27 EHRR 296.
[100] *X v United Kingdom* (1980) Application No. 6998/75 (1981) 4 EHRR 181.

However, a medical examination must occur promptly after the emergency admission has taken place. That case concerned a mental patient who was subject to a conditional discharge and was recalled to hospital for examination as it was felt that he was suffering from a relapse in his mental illness. The Commission felt that no violation of Article 5 had occurred, as the applicant was examined promptly upon readmission and was entitled to avail of a system of review of his detention.

Finally, in *LR v France*[101] the applicant had applied to a prosecutor and a court for immediate release following her transfer to a psychiatric hospital by the police after she had attended at a police station to make a complaint against another person. A delay of four days occurred between her application to the court and the court's decision to order her immediate release. The ECtHR held that this amounted to an unaccepted delay and a violation of Article 5 (4).

2.4.2 (c) Reasons, review, and recompense

Under Article 5 (4) a detained mental patient must have access to a review mechanism that will review his detention. The review body must be a 'court' in the sense of being a neutral arbitrator that follows the requirements of fair procedures; the review must occur within a reasonably prompt time frame; and the review body must have the power to order the release of a person if it finds that they have been unlawfully detained.

The decision in *X v United Kingdom*[102] requires that the review must be more than a mere formality, and must constitute a serious examination of the merits of the detention in accordance with both domestic and ECHR law. This case is also the authority for the requirement that the review body must have the power to order the release of a person found to have been unlawfully deprived of their liberty under Article 5.

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[101] *LR v France* (2002) Application No. 33395/96, judgment 27 June 2002 (available in French only). For a summary of this decision in English, see Mental Disability Advocacy Centre, *Summaries of Mental Disability Cases decided by the European Court of Human Rights* (Budapest: Mental Disability Advocacy Centre, 2007) <http://www.mdac.info/documents/ECHR_case_summaries_English.pdf> accessed 9 May 2011.

[102] *X v United Kingdom* (1980) Application No. 6998/75 (1981) 4 EHRR 181.

Under *Winterwerp*, the review body must be of a judicial character and must afford the expected procedural safeguards to all parties involved. It must be independent of both the parties and of the executive. While strict adherence to the letter of Article 6 of the ECHR is not mandated, the detained person must have an opportunity to present his case and to challenge the medical and social evidence presented in support of detention. In some instances special procedural safeguards must be in place to support the patient given their mental disability.[103]

The review of detention must take place within a reasonably prompt time period.[104] In *Koendjbiharie v Netherlands*[105] a period of four months was held to constitute an unreasonable delay; in *Van der Leer v Netherlands*[106] the offending period amounted to five months; and in *E v Norway*[107] – eight weeks. In *Musial v Poland*[108] the court held that the medical complexity of a case does not absolve the State of its obligation to initiate a prompt review of detention.

A slightly different system is applied in respect of forensic committals, as opposed to civil committal regimes. Where an offender is ordered by a court to be detained, the ECtHR accepts the court order as a satisfactory review of the lawfulness of the detention for the purposes of Article 5 (*Winterwerp*). The court order remains an effective review of detention for a period of time that is considered proportional to the gravity of the offence committed (*Silva Rocha v Portugal*[109]). A person detained as a forensic mental health patient under a court order of detention, is entitled to periodic reviews of detention in a similar fashion to those subject to a civil committal regime (*Weeks v UK*[110]).

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[103] *Winterwerp v Netherlands* (1979) Application No. 6301/73, [1979] 2 EHRR 387, § 60.
[104] In *Van der Leer v Netherlands* (1990) Application No. 11509/85 (1990) 12 EHRR 567 the ECtHR held that for this purpose, time begins to run from the time an application for release is lodged. Under the Mental Health Act 2001 no formal application for release is required before the time periods for review of a committal begin to run.
[105] *Koendjbiharie v Netherlands* (1990) Application No. 11487/85, (1990) 13 EHRR 820.
[106] *Van der Leer v Netherlands* (1990) Application No. 11509/85 (1990) 12 EHRR 567.
[107] *E v Norway (*1990) Application No. 11701/85 (1990) 17 EHRR 30.
[108] *Musial v Poland* (1999) Application No. 24557/94 (1999) ECHR 15.
[109] *Silva Rocha v Portugal* (1991) Application No. 18165/91, (2001) 32 EHRR 333.
[110] *Weeks v United Kingdom* (1988) Application No. 9787/82 (1988) 10 EHRR 293.

The most significant ECtHR decision in this area is *X v United Kingdom*.[111] In that decision, the ECtHR held that since mental illness is subject to amelioration and cure, all mental patients have the right to periodic judicial review. The applicant, as a forensic mental health patient, had no forum in which to challenge his detention which satisfied the requirements of *Winterwerp*. The Mental Health Review Tribunals could not order the release of a forensic mental health patient – they could merely advise the Home Secretary that his release was recommended. The Home Secretary, who could order his release, was not independent of the executive. The only other avenue open to the applicant was the common law writ of *habeas corpus*, which could only enquire as to the legal validity of detention and not its merits. This ECtHR decision led directly to the introduction of the Mental Health (Amendment) Act 1982 in the United Kingdom which established the Mental Health Act Commission and provided a mechanism by which forensic mental health patients could appeal to a court to have their detentions reviewed.

2.5 Autonomy, Bodily Integrity and Privacy Claims

Autonomy, bodily integrity, and privacy claims are founded on the concept that each individual person has the right to be the decision-maker in respect of what happens to their body. In the mental health context, it arises in cases where people wish to challenge the administration of particular treatments; compulsory admission and detention regimes; and the operation of mental health care regimes including pertaining to the keeping and processing of personal data.[112]

In the context of the mental health law reforms undertaken in Ireland with the introduction of the MHA 2001, the creation for the first time of detailed provisions in respect of consent to treatment are clear evidence of the importance to its framers of achieving compliance with the requirements of the rights to autonomy, bodily

[111] *X v United Kingdom* (1980) Application No. 6998/75 (1981) 4 EHRR 181.

[112] *See* for example *Herczegfalvy v Austria* (1992) Application No. 10533/83, (1992) 15 EHRR 437, discussed in detail below. *See* also Hogan, Gerard, "Unenumerated Personal Rights: Ryan's Case Reevaluated" (1990-1992) xxv-xxvii *Irish Jurist (n.s.)* 95; Humphreys, Richard, "Interpreting Natural Rights" (1993-1995) xxviii-xxx *Irish Jurist (n.s.)* 221; Murray, Claire, "Safeguarding the Right to Liberty of Incapable Compliant Patients with a Mental Disorder in Ireland" (2007) 29 *Dublin University Law Journal* 279; Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.

integrity and privacy in the new regime. The precise nature and scope of these rights under the international human rights instruments, and their meaning for mental health patients, is therefore important to the evaluation that is performed in this thesis of the degree to which the mental health law regime in Ireland has succeeded in achieving compliance with the international human rights model of protection of this category of human rights.

The right to autonomy is the right to be the decision-maker in respect of the actions one wishes to take, or the experiences one wishes to have. It has been been encapsulated by some writers as 'the right to say no.' Autonomy is, at its core, the individual's separateness and difference from other individuals, the right to refuse experiences others value or wish to share, and the right to choose experiences according to one's individual preferences rather than societal norms.

The right to bodily integrity is a facet of the rights to autonomy and to privacy. It is recognised in the Irish context as one among the penumbra of unenumerated rights protected by the Constitution. The right to bodily integrity is the right to decide what is done to, or put into, one's physical body. The importance of this right for mental health patients is immediately obvious in the context of legal regimes permitting compulsory treatment irrespective of the patient's wishes with regard to that particular treatment.

The right to privacy encompasses a right to keep the details of one's personal life secluded from scrutiny by others and also the rights to freedom of expression, association and religion. It includes the right to control of one's personal correspondence and of one's medical records. It also includes the right to a family life. These are issues which inevitably arise in the context of a compulsory mental health detention and treatment regime.

2.5.1 Autonomy, Bodily Integrity, and Privacy Claims under the UN Human Rights Instruments

All of the core UN human rights documents protect the rights to autonomy, bodily integrity, and privacy, in varying forms appropriate to that particular document.

Article 12 of the UDHR protects the right to freedom from arbitrary interference with privacy, family or home.[113] Article 17 of the ICCPR mandates the right to privacy as being of such vital importance that it must not be interfered with or infringed upon by the State, other than 'in accordance with law' where the limitation is necessary to protect national security; public order; public health or morals; or the rights and freedoms of others.[114] Article 3 of the CRPD identifies the right to 'individual autonomy including the freedom to make one's own choices, and independence of persons' as one of the guiding principles of the convention.[115] Articles 22 and 23 of the CRPD recognise the right to respect for privacy[116] and for one's home and family life.[117]

Articles 12 and 17 of the CRPD are also significant. Article 12 provides for equal recognition before the law and provides that the right to possess and to exercise legal capacity is to be protected. Kämpf has interpreted this provision as meaning that if a person suffers from a deficit in decision-making, this must not be a ground for excluding them from making decisions pertaining to their own rights – rather, the individual must always "remain an integral driver of decision-making" and support structures must be put in place to facilitate a person in the exercise of their capacity to

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[113] United Nations, *Universal Declaration of Human Rights*, (1948) G.A. Res. 217A, U.N. GAOR, 3rd Sess. U.N. Doc. A/311, Article 12.
[114] United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Article 17.
[115] United Nations, *Convention on the Rights of Persons with Disabilities* (New York: United Nations Secretariat Centre for Human Rights, 2008); (2006) G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611; 13 December 2006, 93 U.N.T.S. 3, Article 3.
[116] United Nations, *Convention on the Rights of Persons with Disabilities* (New York: United Nations Secretariat Centre for Human Rights, 2008); (2006) G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611; 13 December 2006, 93 U.N.T.S. 3, Article 22.
[117] United Nations, *Convention on the Rights of Persons with Disabilities* (New York: United Nations Secretariat Centre for Human Rights, 2008); (2006) G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611; 13 December 2006, 93 U.N.T.S. 3, Article 23.

the full degree of their capabilities.[118] Article 12 may in fact amount to an obligation to provide a formal structure for supported decision-making.[119] Article 17 provides for a right to respect for one's physical and mental integrity on a equal basis, whether one is a person with a disability or a person without a disability. As with Article 14, Article 17 is silent as to the lawfulness or otherwise of compulsory civil committal and compulsory treatment powers, although additional guidance has been provided by the UNHCR Thematic Study on enhancing awareness and understanding of the CRPD.[120]

In the case of *MG v Germany*[121] the Human Rights Committee considered the extent of Article 17 of the ICCPR in the context of an assessment of a person's capacity to participate in legal proceedings. The applicant had been ordered by a court to undergo an examination for the purposes of determining her capacity to take part in legal proceedings, and had thereafter been found to lack that capacity; without the court having seen the applicant, or having heard submissions from her in respect of the examination, the assessment of her capacity, or the proposed order restricting her ability to participate in legal proceedings. The Human Rights Committee held that where a person is ordered to undergo a medical examination, this is a substantial interference with their rights under Article 17 and has the potential to amount to an unlawful intrusion on their privacy. The Committee then held that for a medical examinations in this context to comply with Article 17 it must (a) be provided for by law; (b) be conducted in accordance with the provisions, aims and objectives of the ICCPR; and (c) be reasonable in all of the circumstances of the case.[122] In the instant case, the intrusion with the applicant's rights could not be considered reasonable in all

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[118] Kämpf, Annegret, "Involuntary Treatment Decisions: Using Negotiated Silence to Facilitate Change?" *in* McSherry, Bernadette and Walker, Penelope, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), 129-150, 140.

[119] Minkowitz, Tina, "Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities" *in* McSherry, Bernadette and Walker, Penelope, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), 151-178, 158-166.

[120] For further information *see* United Nations Enable, *Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities* (United Nations, U.N. Doc. A/HRC/10/48, 26th January 2009) <http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf> accessed 14 May 2011.

[121] *MG v Germany*, Communication No. 1482/2006, U.N. Doc. CCPR/C/93/D/1482/2006 (2 September 2008) <http://www1.umn.edu/humanrts/undocs/1482-2006.pdf> accessed 5 May 2011.

[122] *MG v Germany*, Communication No. 1482/2006, U.N. Doc. CCPR/C/93/D/1482/2006 (2 September 2008), § 10.1 <http://www1.umn.edu/humanrts/undocs/1482-2006.pdf> accessed 5 May 2011.

of the circumstances, most particularly in light of the failure on the part of the court to conduct an oral hearing prior to the making of the order, and as such the applicant's rights under Article 17 had been violated.[123]

The secondary UN human rights instruments recognise the right to privacy also. For example, the Mental Illness Principles explicitly reference the rights to privacy and confidentiality.[124] These rights apply to all people with a mental disability, irrespective of whether or not they reside in a mental health facility.

2.5.2 Autonomy, Bodily Integrity, and Privacy Claims under the ECHR and ESC

Article 8 of the ECHR protects the right to privacy. Article 8(1) prohibits public authorities from interfering with a person's right to respect for their private and family life; home; and correspondence, and imposes a positive obligation on the State to protect private and family life:

> Everyone has the right to respect for his private and family life, his home and his correspondence.

Under Article 8(2) it is only permissible to limit a person's rights under Article 8(1) where the limitation in question is considered necessary in a democratic society in the interest of public safety or the protection of the health, morals, or rights and freedoms of others, and the limitation in question is proportionate to the particular legitimate interest it is sought to protect:

> There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

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[123] *MG v Germany*, Communication No. 1482/2006, U.N. Doc. CCPR/C/93/D/1482/2006 (2 September 2008), § 10.2 <http://www1.umn.edu/humanrts/undocs/1482-2006.pdf> accessed 5 May 2011.

[124] United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (New York: United Nations Secretariat Centre for Human Rights, 1991); (1991) G.A. Res. 119, U.N. GAOR, 46th Sess., U.N. Doc. A/46/49, Supp. No. 49, Annex, 188-92.

In *Herczegfalvy v Austria*[125] the ECtHR found that interference by a mental hospital in the applicant's personal correspondence amounted to a violation of Article 8.

Where limitations are imposed on patients receiving family visits, or where patients are deprived of their autonomy or liberty despite family objections, Article 8 may also be engaged in addition to Article 5. In *JT v United Kingdom*[126] Article 8 was found to have been breached where a mental health patient was prevented from applying to a court to change her 'nearest relative' under the Mental Health Act 1983. The violation of Article 8 occurred because the nearest relative would have access to the applicant's personal information during her Mental Health Tribunal hearings, and her inability to change the appointed nearest relative meant that a person she distrusted would have access to information she desired would be kept private from that person.

2.6 Fair Procedures Claims

Fair procedures claims are grounded in an argument that where a person's rights are adjudicated by a legal process, they are entitled to expect that the legal process will be fair in the adjudication of questions of law concerning rights and obligations.[127]

In the criminal context fair procedures means the 'right to a fair trial', i.e., the presumption of innocence; the right to know the evidence to be brought forward; the right to address the court in one's defence; and the right to a competent and neutral judge of one's guilt or innocence.

In the private law context, it means the right to have one's dispute heard and adjudicated on by a competent and unbiased judge or tribunal that hears both sides of the dispute and issues a reasoned decision that is capable of being lawfully enforced.

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[125] *Herczegfalvy v Austria* (1992) Application No. 10533/83, (1992) 15 EHRR 437.
[126] *JT v United Kingdom* (1997) Application No. 26494/95 (2000) ECHR 133.
[127] *See* Cook, Timothy, "Substantive Due Process Rights of Mentally Disabled Clients" (1983) 7 (4) *Mental Disability Law Reporter* 346, Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.

In mental health law, the right to fair procedures arises in respect of the manner and form of decisions to detain and treat patients without their consent, and in the availability and format of the means of reviewing those decisions. It has obvious application in compulsory admission, detention and treatment cases, and in the regulation of the operation of review mechanisms to oversee decisions taken under the mental health regime.[128]

The MHA 2001 introduces an automatic mechanism whereby all decisions to compel the admission and detention of a person for mental health treatment (and certain decisions to compel mental health treatment) are subject to review by an independent tribunal with the power to order the overturning of the decision if is found to have been unjustified. The new review procedures were introduced due to an awareness that Irish mental health law as it stood prior to the MHA 2001 did not succeed in measuring up to the model of fair procedures protections that is established at the international human rights level, most particularly under the ECHR. A clear description of the requirements expected by the international human rights vision of fair procedures is therefore crucial to the 'human rights audit' performed in Chapter 5 of this work, when the degree of success of the new provisions in achieving the sought after international human rights norms compliance is evaluated.

2.6.1 Fair Procedures Claims under the UN Human Rights Instruments

Article 14(1) of the ICCPR enshrines the right to a fair trial, providing that all persons shall be equal before courts and tribunals. General Comment 32 of the Human Rights Committee states that this provision applies as follows:

> The right to a fair and public hearing by a competent, independent and impartial tribunal established by law is guaranteed, according to the second sentence of article 14, paragraph 1, in cases regarding the determination of criminal charges against individuals or of their rights and obligations in a suit at law. Criminal charges relate in principle to acts declared to be punishable under domestic criminal law. The notion may also extend to acts that are criminal in nature with sanctions that, regardless of their qualification in

[128] *See* for example *Winterwerp v Netherlands* (1979) Application No. 6301/73, (1979) 2 EHRR 387, discussed in detail below.

> domestic law, must be regarded as penal because of their purpose, character or severity.[129]

Article 14(1) also applies in the following circumstances:

> The concept encompasses (a) judicial procedures aimed at determining rights and obligations pertaining to the areas of contract, property and torts in the area of private law, as well as (b) equivalent notions in the area of administrative law such as the termination of employment of civil servants for other than disciplinary reasons, the determination of social security benefits or the pension rights of soldiers, or procedures regarding the use of public land or the taking of private property. In addition, it may (c) cover other procedures which, however, must be assessed on a case by case basis in the light of the nature of the right in question.[130]

Article 14(3) provides a set of minimum criteria that must be met for a hearing to be considered fair under the UDHR. These include the right to be informed of the charges against one, in a language one can understand; being allowed adequate time and facilities to prepare a defence; to be tried without undue delay; not to be tried in one's absence; and to have a right of appeal to a higher tribunal or court.[131]

2.6.2 Fair procedures Claims under the ECHR and ESC

Article 6 of the ECHR guarantees the right to due process of law:

> 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. Judgement shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interest of morals, public order or national security in a democratic society, where the interests of juveniles or

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[129] United Nations Office of the High Commissioner for Human Rights, *General Comment 32 of the Committee on Human Rights: Article 14: The Right to Equality before Courts and Tribunals and to a Fair Trial (CCPR/C/CG/32)* (Geneva: UNHCR, 2007) § 15 <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G07/437/71/PDF/G0743771.pdf?OpenElement> accessed 28 August 2010.

[130] United Nations Office of the High Commissioner for Human Rights, *General Comment 32 of the Committee on Human Rights: Article 14: The Right to Equality before Courts and Tribunals and to a Fair Trial (CCPR/C/CG/32)* (Geneva: UNHCR, 2007) § 16 <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G07/437/71/PDF/G0743771.pdf?OpenElement> accessed 28 August 2010.

[131] United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Article 14 (3).

the protection of the private life of the parties so require, or the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.

Everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.

Everyone charged with a criminal offence has the following minimum rights:

(a) to be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusation against him;

(b) to have adequate time and the facilities for the preparation of his defence;

(c) to defend himself in person or through legal assistance of his own choosing or, if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require;

(d) to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;

(e) to have the free assistance of an interpreter if he cannot understand or speak the language used in court.[132]

Helen Fenwick describes Article 6 as the ECHR right "which is most frequently found to have been violated" – a fact she ascribes to the breadth of the right, covering numerous circumstances, including where a substantive claim under another Article may fail but the Article 6 procedural claim may succeed.[133]

2.6.2 (a) 'Civil rights and obligations'

Article 6 protects a person who is accused of a 'criminal charge' or whose 'civil rights and obligations' fall for legal determination. An analysis of Article 6 in the criminal context, and its application in the mental health context is a task that is beyond the scope of this work. The meaning of a 'determination of civil rights and obligations' has been addressed by the ECtHR – the particular characteristics of the right or obligation as they are considered by the national legislatures is not the crux of the

[132] European Convention on Human Rights, Article 6.
[133] Fenwick, Helen, *Civil Liberties and Human Rights*, 3rd ed. (London: Cavendish Publishing Limited, 2004), at 58.

Convention definition; rather the Court will look to the content and effect of the right or obligation in question and whether it could be considered possible to ascribe 'civil right' or 'civil obligation' meaning to it.[134]

In *Matter v Slovakia*[135] the ECtHR held that any finding of mental incapacity to acquire rights and undertake obligations will come within Article 6.[136] Similarly, in *Bock v Germany*[137] the placement of a person into guardianship was held to come within Article 6, and under *B v United Kingdom*,[138] determinations of a person's access rights to their child were held to be encompassed within Article 6. In *Golder v United Kingdom*,[139] the ECtHR held that it must be open to a person to address any claim relating to civil rights or obligations to a court or tribunal of law. This right may be limited: if the limitation is based on a legitimate aim; if the limitation is proportionate to the aim sought; and if the limitation does not restrict access to justice to such an extent as to render the very essence of the right itself to be impaired.[140]

The most recent ECtHR decision in which the Article 6 guarantee to fair procedures was considered in the mental health context is *Shtukaturov v Russia*,[141] a case in which a mental health patient appealed against a judicial decision that he should be deprived of legal capacity. The ECtHR stated that:

> In the context of Article 6 § 1 of the Convention, the Court assumes that in cases involving a mentally ill person the domestic courts should also enjoy a certain margin of appreciation. Thus, for example, they can make the relevant procedural arrangements in order to secure the good administration of justice, protection of the health of the person concerned, etc. However, such measures should not affect the very essence of the applicant's right to a fair trial as guaranteed by Article 6 of the Convention. In assessing whether or not a particular measure, such as exclusion of the applicant from a hearing, was necessary, the Court will take into account all relevant factors (such as the nature and complexity of the issue before the domestic courts, what was at

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[134] *O v United Kingdom* (1987) 10 EHRR 82. *See* Fenwick, Helen, *Civil Liberties and Human Rights*, 3rd ed. (London: Cavendish Publishing Limited, 2004), at 59.
[135] *Matter v Slovakia* (1999) Application No. 31534/96, (2001) 31 EHRR 31.
[136] *Osman v United Kingdom* (1998) Application No. 23452/94 (1999) 25 EHRR 245.
[137] *Bock v Germany* (1989) Application No. 11118/84, (1989) 12 EHRR 247.
[138] *B v United Kingdom* (1977) Application No. 6870/75, Commission decision.
[139] *Golder v United Kingdom* (1975) Application No. 4451/70 (1975) 1 EHRR 524.
[140] *Osman v United Kingdom* (1998) Application No. 23452/94 (1999) 25 EHRR 245.
[141] *Shtukaturov v Russia* (2008) Application No. 44009/05, judgment made final 27 June 2008.

> stake for the applicant, whether his appearance in person represented any threat to others or to himself, etc.).[142]

The Court further stated that:

> In a number of previous cases (concerning compulsory confinement in a hospital) the Court confirmed that a person of unsound mind must be allowed to be heard either in person or, where necessary, through some form of representation – see, for example, *Winterwerp*, cited above, § 60. In *Winterwerp* the applicant's freedom was at stake. However, in the present case the outcome of the proceedings was at least equally important for the applicant: his personal autonomy in almost all areas of life was at issue, including the eventual limitation of his liberty.[143]

This represents a welcome expansion of the principle in *Winterwerp*, to encompass determinations not just of the patient's right to liberty, but also of his right to personal autonomy. Given the significant ramifications of a finding that a person is not vested with legal capacity, that fair procedures are followed in the making of such a finding is clearly of enormous importance. It remains to be seen whether the fair procedures obligations may be further extended to encompass decisions concerning certain kinds of medical treatment.

2.6.2 (b) Access to a court or tribunal

In *Winterwerp v Netherlands* the Court stated that it may, in certain circumstances, be legitimate to curtail a person's right to exercise their rights under Article 6 on the grounds of mental illness. However, a blanket prohibition on a detained person dealing with their property, without any consideration being given to their capacity to do so, amounts to an infringement of Article 6.[144] As is noted above, *Winterwerp* is the seminal Article 5 right to liberty case. It requires that a person of unsound mind cannot lawfully be detained solely because "his views or behaviour deviate from the norms prevailing in a particular society",[145] and that to lawfully detain a person on the grounds of unsoundness of mind, the additional requirements of objective medical

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[142] *Shtukaturov v Russia* (2008) Application No. 44009/05, judgment made final 27 June 2008, at § 68.
[143] *Shtukaturov v Russia* (2008) Application No. 44009/05, judgment made final 27 June 2008, at § 71.
[144] *Winterwerp v Netherlands* (1979) Application No. 6301/73, (1979) 2 EHRR 387, § 75.
[145] *Winterwerp v Netherlands* (1979) Application No. 6301/73, (1979) 2 EHRR 387, § 37.

expertise underpinning the decision; the mental infirmity being of such a degree as to warrant the deprivation of liberty; and the ongoing review of the persistence of the illness, must be met. The final of these requirements clearly engages Article 6 in requiring that there must be a means for ongoing determination by an independent legal tribunal of the basis for the determination of the ongoing necessity of the curtailment of the detained person's right to liberty.[146]

In *Ashingdane v United Kingdom*,[147] the applicant alleged that the limitations placed on his right to litigate, where his proposed litigation was believed to be unlikely to succeed, amounted to a violation of Article 6 of the Convention. The respondent State successfully argued, that the restrictions in question were justified on the grounds that mentally ill patients bring vexatious litigation. Despite the respondent State providing no evidence to support this assumption, the ECtHR was prepared to accept it as a legitimate justification of the restriction of Article 6 fair procedures rights. The effect of this judgment is that if a person who is detained as a mental health patient wishes to litigate a claim that is likely to fail, then he can be barred from access to the courts, notwithstanding the fact that no such limitation is imposed on mentally healthy people who bring actions that are likely to fail. It is difficult to reconcile this decision with the later decision in *Osman v United Kingdom*, in which police immunity from actions in negligence for a failure to prevent the commission of a crime was found to be an unjustifiable restriction on the right of access to the courts, and as such it amounted to a breach of the applicant's Article 6 Convention rights.[148]

2.6.2 (c) Independence and impartiality

The hearing provided must be independent of external influence, and must not demonstrate bias in favour of one party over another. In *Shtukaturov*, the applicant was represented in the proceedings determining his legal capacity only by representatives of the psychiatric hospital where he was detained. The hearing lasted

[146] *Winterwerp v Netherlands* (1979) Application No. 6301/73, (1979) 2 EHRR 387, § 75.
[147] *Ashingdane v United Kingdom* (1985) Application No. 8225/78, (1985) 7 EHRR 528.
[148] *Osman v United Kingdom* (1998) Application No. 23452/94 (1999) 25 EHRR 245.

approximately ten minutes and the hospital representatives played a passive role in it.[149] Accordingly, the Court held that a violation of Article 6 had occurred.

Article 6 requires that the court or tribunal to which complaints are addressed must be: established by law, independent of the Executive, and impartial.[150] The Court may engage in examination of the appointment of judges or adjudicators, their terms of office, and the protections in place to ensure their impartiality.[151] Allegations of bias are assessed both objectively and subjectively.[152]

2.6.2 (d) Speedy review

Determination of civil rights and obligations must be available to applicants within a 'reasonable' period of time or a violation of Article 6 will be held to have occurred. The standard of what amounts to a 'reasonable' period of time is variable depending on the circumstances of the individual case. The Court may give consideration to whether the applicant may be considered to have contributed to the delay.

2.6.2 (e) Other aspects of Article 6

Article 6 has also been interpreted to guarantee the following: equality of arms;[153] a non-absolute right to be present in person at the hearing;[154] an adversarial hearing;[155] the opportunity to comment on all evidence adduced;[156] the right to summon witnesses;[157] the right to disclosure of evidence;[158] and a reasoned judgment.[159]

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[149] *Shtukaturov v Russia* (2008) Application No. 44009/05, judgment made final 27 June 2008, at § 74.
[150] *See Zand v Austria* (1978) 15 DR 70 and *Benthem v Netherlands* (1985) 8 EHRR 1. In the mental health context specifically, *see Winterwerp v Netherlands* (1979) Application No. 6301/73, (1979) 2 EHRR 387.
[151] *Bryan v UK* (1995) 21 EHRR 342.
[152] *Pullar v UK* (1996) 22 EHRR 391.
[153] *De Haes and Gijsels v Belgium* (1997) 25 EHRR 1.
[154] *Colloza v Italy*, Judgment of 12 February 1985, A 89 (1985).
[155] *Ruiz-Mateos v Spain* (1993) 16 EHRR 505.
[156] *Mantovanelli v France* (1997) 24 EHRR 370.
[157] *X v Austria*, Application No. 5362/72, Coll 42 (1973), p145.
[158] *Edwards v United Kingdom* (1992) 15 EHRR 417.
[159] *Hadjianastassiou v Greece* (1992) 16 EHRR 219, at § 33.

2.7 Freedom from Torture and Inhuman and Degrading Treatment or Punishment Claims

Claims founded in the right to freedom from torture and from inhuman and degrading treatment or punishment frequently arise alongside claims that a person's rights to liberty and to autonomy, bodily integrity, and privacy have been infringed. The connection between the two categories of rights is clear – where a person is alleging that they have been tortured, or treated in an inhuman or degrading fashion, the treatment complained of is almost certainly bound to amount to at least one of a deprivation of liberty, an unlawful curtailment of autonomy, or a wrongful invasion of bodily integrity or privacy.[160]

The inclusion in the MHA 2001 of a comprehensive set of protections around the area of consent to treatment demonstrates the importance of the right to freedom from torture and from inhuman and degrading treatment and punishment in Ireland's new human rights based mental health law regime. By closely regulating the provision of mental health treatment in this fashion the drafters of the MHA 2001 hoped to ensure that Irish law in this area would measure up successfully to the international human rights expectations. An account is provided here of the meaning and scope of those international human rights expectations, in order to underpin the assessment in Chapter 5 of the extent to which those hopes have been fulfilled.

The right to freedom from torture and inhuman and degrading treatment or punishment is a significant right that is non-derogable in both the UN rights regime and the European rights regime. This means that a State is never permitted in sanctioning or permitting acts of torture or inhuman and degrading treatment or punishment to occur, even in times of national emergency.

At the UN level, the monitoring and reporting agencies have avoided engaging in an analysis of where the dividing line between 'torture' and 'inhuman and degrading treatment or punishment' should be drawn. In the European human rights framework,

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[160] Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.

the dividing line between treatment that amounts to torture, and treatment that is inhuman or degrading, is the presence of an invidious purpose on the part of the aggressor who metes out the treatment that is complained of.[161]

An individual action such as particular methods of interrogation (for example sleep deprivation) or specific physical acts such as beatings or strippings, may of itself constitute torture or inhuman or degrading treatment or punishment. Alternatively, it may be an overall regime or system that is alleged to be torturous or inhuman or degrading (for example a blanket policy of solitary confinement). While torture claims have not fared well in mental health cases, claims in which involuntary detention (particularly detentions in the absence of any therapeutic purpose) or particular forms of treatment have been argued to amount to inhuman or degrading treatment have fared better.[162]

2.7.1 Freedom from Torture and Inhuman and Degrading Treatment and Punishment Claims under the UN Human Rights Instruments

Article 7 of the ICCPR prohibits torture and inhuman and degrading treatment or punishment. Rehman describes Article 7 as having as its fundamental objective "the protection of the dignity as well as the mental and physical integrity of an individual."[163]

Article 10(1) of the ICCPR provides a right for persons lawfully deprived of their liberty to be treated with humanity:

> All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.[164]

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[161] *Ireland v United Kingdom* (1971) Application No. 5310/71, (1978) 2 EHRR 25.
[162] *See* for example *Herczegfalvy v Austria* (1992) Application No. 10533/83, (1992) 15 EHRR 437, discussed in detail below.
[163] Rehman, Javaid, *International Human Rights Law*, 2nd ed. (Essex: Perason Education Limited, 2010), at 96.
[164] United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Article 10 (1). Articles 10 (2) and 10 (3) provide specific protection for persons deprived of their liberty under the criminal justice system.

The Human Rights Committee has stated that this provision applies to mental health detentions,[165] and that no derogation from its provisions is permissible:

> [t]reating all persons deprived of their liberty with humanity and with respect for their dignity is a fundamental and universally applicable rule. Consequently, the application of this rule, as a minimum, cannot be dependent on the material resources available in the State party. This rule must be applied 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.[166]

By contrast with the jurisprudence on torture, 'inhuman or degrading treatment' does not require a malevolent intent on the part of the aggressor. The UN Torture Declaration even goes so far as to assert that 'inhuman and degrading treatment' should be interpreted "so as to extend to the widest possible protection against abuses, whether physical or mental."[167]

2.7.2 Freedom from Torture and Inhuman and Degrading Treatment and Punishment Claims under the ECHR and ESC

Article 3 of the ECHR contains an unequivocal prohibition on all forms of torture, and cruel or inhuman or degrading treatment or punishment, and significantly there is no provision for any form of derogation:

> No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Derogation from Article 3 is not permitted in any circumstances.

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[165] United Nations Office of the High Commissioner for Human Rights, *General Comment 21 of the Committee on Human Rights: Replaces General Comment 9 Concerning Humane Treatment of Persons Deprived of Liberty* (Geneva: UNHCR, 1992) para 4. <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/3327552b9511fb98c12563ed004cbe59?Opendocument> accessed 24 May 2010.

[166] United Nations Office of the High Commissioner for Human Rights, *General Comment 21 of the Committee on Human Rights: Replaces General Comment 9 Concerning Humane Treatment of Persons Deprived of Liberty* (Geneva: UNHCR, 1992) para 4. <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/3327552b9511fb98c12563ed004cbe59?Opendocument> accessed 24 May 2010.

[167] United Nations, *Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, G.A. res. 3452 (XXX), annex, 30 U.N. GAOR Supp. (No. 34) at 91, U.N. Doc. A/10034 (1975) 9 December 1975, 297.

In a number of cases the ECtHR has considered the meaning of 'torture' and 'inhuman treatment or punishment'. In *The Greek Case*[168] the ECtHR held that torture is inhuman treatment that has a purpose such as obtaining information or confession or the infliction of punishment.

In *Ireland v UK*[169] the ECtHR further described torture as having a special stigma involving deliberate inhuman treatment causing very serous and cruel suffering. It is reasonable to interpret these cases as meaning that torture is the most serious level of inhuman and degrading treatment, and that for a finding of torture to be made, it is necessary to demonstrate unlawful behaviour and an invidious purpose in the aggressor's actions.[170] As a result, torture is unlikely to apply to most mental health cases, unless some anti-therapeutic or unethical motive to the admission, detention, or administration of treatment is shown (Gostin gives the example of political oppression[171]).

In *Ireland v UK* the ECtHR held that treatment will be 'inhuman' if it reaches a level of gravity involving considerable mental or physical suffering; and will be 'degrading' if the person has undergone humiliation or debasement involving a minimum level of severity. Relevant factors to be borne in mind in evaluating these thresholds include: the nature, context, manner and duration of the treatment; its physical and mental effects; and the victim's gender, age and state of health (including mental health).[172]

One of the leading cases on mental health rights in ECHR jurisprudence is an Article 3 case – *Herczegfalvy v Austria*.[173] In this ruling, building on the line of jurisprudence

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[168] *Greek Case* (1969) Report of 5 November (1969) 12 YB 1.
[169] *Ireland v United Kingdom* (1971) Application No. 5310/71, (1978) 2 EHRR 25.
[170] For a more detailed discussion of the meaning of 'torture' *see* the United Nations, *Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, G.A. res. 3452 (XXX), annex, 30 U.N. GAOR Supp. (No. 34) at 91, U.N. Doc. A/10034 (1975) 9 December 1975, which discusses the intention requirement in respect of torture in great detail.
[171] Gostin, Lawrence O., "Human Rights of Persons with Disabilities: The European Convention on Human Rights" (2000) 23(2) *International Journal of Law and Psychiatry* 125, at 149.
[172] *Ireland v United Kingdom* (1971) Application No. 5310/71, (1978) 2 EHRR 25.
[173] *Herczegfalvy v Austria* (1992) Application No. 10533/83, (1992) 15 EHRR 437.

from *Ireland v UK*, the ECtHR delivered a powerful message with respect to interpretation of the rights of people in mental health institutions:

> ...the position 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.[174]

However, *Herzcegfalvy* is not without its faults and has been subject to criticism for an overly deferential approach to medical authorities' decisions regarding compulsory detention and treatment. Under the precedent in *Herczegfalvy*, in determining whether or not a patient has suffered inhuman or degrading treatment, the ECtHR at all times defers to the medical authorities at the institution with respect to the therapeutic methods used (including as to whether these methods required administration by force). Gostin is highly critical of this approach, arguing that it is too deferential to the medical professionals and that what the ECtHR has done is to adopt "a medically oriented standard that requires the government to demonstrate that the treatment was prescribed under internationally recognised mental health standards" and to demonstrate nothing more than that.[175] The effect of this deferment to the medical model is to neuter the protections granted in the sensitive approach to interpreting what constitutes inhuman treatment in the psychiatric setting.

Under *Herczegfalvy*, almost anything can be done once it is done under the auspices of medical science, and only actions which can be see to blatantly lack a therapeutic aim will be scrutinised for inhumanity or degradation. This is an overly high hurdle for the applicant to overcome, and perhaps it is unsurprising then that the ECtHR has never found conditions in a psychiatric institution to be so inhuman or degrading as to violate Article 3. In no instance has the Strasbourg court found that a psychiatric institution has engaged in activity abhorrent enough to violate Article 3, despite several cases before it containing harrowing accounts of severe maltreatment; neglect; humiliation; and placement in punitive or unsafe environments.[176]

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[174] *Herczegfalvy v Austria* (1992) Application No. 10533/83, (1992) 15 EHRR 437, § 82.

[175] Gostin, Lawrence O., "Human Rights of Persons with Disabilities: The European Convention on Human Rights" (2000) 23 (2) *International Journal of Law and Psychiatry* 125, 150.

[176] By way of contrast, see the discussion of the attitude adopted to the compulsory administration of psychiatric treatments to patients with a disability in the *United Nations Special Rapporteur's Interim Report on Torture and other Cruel, Inhuman and Degrading Treatment or Punishment* provided in Minkowitz, Tina, "Abolishing Mental Health Laws to Comply with the Convention on the Rights of

Thus, while the ECtHR has held that a complete absence of any opportunity for recreation or exercise will amount to an Article 3 violation (*McFeeley v UK*[177]), keeping a patient in permanent restraint will not amount to a violation where a psychiatrist avers that the restraint was a part of the patient's treatment plan (*Hilton v United Kingdom*;[178] *Dhoest v Belgium*;[179] *Storck v Germany*[180]). This deference was maintained even in *Hilton v UK*, where though the applicant had described himself as having been reduced to a state 'like an animal, to such an extent he would roll in his own excrement,' the Commission found no violation of Article 3.[181]

In *Dhoest v Belgium* it was held that although a persons' revolt or non-cooperation does not excuse inhuman and degrading treatment, it may be taken into account in determining whether restraint (in the instant case, the restraint was of both the physical and chemical natures) violates Article 3. In other words, the more a patient protests to an invasion of his rights, the less likely it is that the ECtHR will find that his rights have been violated. In *Aerts v Belgium* it was held that the living conditions in a psychiatric institution must "demonstrably" have "serious effects" on the patient's mental health before a violation of Article 3 will be found. Given that people in full mental health are rarely admitted to psychiatric institutions in the first place, this test is virtually impossible for any applicant alleging an Article 3 violation in a mental health facility to satisfy.

Persons with Disabilities" *in* McSherry, Bernadette and Walker, Penelope, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), 151-178, 172-176. *See* also the discussion in Hunt, Paul and Mesquita, Judith, "Mental Disabilities and the Human Right to the Highest Attainable Standard of Health" (2006) 28 *Human Rights Quarterly* 332 of the decision of the Inter-American Commission on Human Rights in *Victor Rosario Congo v Ecuador* (Case No. 11.427, Inter-American Commission on Human Rights, Report No. 63/1999, OEA/Ser.L/V/II.102 doc. 6 rev. (1998)) in which violations of the physical integrity, life, and judicial protection under the Inter-American Convention on Human Rights were found to have occurred in a case in which a patient in a rehabilitative centre was denied psychiatric care, and further, following a blow to the head was denied medical care, and thereafter was left in isolation for 40 days, until his death.

[177] *McFeeley v United Kingdom* (1980) Application No. 8317/78, decision of the Commission (1980) 20 DR 44.

[178] *Hilton v United Kingdom* (1976) Application No. 5613/72, decision of the Commission (1976) 4 DR 177.

[179] *Dhoest v Belgium* (1987) Application No. 10448/83, decision of the Commission (1987) 55 DR 5, (1987) 23 EHRR 97.

[180] *Storck v Germany* (2005) Application No. 61603/00 (2005) 43 EHRR 96.

[181] *Hilton v United Kingdom* (1976) Application No. 5613/72, decision of the Commission (1976) 4 DR 177, (1978) 3 EHRR 104 at § 126. *See* Gostin, Lawrence O., "Human Rights of Persons with Disabilities: The European Convention on Human Rights" (2000) 23 (2) *International Journal of Law and Psychiatry* 125, at 150-152 for a detailed discussion of these cases and a criticism of the *Herczegfalvy* deference.

In *B v UK* while the court recognised that the overall circumstances of the applicant's confinement were appalling, it nonetheless held that the absence of one single incident of inhuman or degrading treatment meant there had been no violation of Article 3. Gostin interprets this as meaning that the ECtHR will not "take cognisance of the totality of conditions in the absence of a single factor that was so gross as to shock the conscience."[182] *B v UK* fails to take account of everyday human reality, where more often than not it is a general regime that is brutal (or inhuman), rather than one single isolated incident.

The 'invidious motive' threshold is not applied to cruel and inhuman or degrading treatment or punishment. However, while the *Herzcegfalvy v Austria*[183] and *Winterwerp v Netherlands*[184] judgments make it explicitly clear that any treatment given in a mental health context without a therapeutic intention is a violation of Article 3, and that the test for what amounts to 'cruel and unusual' treatment must take account of the uniquely vulnerable position of the mental health patient, the Strasbourg court has to date never found a violation of Article 3 to have occurred in any of the mental health cases that have been pleaded before it. It would be naïve to imagine that this is due to a complete absence of inhumane treatment of mental health patients across Europe. The reality is that the *Herzcegfalvy* and *Winterwerp* jurisprudence means that in all cases where cruel and inhuman or degrading treatment or punishment is alleged in a mental health context, the Strasbourg court must apply deference where any clinical link, no matter how small, can be established between the treatment in question and the patient's medical care.

A further constraining aspect of the ECtHR's jurisprudence on Article 3 is that under *B v UK*, the court has held that it will not be prepared to consider the totality of a patient's conditions in assessing whether a violation of Article 3 has occurred. In other words, in order for the court to find that a violation has occurred, there must be one single identified act which is capable, when singled out, of being found to amount to an Article 3 violation. If it is an overall regime or a set of prevailing conditions that

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[182] Gostin, Lawrence O., "Human Rights of Persons with Disabilities: The European Convention on Human Rights" (2000) 23 (2) *International Journal of Law and Psychiatry* 125, 151.
[183] *Herczegfalvy v Austria* (1992) Application No. 10533/83, (1992) 15 EHRR 437.
[184] *Winterwerp v Netherlands* (1979) Application No. 6301/73, (1979) 2 EHRR 387.

are alleged to be torturous or inhuman, no violation will be found. This is a significant hurdle to overcome in the mental health context, where often it is the totality of a regime that a patient finds inhuman, rather than any one individual act capable of being singled out for challenge on its own.

In this light, the friendly settlement reached in *A v UK*[185] is of interest. In that case, the applicant had endured five weeks' seclusion with limited exercise or association with other people. The friendly settlement included an *ex gratia* payment to the applicant and a requirement that new working guidelines for seclusion at Broadmoor Hospital be introduced. The *A v UK* challenge demonstrates that notwithstanding Strasbourg's reluctance to admit of Article 3 violations in psychiatric institutions, it is nonetheless possible to use Article 3 to effect improvements in the conditions in these institutions.

Two Article 5 cases (on the right to liberty) also touched on issues related to Article 3. In *Ashingdane* and *Dhoest* the ECtHR rejected the argument that a relationship may exist between the actual detention (which is an Article 5 issue) and the conditions of confinement (which is considered an Article 3 issue) in psychiatric institutions. However, in *Ashingdane*, the court held that any detention of a person of unsound mind is 'lawful' only if effected in a 'hospital, clinic, or other appropriate institution'. Taking up this point, in *Aerts v Belgium*, the court stated that persons with mental illness must be confined in a 'minimally therapeutic environment'.[186] If such an environment is not provided the proper relationship between the aim of the detention and the conditions in which it takes place is deemed 'deficient'. In the instant case the relationship was satisfied, and it remains to be seen whether the *Aerts* ruling will result in an Article 3 declaration against a psychiatric declaration at some point in the future.

Ireland is also a signatory to the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. This is designed to supplement the protections afforded by Article 3 of the ECHR, through making provision for visits to signatory states by representatives of the European Committee for the

[185] *A v United Kingdom* (1980) Application No. 6840/74, (1980) 3 EHRR 131.
[186] *Aerts v Belgium* (1998) Application No. 25257/94, (1998) 29 EHRR 50.

Prevention of Torture and Inhuman or Degrading Treatment or Punishment. The most recent report in relation to Ireland is from 2006. A visit occurred in early 2010, with the delegation's remit being as follows:

> The delegation assessed progress made since the previous visit in 2006 and the extent to which the Committee's recommendations have been implemented. Particular attention was paid to the conditions of detention of persons in prison, and to the care afforded to patients in psychiatric institutions. The operation of the various safeguards in place in An Garda Síochána (Police) Stations was also examined, and the delegation visited for the first time in Ireland an establishment for the intellectually disabled.[187]

The Committee's report from the 2002 visit raised a number of concerns in relation to the prevailing conditions at both the Central Mental Hospital and in the facilities for persons with intellectual disabilities visited.[188] In particular, in relation to the detention of persons with intellectual disabilities, the Committee expressed the following concerns:

> The Committee has nonetheless expressed concern about the absence of a clear legal or administrative framework for involuntary admission to establishments for mentally disabled persons. It has recommended that the legal situation of persons placed in mental disability facilities be reviewed as a matter of urgency and that action be taken with a view to providing a comprehensive legal framework for such institutions, offering an adequate range of safeguards to persons placed in them.[189]

The Irish government, in its 2003 response to the Committee's report, chose not to comment on the portions of that report addressing the detention of persons with intellectual disabilities.[190]

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[187] Council of Europe, *Council of Europe and anti-torture Committee visits Ireland* <http://www.cpt.coe.int/documents/irl/2010-02-09-eng.htm> accessed 24 May 2010.

[188] Council of Europe, *Council of Europe, Report to the Government of* Ireland *on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 20 to 28 May 2002*, CPT/Inf (2003) 36 <http://www.cpt.coe.int/documents/irl/2003-36-inf-eng.htm#_Toc29353559> accessed 24 May 2010.

[189] Council of Europe, *Council of Europe, Report to the Government of* Ireland *on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 20 to 28 May 2002*, CPT/Inf (2003) 36 para 139 <http://www.cpt.coe.int/documents/irl/2003-36-inf-eng.htm#_Toc29353559> accessed 24 May 2010.

[190] Council of Europe, *Response of the Government of* Ireland *to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to Ireland from 20 to 28 May 2002,* CPT/Inf (2003) 37 <http://www.cpt.coe.int/documents/irl/2003-37-inf-eng.htm> accessed 24 May 2010.

The report of the Committee's 2006 visit, after expressing approval for the regime introduced by the MHA 2001, proceeded to address the Central Mental Hospital exclusively and did not address conditions of civil detention.[191]

2.8 Equality Claims

Equality, or 'freedom from discrimination', claims are based on an argument that a person is entitled to be treated in the same manner as other people in society, or in the same manner as others in society who are similarly situated are treated.[192]

This may arise in the mental health context in the form of arguments for parity between particular categories of patients in terms of the legal protections afforded to them by the mental health law regime, or in the form of a claim that a person has been discriminated against in the provision of a public service or in the workplace on the basis of their suffering from a mental illness. It may also arise in the form of an affirmative rights argument for an entitlement to parity in the funding for and provision of mental health care services, when compared to the provision of services in other areas of health care.[193]

The disability and employment law regimes in Ireland provide extensive protection of the right to freedom from discrimination on the ground of disability, which is interpreted as including a mental health disability. These provisions also establish an entitlement to reasonable accommodation in order to promote inclusion of people

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[191] Council of Europe, *Report to the Government of* Ireland *on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 2 to 13 October 2006,* CPT/Inf (2007) 40 <http://www.cpt.coe.int/documents/irl/2007-40-inf-eng.htm> accessed 24 May 2010 and Council of Europe, *Response of the Government of* Ireland *to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to Ireland from 2 to 13 October 2006,* CPT/Inf (2007) 41 <http://www.cpt.coe.int/documents/irl/2007-41-inf-eng.htm> accessed 24 May 2010.

[192] Kimber, Cliona, "Equality Disability (Part I)" (2001) 6 (9) *Bar Review* 494; Kimber, Cliona, "Equality Disability (Part II)" (2001) 7 (2) *Bar Review* 66; Smith, Olivia, "Side-Stepping Equality? Disability Discrimination and "Generally Accepted Qualifications" (2008) 30(1) *Dublin University Law Journal* 279; Doyle, Oran J., *Constitutional Equality* (Dublin: Thomson Round Hall, 2004); Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.

[193] *See* for example *F. H. Zwaan De Vries v Netherlands*, Communication No. 182/1984 (9 April 1987) UN Doc. Supp. No. 40 (A/42/40) at 160 (1987), discussed in detail below.

with disabilities in society, in mainstream education, and in the workplace. Similarly, the constitutional guarantee of equality purports to safeguard citizens from arbitrary discrimination in the drafting and application of legislation. The disability and employment law regimes are, however, limited in their scope, and the constitutional equality guarantee has been kept on a 'short leash' by the courts. An account here of the parameters of the international human rights instruments' conception of equality is essential to inform the 'human rights audit' performed in Chapter 5 below of the relative success or failure of the Irish disability regime, and the mental health regime in particular, to measure up to the expections created by the international human rights standards.

Rehman describes the principles of equality and non-discrimination as "the twin pillars upon which the whole edifice of the modern international law of human rights is established."[194] The concepts are given extensive protection in both the core UN human rights covenants, and in a substantial number of secondary human rights documents, and also in the non-discrimination provisions of the ECHR and the ESC.

2.8.1 Equality Claims under the UN Human Rights Instruments

The UDHR provides for a right to equality in Article 7:

> All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.[195]

The ICCPR makes similar provision in Article 26:

> All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex,

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[194] Rehman, Javaid, *International Human Rights Law*, 2nd ed. (Essex: Pearson Education Limited, 2010), at 401.

[195] United Nations, *Universal Declaration of Human Rights*, (1948) G.A. Res. 217A, U.N. GAOR, 3rd Sess. U.N. Doc. A/311, Article 7.

language, religion, political or other opinion, national or social origin, property, birth or other status.[196]

This equality protection in Article 26 is a free standing right and does not require to be argued in conjunction with another right and in this respect differs from the Article 14 protection of equality in the ECHR, which needs to 'piggy-back' on another Convention right. An example of a determination on the ICCPR right to equality is the case of *Zwaan De Vries v Netherlands*[197] in which the Committee found that discrimination between the genders within the Dutch social welfare code amounted to a violation of the ICCPR on the basis of the Article 26 protection for equality, notwithstanding the fact that no right to social welfare exists under the ICCPR.

There are a substantial number of specialised UN conventions and declarations addressing the question of inequality in its various guises (for example religious discrimination; racial discrimination; gender discrimination; or discrimination against children). In the context of mental health, the CRPD addresses discrimination against people with disabilities in Article 5:

1. States Parties recognise that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.

2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.

3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.

4. Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.[198]

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[196] United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Article 26.

[197] *F. H. Zwaan De Vries v Netherlands*, Communication No. 182/1984 (9 April 1987) UN Doc. Supp. No. 40 (A/42/40) at 160 (1987).

[198] United Nations, *Comprehensive and Integral Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities*, G.A. Res. 168, U.N. GAOR, 56th Sess., 88th plenary meeting, U.N. Doc. A/56/583/Add.2 (New York: United Nations, 2001), Article 5.

The specific protection provided in the CRPD is of vital importance given the long standing history of discrimination and abuse suffered by people with disabilities. Discrimination remains a particular problem in the mental health context, with many people suffering at the hands of stigma and ignorance, and being subjected to unnecessary institutionalisation or even incarceration by virtue of their disability. The equality provided for in the CRPD is a formal equality, entitling persons with disabilities to the provision of reasonable accommodation to ensure that they are, as far as is possible, not placed at a disadvantage in a given situation when compared with a person without their disability.

Importantly, the CRPD also provides for equality in conjunction with other rights guaranteed in the Convention: Article 13 provides for equality of access to justice; Article 14 provides for equality of entitlement to the right to liberty and security of the person and Article 17 provides for equality of entitlement to physical and mental integrity. Article 12 requires that States safeguard the right of people with disabilities to legal capacity as persons before the law, and requires States to adopt a functional model of capacity rather than a status-based one.

2.8.2 Equality Claims under the ECHR and ESC

Article 14 of the Convention prohibits discrimination:

> The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

Unlike Article 26 of the ICCPR, which is a stand-alone right to equality, Article 14 of the ECHR is a 'parasitic' right that requires the applicant to demonstrate the manner in which they have suffered discrimination in respect of another right contained in the Convention. Article 1 of Protocol 12 to the Convention expands the scope of Article 14 to encompass 'any right set forth by law', which would include rights set forth in domestic law but not necessarily in the Convention:

1. The enjoyment of any right set forth by law shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

2. No one shall be discriminated against by any public authority on any ground such as those mentioned in paragraph 1.

Ireland signed Protocol 12 on 4 November 2000.[199] Protocol 12 still requires that the right to non-discrimination 'piggy back' on a law established in the domestic state if not in the Convention itself. It should be noted that Protocol 12 is not subject to the European Convention on Human Rights Act 2003 incorporating the ECHR into domestic law in Ireland.

In *Pretty v United Kingdom*[200] the applicant argued that she was discriminated against on the basis of disability, in that while an able-bodied person could legally take their own life without criminal sanction against themselves or their estate, a person with a disability who would require assistance to perform the same action risked exposing their assistant to criminal prosecution for manslaughter. The ECtHR assessed the Article 14 claim and found that while there was a discrimination as a result of the failure to provide an exception for certain categories of persons who could not physically commit suicide, there was an "objective and reasonable justification" for the refusal to draw this distinction in the law, in that it would "seriously undermine the protection of life which the 1961 Act was intended to safeguard and greatly increase the risk of abuse."[201]

The right to freedom from discrimination was argued in the case of *Koendjbiharie v Netherlands*.[202] The applicant argued that he had been discriminated against on the basis of his national origin, but withdrew that claim prior to the hearing of the case

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[199] Council of Europe, *Protocol Number 12* <http://conventions.coe.int/Treaty/Commun/ChercheSig.asp?NT=177&CM=8&DF=7/6/2009&CL=ENG> accessed 19 July 2010.
[200] *Pretty v United Kingdom*, Application No. 2346 of 2002 (judgment delivered 29 April 2002).
[201] *Pretty v United Kingdom*, Application No. 2346 of 2002 (judgment delivered 29 April 2002), at § 89.
[202] *Koendjbiharie v Netherlands* (1990) Application No. 11487/85, (1990) 13 EHRR 820.

before the Court.[203] No other case taken before the Strasbourg Court has argued discrimination on the grounds of mental illness.

2.9 Affirmative Rights Claims

Affirmative rights claims are the most controversial of the types of human rights claims that may be mounted in the context of mental health rights litigation.[204] Affirmative rights claims are based on an argument that a person has a right to receive a minimum standard in a particular aspect of society, that is, it is an argument seeking to compel a state to provide particular services or to guarantee certain minimum standards of services.

These affirmative rights claims arise most frequently as arguments for the provision of access to mental health care, or for the particular mental health services, but they may also arise in the Irish context as arguments for an entitlement to education where the provision of certain mental health treatments or services are presented as being essential to the ability of the claimant to participate in education or where the provision of education is essential to the maintenance of the claimant's mental health.[205]

Ireland is somewhat unique among constitutional democracies in its provision in the Constitution for a justiciable right to primary education, and for non-justiciable Directive Principles of Social Policy which appear to encompass a right to a certain degree of protection of health and of access to health care. By outlining here the international human rights measures in respect of an entitlement to the provision of

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[203] *Koendjbiharie v Netherlands* (1990) Application No. 11487/85, (1990) 13 EHRR 820, §§ 22 and 32.
[204] Birnbaum, Morton, "The Right to Treatment" (1960) 46(5) *American Bar Association Journal* 499; Hogan, Gerard, "Directive Principles, Socio-Economic Rights and The Constitution" (2001) 36 *Irish Jurist (new series)* 174; Langwallner, David, "Separation of Powers, Judicial Deference and the Failure to Protect the Rights of the Individual", *In* Carolan, Eoin and Doyle, Oran, eds., *The Irish Constitution: Governance and Values* (Dublin: Thomson Round Hall, 2008); McHugh, Claire, "Socio-Economic Rights in Ireland: Lessons to be learned from South Africa and India" (2004) 4 *Hibernian Law Journal* 109; Ruane, Blathnaid, "The Separation of Powers and the Grant of Mandatory Orders to Enforce Constitutional Rights" (2000-1) 5 *Bar Review* 416; Whyte, Gerard, *Social Inclusion and the Legal System: Public Interest Law in Ireland* (Dublin: Institute of Public Administration, 2002); Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.
[205] *See* for example *X v Ireland*, Application No. 6839/74, 7 DR 78 (1976).

health care, it is possible to trace the parameters of the affirmative rights claims that may be said to arise from the international human rights framework. It will then be possible in Chapter 5 below to compare the Irish position, in constitutional and mental health law in respect of arguments seeking to assert an entitlement to health care, against the international human rights standards as ascertained in this description.

2.9.1 Health Claims under the UN Human Rights Instruments

The UDHR provides for no express right to health care although Article 25 recognises an interest therein by providing for a right to a standard of living which is adequate for health and well-being, with specific recognition of the need for access to medical care, and of a right to security in the event of sickness, disability, or old age, among other circumstances:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.[206]

There is no right to health or health care recognised in the ICCPR but the ICESCR does contain an explicit protection of a right to health.[207] It should be noted that in contrast to the ICCPR's negative rights that require States to avoid actions that infringe the rights provided for, the ICESCR recognises rights that impose affirmative obligations on States to take action to ensure that the rights it provides for are attained. Accordingly, the right to health as mandated in the ICESCR is an affirmative obligation on the State to adopt policies and direct actions that ensure that citizens can avail of the right.

The ICESCR, however, does not mandate strict compliance with its provisions to the same standard as the ICCPR. Article 2 of the ICESCR provides that the governments of States parties must take positive steps to bring about enforcement of the rights

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[206] United Nations, *Universal Declaration of Human Rights*, (1948) G.A. Res. 217A, U.N. GAOR, 3rd Sess. U.N. Doc. A/311, Article 25.

[207] United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3, Article 12.

under the Convention.[208] Known as 'progressive realisation', this is a duty on governments to plan for the full implementation of rights and to institute policies to bring about that full implementation – it is not a duty on governments to recognise the ICESCR rights immediately and in their entirety.[209] Lester, Pannick and Herberg propose that the implementation measures required by the ICESCR are not necessarily confined to legislative measures only, but may also extend to "the provision of judicial remedies with respect to rights which may, in accordance with the national legal system, be considered justiciable."[210]

Article 12(1) of the ICESCR provides that everyone has the right to the 'highest attainable' standard of physical and mental health, thus providing both a positive obligation on governments to take immediate steps to protect and promote the right to health; and additionally a negative right for individuals to protection against conditions unhealthy or dangerous to one's health.[211] Article 12(2) then goes on to list specific provisions that States are expected to provide in order to secure the right to health: provisions aimed at reducing infant and child mortality, and ensuring healthy childhood development (Article 12(2)(a)); provisions aimed at making improvements in the standards of industrial and environmental hygiene (Article 12(2) (b)); provisions aimed at preventing and treating endemic, epidemic and other diseases (Article 12(2)(c)); and provisions aimed at achieving a system whereby essential health care is available to everyone (Article 12(2)(d)). Furthermore, Article 12 mandates that health care services must be available; accessible; appropriate to people's needs; and of a good quality.[212]

General Comment 14: The Right to the Highest Attainable Standard of Health clarifies the scope and meaning of the Article 12(1) right to health:

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[208] United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3, Article 2.

[209] Rosenthal, E., and Sundram, C.J., "International Human Rights in Mental Health Legislation" (2002) 21 *New York Law School Journal of International and Comparative* Law 469, 483-485.

[210] Lord Lester of Herne Hill QC, Lord Pannick QC, Javan Herberg (eds), *Human Rights Law and Practice*, 3rd ed. (London: Butterworths, 2009), at 878.

[211] United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3, Article 12 (1). *See* also World Health Organisation, *Twenty-five Questions and Answers on Health and Human Rights*, 6 July 2002, 11 <http://www.who.int/hhr/information/25_questions_hhr.pdf> accessed 24 October 2009.

[212] United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3, Article 12 (2).

> The right to health is not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.[213]

Unlike the ICCPR, the ICESCR does not provide for any completely non-derogable rights. Furthermore, the threshold for permissible limitations on the ICESCR rights is significantly lower than the 'public emergency' standard of the ICCPR. Article 4 of the ICESCR permits limitations on ICESCR rights where the limitation is determined by law, compatible with the nature of the rights in question, and solely for the purpose of promoting the general welfare in a democratic society.[214]

Thus, while a person can mount a challenge to compulsory civil detention if the detention was not necessary to protect national security, public order, public health or morals, or the rights and freedoms of others; a challenge on the basis of failure to make provision for adequate mental health services must demonstrate that the limitations on the services provided are not compatible with the nature of the rights in question or in some way related to the general welfare of society. These thresholds can be met by the State mounting an argument that complete health for all members of society is an unattainable goal and that rationing of resources is therefore a legitimate exercise that operates to safeguard other rights that are attainable (and perhaps specifically, civil and political rights such as freedom from arbitrary detention). These acceptable limitation criteria are reinforced in the Siracusa Principles 1985, which state that rights may be limited if: (1) the restriction is provided for and carried out in accordance with law and not drafted or imposed arbitrarily; (2) the restriction is in the interest of a legitimate object of general interest; (3) the restriction is strictly necessary in a democratic society to achieve the objective sought; and (4) there are no less intrusive and restrictive means available to achieve

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[213] United Nations Office of the High Commissioner for Human Rights, *General Comment 14 of the Committee on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health* (Geneva: UNHCR, 2000), para 8.

[214] United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3, Article 4.

the same objective.[215] These criteria are also mirrored in the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care 1991.[216]

The Committee on Economic, Social and Cultural Rights (CESCR) established under the United Nations Economic and Social Council (ECOSOC) Resolution 1985/17 monitors the implementation of the ICESCR via a system of reporting and assessment, and the production of General Comments to assist and aid in the implementation of the Covenant rights. Ireland was last assessed during the 28th Session of the CESCR, from 29 April to 17 May 2002.[217] In the Report from that session, the CESCR praises Ireland for, among other steps, the establishment of the Equality Authority and the Human Rights Commission. However, a number of areas of concern were also identified. These may be summarised as follows:

1. The failure to incorporate or reflect the ICESCR in domestic legislation, or to track its use in domestic case law;[218]
2. The failure to have the Human Rights Commission fully operational (the Commission has since the Report been fully established);[219]
3. The failure to adopt a human rights-based approach in the Disability Bill 2004 (now the Disability Act 2005), and the inclusion of a provision in section 47 of

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[215] UN Commission on Human Rights, *The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, 28 September 1984, E/CN.4/1985/4 <http://www.unhcr.org/refworld/docid/4672bc122.html> accessed 24 May 2010.

[216] United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (New York: United Nations Secretariat Centre for Human Rights, 1991); (1991) G.A. Res. 119, U.N. GAOR, 46th Sess., U.N. Doc. A/46/49, Supp. No. 49, Annex, 188-92. The MI Principles are discussed in detail below.

[217] The full text of the *Second Periodic Report: Ireland 06/10/2000* (Geneva: United Nationals Committee on Economic Social and Cultural Rights, 28th Sess. U.N. Doc. E/1990/6/Add.29) (State Party Report), 2000 is available at <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.1990.6.Add.29.En?Opendocument> accessed 24 May 2010.

[218] United Nations, *Concluding Observations of the Committee on Economic, Social and Cultural Rights : Ireland. 05/06/2002* (Geneva: United Nations Committee on Economic Social and Cultural Rights, 28th Sess., U.N. Doc. E/C.12/1/Add.77. (Concluding Observations/Comments), 5 June 2002) para 12 <http://www.unhchr.ch/tbs/doc.nsf/%28Symbol%29/E.C.12.1.Add.77.En?Opendocument> accessed 24 May 2010.

[219] United Nations, *Concluding Observations of the Committee on Economic, Social and Cultural Rights : Ireland. 05/06/2002* (Geneva: United Nations Committee on Economic Social and Cultural Rights, 28th Sess., U.N. Doc. E/C.12/1/Add.77. (Concluding Observations/Comments), 5 June 2002) para 13 <http://www.unhchr.ch/tbs/doc.nsf/%28Symbol%29/E.C.12.1.Add.77.En?Opendocument> accessed 24 May 2010.

that Bill purporting to remove the rights of people with disabilities to seek judicial redress if any of the Bill's provisions are not carried out;[220]

4. The existence of persistent discrimination against persons with physical and mental disabilities, especially in the fields of employment, social security benefits, education and health;[221]
5. The persistent prevalence of institutional care, particularly in psychiatric hospitals, for people with mental disabilities, rather than a move to care in the community;[222]
6. The failure to legislate to extend the constitutional right to free primary education to all adults with special educational needs.[223]

In the realm of socio-economic rights the CRPD builds upon and develops the rights recognised in the ICESCR, within the context of disability. Article 19 recognises a right to live independently and to be included in the community. Article 20 protects a right to personal mobility. Article 24 contains a right to education and Article 26 establishes rights to habilitation and rehabilitation. Article 27 protects the right to work and employment. Articles 28 and 30 protect rights to an adequate standard of living, and to participation in the cultural life of the community.

Of most interest for the purposes of this work, Article 25 recognises a right to health:

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[220] United Nations, *Concluding Observations of the Committee on Economic, Social and Cultural Rights : Ireland. 05/06/2002* (Geneva: United Nations Committee on Economic Social and Cultural Rights, 28th Sess., U.N. Doc. E/C.12/1/Add.77. (Concluding Observations/Comments), 5 June 2002) para 14 <http://www.unhchr.ch/tbs/doc.nsf/%28Symbol%29/E.C.12.1.Add.77.En?Opendocument> accessed 24 May 2010.

[221] United Nations, *Concluding Observations of the Committee on Economic, Social and Cultural Rights : Ireland. 05/06/2002* (Geneva: United Nations Committee on Economic Social and Cultural Rights, 28th Sess., U.N. Doc. E/C.12/1/Add.77. (Concluding Observations/Comments), 5 June 2002) para 15 <http://www.unhchr.ch/tbs/doc.nsf/%28Symbol%29/E.C.12.1.Add.77.En?Opendocument> accessed 24 May 2010.

[222] United Nations, *Concluding Observations of the Committee on Economic, Social and Cultural Rights : Ireland. 05/06/2002* (Geneva: United Nations Committee on Economic Social and Cultural Rights, 28th Sess., U.N. Doc. E/C.12/1/Add.77. (Concluding Observations/Comments), 5 June 2002) paras 21 and 34 <http://www.unhchr.ch/tbs/doc.nsf/%28Symbol%29/E.C.12.1.Add.77.En?Opendocument> accessed 24 May 2010.

[223] United Nations, *Concluding Observations of the Committee on Economic, Social and Cultural Rights : Ireland. 05/06/2002* (Geneva: United Nations Committee on Economic Social and Cultural Rights, 28th Sess., U.N. Doc. E/C.12/1/Add.77. (Concluding Observations/Comments), 5 June 2002) para 36 <http://www.unhchr.ch/tbs/doc.nsf/%28Symbol%29/E.C.12.1.Add.77.En?Opendocument> accessed 24 May 2010.

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

> Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
>
> Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
>
> Provide these health services as close as possible to people's own communities, including in rural areas;
>
> Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
>
> Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
>
> Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

As Bernadette McSherry points out, this CRPD right to 'the highest attainable standard of health' is subject to the progressive realisation and resource constraints limitations as established under the ICESCR.[224]

While Tunisia and Spain have commenced the reporting procedures, no country has yet completed the review process with the Committee on the Rights of Persons with

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[224] McSherry, Bernadette, "Voluntary Treatment and the Role of the Law" *in* McSherry, Bernadette and Walker, Penelope, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), 379-396, 381. *See also* Hunt, Paul and Mesquita, Judith, "Mental Disabilities and the Human Right to the Highest Attainable Standard of Health" (2006) 28 *Human Rights Quarterly* 332, 342.

Disabilities, and that means that there are no Committee recommendations available to date to assess the degree of scrutiny to which member states are likely to be subjected in respect of these obligations.[225]

It is to be expected that a similar course will be taken as is currently adopted in respect of the universal periodic review under the ICESCR. In respect of that document, the actual value added to service users has been minimal in that once the government can demonstrate that it is engaged in a process of reviewing and implementing policies, then scrutiny will be scant. It remains to be seen the degree of action that will be mandated by the Committee on the Rights of Persons with Disabilities.

A significant number of the secondary UN human rights documents introduced above deal extensively with the right to health. Of particular interest are the Mental Illness Principles;[226] the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities;[227] the Declaration on the Rights of Disabled Persons;[228] the ICESCR's General Comment 5 on Persons with Disabilities;[229] and the ICESCR's General Comment 14 on the Right to the Highest Attainable Standard of Health.[230]

The Mental Illness Principles recognise a mixture of civil and political, and social, economic and cultural rights. Among the economic, social and cultural rights

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[225] As noted above, Spain is due to be the first country to be subject to review – *see* United Nations, *Sessions of the Committee on the Rights of Persons with Disabilities* (Geneva: United Nations High Commissioner for Human Rights, 2010) <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Sessions.aspx> accessed 24 May 2010.

[226] United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (New York: United Nations Secretariat Centre for Human Rights, 1991); (1991) G.A. Res. 119, U.N. GAOR, 46th Sess., U.N. Doc. A/46/49, Supp. No. 49, Annex, 188-92.

[227] United Nations, *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities*, (1993) G.A. Res. 96, 48th Sess., U.N. Doc. A/48/627 <http://www.un.org/documents/ga/res/48/a48r096.htm> accessed 24 May 2010.

[228] United Nations, *Declaration on the Rights of Disabled Persons* (New York: United Nations Secretariat Centre for Human Rights, 1975). G.A. Res. 3447, U.N. GAOR, 30th Sess., Supp. No. 34, at 92, U.N. Doc. A/10034 (1975).

[229] United Nations Office of the High Commissioner for Human Rights, *General Comment 5 of the Committee on Economic, Social and Cultural Rights: Persons with Disabilities* (Geneva: UNHCR, 1996) <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/CESCR%20General%20comment%205.En?Opendocument> accessed 1 October 2006.

[230] United Nations Office of the High Commissioner for Human Rights, *General Comment 14 of the Committee on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health* (Geneva: UNHCR, 2000).

recognised in the MI Principles are: the right to health and social services appropriate to one's health needs; the right to individualised treatment plans; the right to recreational and educational services; and the right to resources for mental health facilities that are comparable to the resources provided to other health facilities. These apply to all people admitted to a mental health facility, irrespective of whether or not they have a mental disability.[231] As noted earlier, these Principles are reviewed at a purely domestic level and there are no specific enforcement or monitoring mechanisms at the UN level in respect of them.

The Standard Rules on the Equalisation of Opportunities for Persons with Disabilities was adopted after a formal call made at the World Conference on Human Rights in Vienna in 1993 for promotion of awareness of human rights in the context of disability.[232] The Standard Rules apply to all aspects of disability, with the aim of maximising equalisation of opportunities for people with disabilities and of maximising the participation in society of people with disabilities.[233]

The Standard Rules are presented as affirmative socio-economic rights, including:

1. The right to effective medical care, including preventive care, given by adequately trained personnel;[234]
2. The right to rehabilitation services in one's local community;[235]
3. The right to accessible public facilities;[236]
4. The right to integrated educational and vocational services;[237]

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[231] United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (New York: United Nations Secretariat Centre for Human Rights, 1991); (1991) G.A. Res. 119, U.N. GAOR, 46th Sess., U.N. Doc. A/46/49, Supp. No. 49, Annex, 188-92, Principle 24, and Rosenthal, E., and Sundram, C.J., "International Human Rights in Mental Health Legislation" (2002) 21 *New York Law School Journal of International and Comparative* Law 469, 489.

[232] United Nations, *Vienna Declaration and Programme of Action*, World Conference on Human Rights, Vienna, 25 June 1993, U.N. Doc. A/CONF.157/23, paragraphs 63-65 <http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.CONF.157.23.En?OpenDocument> accessed 24 October 2009.

[233] United Nations, *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities*, (1993) G.A. Res. 96, 48th Sess., U.N. Doc. A/48/627, Rules 13-15 and 24-27.

[234] United Nations, *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities*, (1993) G.A. Res. 96, 48th Sess., U.N. Doc. A/48/627, Rule 2.

[235] United Nations, *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities*, (1993) G.A. Res. 96, 48th Sess., U.N. Doc. A/48/627, Rule 3.

[236] United Nations, *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities*, (1993) G.A. Res. 96, 48th Sess., U.N. Doc. A/48/627, Rule 5.

5. The right to favourable employment conditions and hiring policies;[238] and
6. The right to social security and income maintenance.[239]

Furthermore, full integration in family life and cultural, recreational and religious activities should be promoted.[240] The ethos of the Standard Rules is ensuring that people with disabilities have the opportunity to participate in society and contributing to national planning for health and for social service reforms. The Standard Rules also provide for a Commission for Social Development, a panel of experts and a Special Rapporteur to oversee their implementation. The Special Rapporteur then, in consultation with the Commission and the panel of experts, constructs questionnaires for completion by the individual member states. The Special Rapporteur, on receipt of the states' answers, seeks to establish a dialogue with the states and to encourage liaison with independent expert groups and with other UN bodies capable of assisting the states in the implementation of the treaty provisions in accordance with the Standard Rules. The Special Rapporter prepares reports for the Commission for Social Development on the progress in adoption of the Standard Rules.

It is important to keep in mind that all of the extensive provisions in the Standard Rules do not specifically address mental illness or other developmental or psychiatric disabilities. However, as a template for the improvement of human rights protections for people with disabilities generally, the Standard Rules do provide a model for inclusion and active participation in society which should apply equally to people with mental disabilities of all kinds. The Standard Rules and the MI Principles should be viewed as complimentary and mutually reinforcing in the promotion of human rights for people with mental disabilities.

Gostin summarises the importance of the Standard Rules and the MI Principles as follows:

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[237] United Nations, *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities*, (1993) G.A. Res. 96, 48th Sess., U.N. Doc. A/48/627, Rule 6.
[238] United Nations, *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities*, (1993) G.A. Res. 96, 48th Sess., U.N. Doc. A/48/627, Rule 7.
[239] United Nations, *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities*, (1993) G.A. Res. 96, 48th Sess., U.N. Doc. A/48/627, Rule 8.
[240] United Nations, *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities*, (1993) G.A. Res. 96, 48th Sess., U.N. Doc. A/48/627, Rules 9-12.

1. They help to mandate a baseline of fair and decent treatment for people with mental disabilities, thus establishing human rights norms for this grouping;
2. They enable fairer and more effective monitoring of human rights abuses in the psychiatric sphere by outlining a standard by which international and non-profit rights advocacy organisations can judge mental health policies;
3. They can be used by States as an interpretative guide to the international treaty obligations in their applicability to mental disabilities.[241]

The Declaration on the Rights of Disabled Persons 1975 outlines a broad range of social, economic and cultural rights that should be afforded to people with a disability. Paragraph 4 of the Declaration states that persons with disabilities have the same civil and political rights as all other human beings. Paragraph 8 states that people with disabilities have a right to have their special needs taken into consideration at all stages of economic and social planning, while Paragraph 12 states that disabilities organisations should be usefully consulted in all matters regarding the rights of people with disabilities. Paragraph 10 recognises the right to protection against exploitation and treatment of an abusive or degrading nature. The Declaration also identifies a number of economic and social rights that are of obvious importance for the development of capacities and social integration at Paragraph 6. These include rights to "medical, psychological and functional treatment"[242] and to economic and social security.[243] Furthermore, the Declaration provides that people with disabilities have a right to live in environments that allow them to be as 'self-reliant' as possible – a provision that endorses community care and integration.[244] Like the Mental Illness Principles in respect of civil and political rights, this Declaration is not legally binding

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[241] Gostin, Lawrence O. and Gable, Lance, "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health" (2004) 63 (1) *Maryland Law Review* 20, 44.

[242] United Nations, *Declaration on the Rights of Disabled Persons* (New York: United Nations Secretariat Centre for Human Rights, 1975). G.A. Res. 3447, U.N. GAOR, 30th Sess., Supp. No. 34, at 92, U.N. Doc. A/10034 (1975), Article 6.

[243] United Nations, *Declaration on the Rights of Disabled Persons* (New York: United Nations Secretariat Centre for Human Rights, 1975). G.A. Res. 3447, U.N. GAOR, 30th Sess., Supp. No. 34, at 92, U.N. Doc. A/10034 (1975), Article 7.

[244] United Nations, *Declaration on the Rights of Disabled Persons* (New York: United Nations Secretariat Centre for Human Rights, 1975). G.A. Res. 3447, U.N. GAOR, 30th Sess., Supp. No. 34, at 92, U.N. Doc. A/10034 (1975), Article 9.

on member states nor does it have any specific enforcement or monitoring mechanisms.

General Comment 5: Persons with Disabilities, of the Committee on Economic, Social and Cultural Rights, addresses the application of the ICESCR to people with disabilities.[245] General Comment 5 reviewed the position of people with disabilities under the ICESCR, and came to the conclusion that while disability is a key issue in the ICESCR, States Parties had not adopted "concerted measures" to improve protection for the rights of people with disabilities.[246] In this light, the purpose of General Comment 5 was to "review, and emphasise, some of the ways in which issues concerning persons with disabilities arise in connection with the obligations contained in the Covenant."[247]

General Comment 5 provides that governments should strive to comply with Article 12 of the ICESCR (the right to health), by providing health care in a way that respects dignity and human rights, thereby ensuring that people with disabilities receive the same levels of medical care as other members of society, and that they receive access to medical, social and rehabilitative services which enable them to achieve their optimum level of independence and functioning.[248] This provision applies equally to a person's physical and mental health.

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[245] United Nations Office of the High Commissioner for Human Rights, *General Comment 5 of the Committee on Economic, Social and Cultural Rights: Persons with Disabilities* (Geneva: UNHCR, 1996) <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/CESCR%20General%20comment%205.En?Opendocument> accessed 1 October 2006.

[246] United Nations Office of the High Commissioner for Human Rights, *General Comment 5 of the Committee on Economic, Social and Cultural Rights: Persons with Disabilities* (Geneva: UNHCR, 1996) para 2 <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/CESCR%20General%20comment%205.En?Opendocument> accessed 1 October 2006.

[247] United Nations Office of the High Commissioner for Human Rights, *General Comment 5 of the Committee on Economic, Social and Cultural Rights: Persons with Disabilities* (Geneva: UNHCR, 1996) para 2 <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/CESCR%20General%20comment%205.En?Opendocument> accessed 1 October 2006.

[248] United Nations Office of the High Commissioner for Human Rights, *General Comment 5 of the Committee on Economic, Social and Cultural Rights: Persons with Disabilities* (Geneva: UNHCR, 1996) para 34. <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/CESCR%20General%20comment%205.En?Opendocument> accessed 1 October 2006.

General Comment 5 also highlights that discrimination against people with disabilities may be subtler than many legal regimes contemplate. In an effort to combat the physical and social barriers faced by people with disabilities, General Comment 5 specifically states that any "distinction, exclusion, restriction or preference, or denial of reasonable accommodation based on disability, which has the effect of nullifying or impairing the recognition, enjoyment or exercise of economic, social or cultural rights" is in violation of the ICESCR.[249]

General Comment 14: The Right to the Highest Attainable Standard of Health[250] focuses on the right to health under Article 12 of the ICESCR, including: its meaning; States' and other parties' obligations thereunder; what will amount to a violation of it; and how it is best to be implemented.[251]

In General Comment 14, the Committee on Economic, Social and Cultural Rights interpreted the right to health as a combination of freedoms and entitlements. The freedoms include the right to control one's health and body (including sexual and reproductive freedom); the right to be free from interference (which encompasses torture; non-consensual medical treatment; and experimentation), and the entitlements include the right to a system of health protection which provides equality of opportunity for people to attain their highest possible levels of physical and mental health.[252] This would appear to interpret Article 12 as meaning that no person should

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[249] United Nations Office of the High Commissioner for Human Rights, *General Comment 5 of the Committee on Economic, Social and Cultural Rights: Persons with Disabilities* (Geneva: UNHCR, 1996) para 15.
<http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/CESCR%20General%20comment%205.En?Opendocument> accessed 1 October 2006.

[250] United Nations Office of the High Commissioner for Human Rights, *General Comment 14 of the Committee on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health* (Geneva: UNHCR, 2000)
<http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument> accessed 24 May 2010).

[251] United Nations Office of the High Commissioner for Human Rights, *General Comment 14 of the Committee on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health* (Geneva: UNHCR, 2000), para 6.
<http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument> accessed 24 May 2010).

[252] United Nations Office of the High Commissioner for Human Rights, *General Comment 14 of the Committee on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health* (Geneva: UNHCR, 2000), para 8.
<http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument> accessed 24 May 2010).

be subject to coerced treatment, which is of enormous significance in the sphere of mental health.

General Comment 14 also addresses the scope of the Article 12 right to health. Under paragraph 11, the right to health is interpreted to encompass the right to timely and appropriate health care, and the right to the 'determinants of health', which are listed as: access to safe and portable water and adequate sanitation; an adequate supply of safe food, nutrition and housing; healthy occupational and environmental conditions; and access to health-related education and information, including information on sexual and reproductive health.[253] The inclusion of occupational conditions in General Comment 14 is of particular importance for people with disabilities, who often have reduced access to employment, or to appropriate occupational or vocational therapy.[254] Paragraphs 18 and 19 of General Comment 14 reinforce the non-discrimination message of General Comment 5 with respect to the Article 12 right to health, and specifically highlight the discriminatory effects of inappropriate health resource allocation.[255]

2.9.2 Health Claims under the ECHR and ESC

As was noted in the introduction to this Chapter, the only socio-economic rights protected under the ECHR are the rights contained in Protocol 1 to own property (Article 1), and to education (Article 2). Article 2 of the main text of the ECHR (the right to life) has featured in one case in which a health argument was raised: *X v Ireland*.[256] In that case the parents of a child with severe disabilities argued that the State's failure to provide free medical treatment to the child amounted to a violation

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[253] United Nations Office of the High Commissioner for Human Rights, *General Comment 14 of the Committee on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health* (Geneva: UNHCR, 2000), para 11. <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument> accessed 24 May 2010).

[254] National Disability Authority, *Conference Proceedings, Disability and Employment: What the Research Tells Us* (Dublin: National Disability Authority, 2005) <http://www.nda.ie/cntmgmtnew.nsf/0/A3CFE76BE6EE5B7080257117005B2A1B/$File/disability_research_conference.htm> accessed 24 October 2009.

[255] United Nations Office of the High Commissioner for Human Rights, *General Comment 14 of the Committee on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health* (Geneva: UNHCR, 2000), paras 18 and 19.

[256] *X v Ireland*, Application No. 6839/74, 7 DR 78 (1976).

of her right to life under the ECHR. The Court found that on the facts of the case the child had been provided with adequate medical treatment and as such did not make any conclusions in relation to the question of whether Article 2 had been violated. This, however, is the only jurisprudence from the ECtHR on the question of an entitlement to health under the Convention. In this regard, the principal document protecting social rights in Europe remains the European Social Charter.

The European Social Charter (ESC) is the economic, social and cultural counterpoint to the ECHR. It was adopted in 1961 and revised in 1996. Ireland ratified the original ESC in 1964 and the revised version in 2000, albeit with a significant number of derogations – Article 8(3) (the right of nursing mothers to sufficient time off from work for this purpose); Article 21 (the right of workers to information and consultation with regard to the financial affairs of their employer); Article 31 (promotion of the right to housing).[257] Ireland accepted the collective complaints mechanism, but does not avail of the provisions enabling Non-governmental Organisations (NGOs) to submit collective complaints.

Article 11 of the ESC protects the right to protection of health:

> With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed *inter alia:*
>
> to remove as far as possible the causes of ill-health;
>
> to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
>
> to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.[258]

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[257] For a chart showing the articles ratified or not ratified by Ireland *see* Council of Europe, *Ireland and the European Social Charter* (Strasbourg: May 2010), <http://www.coe.int/t/dghl/monitoring/socialcharter/CountryFactsheets/Ireland_en.asp> accessed 24 May 2010, and for a chart showing these statistics for all signatories *see* Council of Europe, *Acceptance of Provisions of the Revised European Social Charter (1996)* (Strasbourg: 5 March 2010) <http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/ProvisionTableRev_en.pdf> accessed 24 May 2010.

[258] Council of Europe, *Revised European Social Charter 1996*, Article 11.

Article 12 provides for the right to social security. Article 13 provides for a right to social and medical assistance irrespective of resources, and that persons availing of social and medical assistance shall not suffer from a diminution of their political and social rights.[259] Article 14 provides for the right to benefit from social welfare services.[260] Article 15 protects the right of persons with disabilities to independence, social integration and participation in the life of the community:

> With a view to ensuring to persons with disabilities, irrespective of age and the nature and origin of their disabilities, the effective exercise of the right to independence, social integration and participation in the life of the community, the Parties undertake, in particular:
>
> > to take the necessary measures to provide persons with disabilities with guidance, education and vocational training in the framework of general schemes wherever possible or, where this is not possible, through specialised bodies, public or private;
> >
> > to promote their access to employment through all measures tending to encourage employers to hire and keep in employment persons with disabilities in the ordinary working environment and to adjust the working conditions to the needs of the disabled or, where this is not possible by reason of the disability, by arranging for or creating sheltered employment according to the level of disability. In certain cases, such measures may require recourse to specialised placement and support services;
> >
> > to promote their full social integration and participation in the life of the community in particular through measures, including technical aids, aiming to overcome barriers to communication and mobility and enabling access to transport, housing, cultural activities and leisure.[261]

Article 30 confers a right to protection against poverty and social inclusion, requiring that States take measures to promote effective access to employment, housing, training, education, culture and social and medical assistance for people at risk of poverty or social exclusion.

Ireland has submitted six reports to the European Committee of Social Rights in respect of progress in the implementation of the ESC. The reports deal with the 'hard core articles', those with odd numbers, and the 'soft core articles', those with even

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[259] Council of Europe, *Revised European Social Charter 1996*, Article 13.
[260] Council of Europe, *Revised European Social Charter 1996*, Article 14.
[261] Council of Europe, *Revised European Social Charter 1996*, Article 15.

numbers, in alternate years. If the Committee feels a State is not in compliance with its obligations under the ESC, it can request the Committee of Ministers to address a recommendation to that State asking it to change its practices to come into compliance with the ESC.

Ireland's most recent report, of 6 October 2009[262] reports progress with regard to Articles 3, 11, 12, 13, 14, 23 and 30. A report in respect of the even numbered articles was due in October 2009 but as of April 2010 had not been submitted.

In respect of the articles listed, the government provided information on the structure, form and funding of initiatives intended to safeguard the rights recognised. In particular, general information on the structure of the HSE, health care funding and information pertaining to the initiatives under the National Disability Strategy was given, including outlines of the Disability Act 2005 and the Education for Persons with Special Educational Needs Act 2004. The introduction of the new mental health law regime under the MHA 2001 was also outlined, together with the implementation strategy for the government's Vision for Change policy in relation to the move to community based mental health services.

2.9.3 Education Claims under the UN Human Rights Instruments

All of the United Nations human rights documents provide for a right to education. Article 26 of the UDHR provides for it in the following terms:

1. Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.
2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all

[262] Council of Europe, 6th National Report on the implementation of the European Social Charter (revised) submitted by THE GOVERNMENT OF IRELAND (Articles 3, 11, 12, 13, 14, 23 and 30 for the period 01/01/2005 – 31/12/2007) RAP/RCha/IRE/VI(2009) (Strasbourg: Council of Europe, 2009) <http://www.coe.int/t/dghl/monitoring/socialcharter/Reporting/StateReports/Ireland6_en.pdf> accessed 24 May 2010.

nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

3. Parents have a prior right to choose the kind of education that shall be given to their children.[263]

Article 13 of the ICESCR also provides in detail for the right to education.[264] Two General Comments have addressed the right to education and the need to make provision for free primary education.[265]

Finally, education is explicitly protected in Article 24 of the CRPD:

> 1. States Parties recognize the right of persons with disabilities to education. With a view to realizing this right without discrimination and on the basis of equal opportunity, States Parties shall ensure an inclusive education system at all levels and life long learning directed to:
>
> a. The full development of human potential and sense of dignity and self-worth, and the strengthening of respect for human rights, fundamental freedoms and human diversity;
> b. The development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential;
> c. Enabling persons with disabilities to participate effectively in a free society.

As Flynn points out, it is significant in the context of an analysis of Irish law protecting the rights of persons with disabilities that this right is expressly stated to be of 'life long' application.[266] The approach taken in the Irish context, where the right to education has been capped at eighteen years, is discussed in detail at § 3.10.2 below.

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[263] United Nations, *Universal Declaration of Human Rights*, (1948) G.A. Res. 217A, U.N. GAOR, 3rd Sess. U.N. Doc. A/311, Article 26.

[264] United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3, Article 13.

[265] United Nations Office of the High Commissioner for Human Rights, *General Comment 11 of the Committee on Economic, Social and Cultural Rights: Plan of Action for Primary Education (Article 14)* (Geneva: UNHCR, 1999), and United Nations Office of the High Commissioner for Human Rights, *General Comment 13 of the Committee on Economic, Social and Cultural Rights: The Right to Education (Article 13)* (Geneva: UNHCR, 1999).

[266] Flynn, Ellionóir, "Ireland's Compliance with the Convention on the Rights of Persons with Disabilities: Towards a Rights-Based Approach for Legal Reform?" (2009) 16 (1) *Dublin University Law Journal* 357.

2.9.4 Education Claims under the ECHR and ESC

The ECHR in its main text does not provide for a right to education but it is provided for in Protocol 1, Article 2 to the Convention:

> No person shall be denied the right to education. In the exercise of any functions which it assumes in relation to education and to teaching, the State shall respect the right of parents to ensure such education and teaching in conformity with their own religious and philosophical convictions.

In *D.H. & Others v Czech Republic*[267] the Grand Chamber of the ECtHR held the educational systems in the Czech Republic were discriminatory in their treatment of Roma children, and found that this amounted to a violation of Article 14 when read in conjunction with the right to education contained in Protocol 1 Article 2.

In *DG v Ireland*[268] the ECtHR considered a claim brought under numerous ECHR provisions but his claim under Article 5 in particular addressed the question of the State's obligation to provide educational facilities. The applicant was a minor in the care of the State. He had a criminal history and a history of causing danger to both himself and others, which was ascribed to his suffering from a personality disorder. Upon an application by the State to admit him to secure care facilities, the High Court ordered his detention in St. Patrick's Institution, a close medium-security prison for males aged between 16 and 21 years. The detention in St. Patrick's Institution was ordered as the type of high-support therapeutic unit the applicant required was not available in the State. The applicant argued successfully that his detention amount to a violation of Article 5 (1) as the purported reason for the deprivation of his liberty was the provision of specialised secure accommodation and care to include supervised education, none of which was being provided to him in St. Patrick's Institution. This case may be interpreted as meaning that where the basis of a deprivation of liberty includes the provision of a particular specialised form of educational services, and those services are not then provided at the place of detention, that under the principle

[267] *D.H. and Others v Czech Republic* (2007), Application No. 57325/00, (2008) 47 EHRR 3, paras 205-210.
[268] *DG v Ireland* (2002), Application No. 39474/98, (2002) 35 EHRR 33.

of reciprocity and proportionality the deprivation of liberty is unlawful. The applicant in *DG v Ireland* was awarded damages for the infringement of his Article 5 (1) rights.

The ESC provides for a right to vocational guidance (Article 9) and to vocational training (Article 10). An entitlement to education is also encompassed within the Article 15 provision for the right of persons with disabilities to independence, social integration and participation in the life of the community; and in the Article 17 protection of the right of children and young people to social, legal and economic protection.

Conclusion

The international human rights framework is at its height in the mental health context its protection of the classic 'civil and political rights' – the rights to liberty; to autonomy, bodily integrity and privacy; to fair procedures; and to freedom from torture and from inhuman and degrading treatment or punishment. In all of these categories of rights protections the standards established on the international plane are clear and unambiguous. In Europe, there is a wealth of case law from the European Court of Human Rights that addresses these rights in the context of mental health law regimes. The protection of the right to equality in the sphere of mental health has not been canvassed directly before the international human rights bodies. Finally, the affirmative rights claims arguing for an entitlement to health and to education as a corollary of the protection of health do not enjoy the same degree of protection as the negative 'civil and political' or 'first generation' rights.

3. MENTAL HEALTH RIGHTS: THE IRISH CONSTITUTIONAL HUMAN RIGHTS FRAMEWORK

Introduction

Chapter 2 has provided an account of the types of mental health rights that are explicitly and comprehensively protected on the international human rights level, and a description of the mental health law regime in Ireland was provided in Chapter 1. This Chapter describes the different types of rights that are recognised in the Irish Constitution that have an impact on the lives of people with mental disabilities.

The constitutional human rights protections in the area of mental health form an indispensible supplement to the mental health law regime at statute and at common law in Ireland. The Constitution is the first port of call for Irish litigants seeking to assert a human rights claim, and an understanding of the degree to which the constitutional human rights jurisprudence accords with or departs from the international human rights standards as identified in Chapter 2 is important to performance of the 'human rights audit' of Irish mental health law that will be provided in Chapter 5 below.

This Chapter also explains the state-building provisions in the Constitution that impact upon the way in which the Irish courts interpret those rights, with specific reference to the concept of health or access to health care as a potentially justiciable right. Finally, the various legal mechanisms available to litigants who seek redress where their constitutional rights have been abused are outlined, with analysis of cases alleging that particular actions taken by public bodies constituted an unlawful interference with a person's constitutionally protected human rights and as such should be compensated;[1] cases involving judicial review proceedings seeking to

[1] *See* for example *Croke v Smith* [1998] 1 IR 101; *Re Philip Clarke* (1950) IR 235; *Blehein v. St. John of God Hospital* [2002] IESC 43 (31st May, 2002). *See* also Keys, Mary "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 24 *Dublin University Law Journal* 26 and O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: FirstLaw, 2005) at 141.

overturn the manner in which a decision by a public body to engage in an otherwise legitimate action concerning the claimant was taken;[2] and *habeas corpus* applications seeking to secure the release of a claimant unlawfully deprived of their liberty.[3]

The Chapter begins with an outline of the authority, structure and content of the Irish Constitution, focussing in particular on the human rights protections therein and on the means of redress before the courts for an alleged breach of constitutionally protected human rights. This includes a discussion of the concept of the justiciability of different types of rights, with a particular focus on the justiciability of socio-economic and other social rights. This question arises where applicants seek to litigate an affirmative right to particular services or benefits from the State, on the basis of an entitlement to a social right such as a right to health care or a right to education. The constitutionally derived principles of judicial review of tribunal decisions are discussed, as these principles are of vital importance to mental health service users who allege that they have not received a fair review of their compulsory detention or treatment before a Mental Health Tribunal. The *habeas corpus* mechanism for constitutional review of a person's detention is also discussed, and its effectiveness as a tool for the protection of the rights of mental health patients is assessed.

Thereafter, an account is provided of the constitutional jurisprudence addressing the seven categories of rights claims identified in the Introduction to this work, that it is submitted, encapsulate the types of rights claims most frequently put forward by mental health service users in legal challenges brought pertaining to their experiences within the mental health services, or pertaining to their claimed unsatisfactory treatment in other aspects of society as a result of their status as mental patients. As in Chapter 2, the following discussion provides a detailed analysis of the substance of the rights claims made within each of these categories, assessing the meaning and application of these rights under the Constitution in the context of mental health claims. Some of these categories are grouped together in this Chapter for ease of analysis of the constitutional case law. The cases that are chosen to illustrate the

[2] *See* for example *S.M. v. The Mental Health Commission, The Mental Health Tribunal and The Clinical Director of St. Patrick's Hospital, Dublin; and The Attorney General and The Human Rights Commission* [2008] IEHC 441; *EJW (APUM) v Watters and Ors* [2008] IEHC 462.

[3] *See* for example *The State (C) v Frawley* [1976] IR 365. *See* also Keys, Mary "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 24 *Dublin University Law Journal* 26.

jurisprudence on constitutional rights are those that focus on rights in and around access to health care, and rights to receive and to refuse medical treatment. An assessment of whether these rights have, in legal outcomes, provided for meaningful substantive protection for mental health patients is undertaken in Chapter 5 below.

3.1 Introduction to Human Rights within the Irish Legal System

Ireland is a constitutional democracy with a common law legal system. The Constitution is the ultimate source of law, with all other law being subordinate to it. Any law that is not compatible with the Constitution is declared invalid and has no legal authority. Statutes are signed into law by the President, who must be satisfied that the proposed law is constitutional and any laws that the President suspects may not be constitutional are referred to the Supreme Court for review.[4]

As the core human rights instrument within the State, the Constitution is the final line of protection for human rights in the Irish legal system. The exercise of evaluating legislative and common law provisions in respect of mental health against the human rights protections in the Constitution mirrors the exercise performed in Chapter 5 below of thereafter measuring the results of the constitutional evaluation against the expectations created by the standards set down in the international human rights framework.

Mental health law, and indeed health law in general, is heavily codified in Ireland. The legal regimes for both voluntary and compulsory admission to a mental health treatment centre and for the administration of mental health therapies are regulated by the Mental Health Act 2001, which replaced the earlier Mental Treatment Act 1945. The provision of health care and the organisation of the health system are primarily governed by the Health Act 2004. Entitlements to disability services and the mechanisms for their provision comes under the Disability Act 2005. All of this legislation must comply with the provisions of the Constitution or it will be declared incompatible and therefore invalid.

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[4] *See Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 26.

As a common law jurisdiction, Ireland also places significant reliance on case law. While much of the law relating to mental health is now codified, statutes may be interpreted in light of earlier common law precedents that remain authoritative. One example is the long-standing principle of the adoption of a paternalist approach in the analysis of questions of compulsory treatment which has been utilised in the interpretation of the 'best interests' principle which is laid down by the Mental Health Act 2001, in respect of detention and treatment decisions. As with statute law, all common law precedents must accord with the principles of the Constitution or they will be declared incompatible and accordingly invalid.

In common with most other common law legal systems, Ireland adopts a dualist approach to international law, and this is enshrined in the Constitution. Under the dualist system, international law is binding on Ireland but not in Ireland. Thus, while Ireland is a signatory to the United Nations Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights, these documents are not capable of being canvassed between litigants before the Irish courts. An Irish citizen is however free to litigate, in the Irish courts, a claim against the State for a violation of a right protected by one of these international human rights documents.

A notable exception to this principle is the European Convention on Human Rights. The ECHR contains in its provisions a right to redress to the European Court of Human Rights, once all domestic avenues for legal redress have been exhausted. Under this system, the ECHR remained strictly speaking outside the domestic law, although the courts did refer to its provisions in the determination of rights with increasing frequency throughout the last decade of the 20th century. In 2003, Ireland incorporated the text of the ECHR into domestic Irish law at a sub-constitutional level.[5] This means that the rights protected under the ECHR can now be litigated between individuals in the domestic courts. Under the 2003 Act, however, the EHCR rights remain subject to the Constitution.[6]

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[5] European Convention on Human Rights Act 2003.

[6] Egan, Suzanne "The European Convention on Human Rights Act 2003: A Missed Opportunity for Domestic Human Rights Litigation" (2003) 25 *Dublin University Law Journal* 230; O'Connell, Donncha, "The ECHR Act 2003: A Critical Perspective" *in* Kilkelly, Ursula, *ECHR and Irish Law* (Dublin: Jordans, 2004) at 1; Hogan Gerard, "Incorporation of the ECHR: Some Issues of

3.2 Structure of the Constitution

The Irish Constitution, *Bunreacht na hÉireann*, dates from 1937. It is both a State-building and an aspirational document, with a comprehensive bill of rights and a unique set of Directive Principles of Social Policy.

In terms of its state-building provisions, the document establishes the State as a democratic republic with a bi-cameral legislature and an elected Head of State. The principle of the separation of powers is explicitly enshrined in the nation structure, and the courts are entrusted with the task of judicial review of legislation for compliance with the terms of the Constitution.[7]

The bill of rights provisions of the Constitution provide a list of expressly protected civil and political rights, together with a number of rights of more controversial character, including a right to education. Additionally, the courts have recognised implicitly protected rights, though to date only impliedly protected rights of a civil and political character. These are known as unenumerated rights.[8] Finally, the explicitly non-justiciable Directive Principles of Social Policy provide for a wide range of socio-economic rights, and the State is charged with endeavouring to secure these rights in its policies and government.[9]

3.2.1 The Bill of Rights: Enumerated and Unenumerated Rights, and Directive Principles of Social Policy

As noted above, the Irish Constitution protects rights in three ways: enumerated rights; unenumerated rights; and the Directive Principles of Social Policy. Certain

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Methodology and Process" *in* Kilkelly, Ursula, *ECHR and Irish Law* (Dublin: Jordans, 2004) at 13; and O'Connell, Donncha, "The Added Value of Sub-Constitutional Incorporation: ECHR Act 2003" *in* Carolan, Eoin and Doyle, Oran, eds., *The Irish Constitution: Governance and Values* (Dublin: Thomson Round Hall, 2008), at 490.

[7] *See Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 34.1.

[8] *See Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 34.1, and *Ryan v AG* [1965] IESC 1; [1965] IR 294.

[9] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 45.

rights are expressly named and outlined in detail in the Constitution itself, either in the State-building provisions, or in the 'fundamental rights' portion of the document.

These expressly recognised rights are known as the 'enumerated' rights. Alongside the enumerated rights the Constitution also protects numerous additional rights that are considered to be implicit in its provisions and in keeping with its aspirations. These are known as the 'unenumerated' rights. The courts identify these unenumerated rights and the courts delimit their scope. They were first recognised in *Ryan v AG* in which O'Dálaigh, CJ described a 'reservoir' of such unenumerated rights awaiting recognition by the courts.[10] The concept has been controversial[11] and while no new unenumerated rights have been recognised in recent years,[12] the rights recognised and developed in the past are considered to be well established as being an integral part of the constitutional framework.

Finally, the Constitution contains a set of Directive Principles of Social Policy. These provisions outline a number of ideals the State is directed to aspire to in the recognition and furtherance of rights within the State. They include directions that the State should endeavour to ensure that wealth is distributed equally among society; that a free private market is encouraged to flourish; that weaker members of society (including the infirm and the aged) are supported economically; and that the health of

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[10] *Ryan v AG* [1965] IESC 1; [1965] IR 294.

[11] *See* for instance Casey, Gerard, "Are there Unenumerated Rights in the Irish Constitution?" (2005) 23 *Irish Law Times* 123; Carey, Gearóid, "'Logically Faultless' Arugment for Unenumerated Rights in the Constitution"(2004) 22 Irish Law Times 246; Humphreys, Richard, "Interpreting Natural Rights" (1993-1995) xxviii-xxx *Irish Jurist (n.s.)* 221; Hogan, Gerard, "Unenumerated Personal Rights: Ryan's Case Reevaluated" (1990-1992) xxv-xxvii *Irish Jurist (n.s.)* 95.

[12] The most recently recognised unenumerated right was declared in the case of *O'T v B* [1998] 2 IR 321 in which the Supreme Court recognised an uneumerated right to know the identity of one's natural parents. That case featured a strong dissent by Keane J, in which he expressed doubt as to the soundness of the unenumerated rights doctrine. In the later judgments in *Sinnott (a minor suing by his mother and next friend) v Minister for Education, Ireland and the Attorney General* [2000] IEHC 21; [2001] IESC 63; [2001] 2 IR 545 and *T.D. (a minor suing by his mother and next friend M.D.) v Minister for Education, Ireland and the Attorney General, the Eastern Health Board and by Order of the Minister for Health and Children* [2001] IESC 101; [2001] 4 IR 259 the Supreme Court (Keane CJ) refused to recognise unenumerated socio-economic rights. Doyle has argued that these judgments represent the 'withering' of the unenumerated rights doctrine and that it is unlikely to feature in future case law on constitutional rights (*see* Doyle, Oran, *Constitutional Law: Text, Cases and Materials* (Dublin: Clarus Press, 2008), at 108.

workers is not abused.[13] Notably, these Directive Principles of Social Policy are expressly stated not to be justiciable before the courts.[14]

Article 40 delineates a range of 'Personal Rights' including the right to life (Article 40.3.2); the right to liberty and to fair procedures (Article 40.4.1); the rights to freedom of association (Article 40.6.1.iii) and of expression (Article 40.6.1.i); and the right to equality (Article 40.1). Of these, the right to liberty has featured most prominently in the courts' jurisprudence on issues pertaining to mental health care and psychiatric treatment. The right to life has featured intensely in several general medical cases, in particular those concerning the taking of decisions on behalf of a patient in a permanent vegetative state[15] and those concerning the balancing of the rights to life of a pregnant woman and her unborn child.[16]

3.2.1 (a) Enumerated Rights

The fundamental rights portion of the Constitution, contained in Articles 40-44, enumerates and protects all of the major civil and political rights recognised in international human rights, grouping them under five broad headings: Personal Rights; The Family; Education; Private Property, and Religion.

The above broad headings of fundamental enumerated rights in the Irish Constitution can be broadly grouped into two classifications. First, there are those rights that sit squarely within the type of rights classically denoted as civil and political rights – these are contained in the 'personal rights' provisions. The right to equality, which is of particular interest to this work, is encompassed under this 'personal rights' umbrella. The 'Personal Rights' and 'Equality' provisions are given individual attention below.

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[13] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 45.4.
[14] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 45.
[15] *See Re a Ward of Court* (No 2) (1996) 2 IR 79.
[16] *See Attorney General v X* (1992) IESC 1; (1992) 1 IR 1.

Then there are the two rights that do not neatly fit into either the 'civil and political' rights or the 'socio-economic' rights paradigms – the rights of the family and the right to education. These are discussed below.

The last two rights listed above – the right to hold private property (Article 43) and the right to freedom of religion (Article 44) – are of limited interest to the focus of this work and will not be discussed here.

3.2.1 (b) Unenumerated Rights

As noted above, the general right to 'personal rights' under Article 40.1 has inspired the doctrine of 'unenumerated rights'. Under this theory the courts are prepared to recognise certain personal rights not expressly listed in the Constitution but which are considered to be in keeping with the character of the other expressly recognised rights and with the aims and aspirations of the document as a whole. In an evocative passage in *Ryan v AG*, Ó'Dálaigh, CJ used the memorable imagery of there existing within the philosophical framework of the Constitution a sort of 'unenumerated rights reservoir', filled with rights that mesh with the ethos of the document but that were as yet unutilised.[17] Among the rights judicially retrieved from the reservoir to date are the rights to bodily integrity;[18] to privacy;[19] to travel outside the State;[20] and to earn a livelihood.[21]

In the context of this work, the rights to bodily integrity and to privacy are of most interest. The right to privacy first enunciated in *McGee v AG*[22] has featured prominently in cases concerning mental health treatment, and in medical law cases generally. Privacy is now considered to comprise of a patchwork of rights including the right to autonomy, the right to dignity, and the right to self-preservation or self-

[17] *Ryan v AG* [1965] IESC 1; [1965] IR 294.
[18] *Ryan v AG* [1965] IESC 1; [1965] IR 294.
[19] *McGee v AG* [1974] IR 284.
[20] *The State (M.) v Attorney General* [1979] IR 73; *Attorney General v X* [1992] 1 IR 1; [1992] ILRM 401.
[21] *Cafolla v Attorney General* [1985] IR 486; [1986] ILRM 177.
[22] *McGee v AG* [1974] IR 284.

determination, encompassed in this discussion in the sections dealing with the right to autonomy, privacy and bodily integrity.

3.2.1 (c) Directive Principles of Social Policy

The Directive Principles portion of the Constitution provides aspirational guidelines and frameworks for the safeguarding and promotion of the social and economic rights of citizens. Among them are directions:

1. That the State shall secure and protect a social order in which justice and charity informs all the institutions of the national life;[23]
2. That the right to an adequate means of livelihood shall be protected and that while favouring private enterprise that the State shall ensure that the ownership and control of the material resources of the community shall be distributed as best to subserve the common good, with free competition not being permitted to result in the concentration of such ownership or control in the hands of a few individuals to the common detriment;[24] and
3. That the State shall safeguard the economic interests of the weaker sections of the community and contribute to the support of the infirm, the widowed, the orphaned and the elderly.[25]

Notably, these Directive Principles of Social Policy are expressly stated not to be justiciable before the courts:

> The principles of social policy set forth in this Article are intended for the general guidance of the Oireachtas. The application of those principles in the making of laws shall be the care of the Oireachtas exclusively, and shall not be cognisable by any Court under any of the provisions of this Constitution.[26]

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[23] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 45.1.
[24] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 45.2 and Article 45.3.
[25] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 45.4.
[26] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 45.

3.3 The European Convention on Human Rights Act 2003

Ireland ratified the ECHR in 1953 and was the first contracting party to issue a declaration under Article 46 of the Convention, thereby recognising the validity of the ECtHR. As noted above, Ireland operates a dualist system in respect of international law, the effect of which was to render the ECHR subsequent to its ratification applicable on the State but not in the State. This meant, that while Convention rights could certainly be argued in Irish courts, there was no legal requirement on Irish judges to apply Convention jurisprudence in domestic cases. The only source of redress for an alleged breach of a Convention right was to exhaust the domestic legal system, and thereafter litigate the claim before the European Court of Human Rights in Strasbourg. That is not to say, however, that the Strasbourg jurisprudence had no impact in Ireland. Following a successful litigation of a claim before the ECtHR, the Irish State would be bound to adhere by the Strasbourg judgment and if necessary to amend Irish law to come into compliance with the said judgment as was the outcome of *Norris v Ireland*[27] and *Croke v Smith.*[28]

The ECHR was formally adopted into domestic law in Ireland by virtue of the European Convention on Human Rights Act 2003 (hereafter 'the 2003 Act'). Both the need for incorporation, and the chosen method of incorporation, raised significant academic debate.[29] On the one hand, commentators argued that the 2003 Act added little value for litigants, in that sufficient protection existed already in the constitutional jurisprudence of the Irish courts and in the cognisance already taken of

[27] *Norris v Ireland* Application No. 10581/93, (1988) 13 EHRR 186.
[28] *Croke v Smith* [1998] 1 IR 101; *Croke v Ireland* Application No. 3326/96, Judgment (Striking Out) Strasbourg, December 21, 2000. *See* Keys, Mary "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 24 *Dublin University Law Journal* 26 and O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: FirstLaw, 2005) at 141.
[29] *See* for example Egan, Suzanne "The European Convention on Human Rights Act 2003: A Missed Opportunity for Domestic Human Rights Litigation" (2003) 25 *Dublin University Law Journal* 230; O'Connell, Donncha, "The ECHR Act 2003: A Critical Perspective" *in* Kilkelly, Ursula, *ECHR and Irish Law* (Dublin: Jordans, 2004) at 1; Hogan Gerard, "Incorporation of the ECHR: Some Issues of Methodology and Process" *in* Kilkelly, Ursula, *ECHR and Irish Law* (Dublin: Jordans, 2004) at 13; and O'Connell, Donncha, "The Added Value of Sub-Constitutional Incorporation: ECHR Act 2003" *in* Carolan, Eoin and Doyle, Oran, eds., *The Irish Constitution: Governance and Values* (Dublin: Thomson Round Hall, 2008) at 490.

ECtHR decisions.[30] On the other hand, incorporation was seen as a means to introduce aspects of ECtHR protections that had not heretofore been embraced by the Irish judiciary from the precedents emanating from the ECtHR.[31] The 2003 Act adopts a similar mechanism for incorporation of the ECHR as that adopted in the Human Rights Act 1998 in England.[32] With the sub-constitutional method of incorporation adopted, the ECHR rights remain subject to the provisions of the Constitution and to the unenumerated rights recognised by the courts under Article 40.3.

The 2003 Act introduces a requirement on the judiciary in all cases to 'interpret and apply law' in a manner that is compatible with the State's obligations under the ECHR,[33] and to take 'judicial notice' of the Convention's provisions and of the judgments of the ECtHR and the Council of Europe Committees.[34] Possibly the most important provision in the 2003 Act for litigants seeking to mount human rights claims before the Irish courts is section 3(1) which provides as follows:

> 3.—(1) Subject to any statutory provision (other than this Act) or rule of law, every organ of the State shall perform its functions in a manner compatible with the State's obligations under the Convention provisions.[35]

An 'organ of the State' is defined in the Act as:

> 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.[36]

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[30] *See* for example the summary of the arguments of opponents in O'Connell, Donncha, "The ECHR Act 2003: A Critical Perspective" *in* Kilkelly, Ursula, *ECHR and Irish Law* (Dublin: Jordans, 2004) at 1.

[31] *See* O'Connell, Donncha, "The Added Value of Sub-Constitutional Incorporation: ECHR Act 2003" *in* Carolan, Eoin and Doyle, Oran, eds., *The Irish Constitution: Governance and Values* (Dublin: Thomson Round Hall, 2008) at 490.

[32] Human Rights Commission, *European Convention on Human Rights Act 2003* (Dublin: Human Rights Commission, 2011) <http://www.ihrc.ie/enquiriesandlegal/europeanconvent.html> accessed 10 January 2011.

[33] European Convention on Human Rights Act 2003, s 2.

[34] European Convention on Human Rights Act 2003, s 4.

[35] European Convention on Human Rights Act 2003, s 3(1).

[36] European Convention on Human Rights Act 2003, s 1.

In *Application of Gallagher (No. 2)*[37] a divisional sitting of the High Court (Geoghegan, Laffoy and Kelly JJ) considered the question of whether decisions of the Minister for Justice on the continued detention of the applicant in the Central Mental Hospital on foot of the criminal law's special 'guilty but insane' verdict[38] could be amendable to judicial review. That question was answered in the affirmative. The High Court has subsequently, on this rationale, accepted the application of the 2003 Act to judicial review challenges brought in respect of both the Mental Health (Criminal Law) Review Board under the Criminal Law (Insanity) Act 2006[39] and the Mental Health Tribunals under the MHA 2001.[40]

Under the 2003 Act, the Court can award a successful applicant damages for a breach of their ECHR rights, but only where no other damages (such as damages for breach of a constitutional right, or injunctive relief) are available.[41] Under section 5 of the Act, the Court may make a 'declaration of incompatibility', if it finds that legislation or a rule of law is incompatible with the State's obligations under the ECHR.[42] Copies of all declarations made under section 5 must be laid before the Houses of the Oireachtas by the Taoiseach within 21 days. The affected provisions remain in force until their amendment, or until they are declared unconstitutional. This has the effect of requiring that any necessary law reform is performed by the legislature, and not by the judiciary, and preserves the separation of powers.[43]

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[37] *Application of Gallagher (No. 2)* [1996] 3 I.R. 10 (H.C.).
[38] The 'guilty but insane' verdict has now been replaced with the 'not guilty by reason of insanity' verdict by the Criminal Law (Insanity) Act 2006.
[39] *See* for example *JB v Mental Health (Criminal Law) Review Board & Ors* [2008] IEHC 303.
[40] *See* for example *JH v Russell (Clinical Director of Cavan General Hospital); and the Health Service Executive and the Human Rights Commission (Notice Parties)* [2007] IEHC 7 and *SM v. The Mental Health Commission, The Mental Health Tribunal and The Clinical Director of St. Patrick's Hospital, Dublin; and The Attorney General and The Human Rights Commission (Notice Parties)* [2008] IEHC 441.
[41] European Convention on Human Rights Act 2003, s 3(2).
[42] European Convention on Human Rights Act 2003, s 5.
[43] Human Rights Commission, *European Convention on Human Rights Act 2003* (Dublin: Human Rights Commission, 2011) <http://www.ihrc.ie/enquiriesandlegal/europeanconvent.html> accessed 10 January 2011.

3.4 Interpretation of constitutional rights claims

For a constitutional rights claim to be adjudicated upon and interpreted by the courts, the claim must be accepted to be justiciable, that is, a claim that is amenable to judicial scrutiny.[44] The justiciability of certain rights has proved contentious in Irish constitutional law. A right that is justiciable, is a right, the defence or provision of which, is not reserved to the exercise of the legislative or executive functions.

In particular, the scope and breadth of the right to provision of education has been the subject of significant legal challenges and has been addressed on several occasions by the Supreme Court. In many of the 'right to education' cases, the idea of an entitlement to access to a certain standard of health care has also been canvassed, and the 'right to health care' argument has also been utilised in some traveller accommodation cases, where the conditions of the applicant's housing is argued to have injured their health to such an extent as to infringe on their right to bodily integrity and thereby trigger a right to better housing.

The issue of whether or not a particular type of rights dispute is amenable to scrutiny by the courts is commonly referred to as 'the justiciable controversy'. The conventional position is that a court will not adjudicate on any controversies that concern a purely political matter, or on a controversy concerning the manner of an administrative body's legitimate exercise of its administrative function.

The precedent in *McDonald v Bord na gCon (No. 2)*[45] is used to filter out the justiciable from the non-justiciable. The case establishes the criteria that must be addressed if the controversy is to be considered justiciable, and these are discussed in more detail at § 3.4.2 below. In other jurisdictions efforts have been made to formulate a universal test for the discovery of justiciable controversies but the Irish courts have chosen to adopt a more pragmatic approach to the question.

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[44] *See* Hogan, Gerard and Gerry Whyte, eds, *JM Kelly's The Irish Constitution*, 4th ed (Dublin: Butterworths, 1994), at 609 *et seq*.
[45] *McDonald v Bord na gCon (No. 2)* [1965] IR 217; (1965) 100 ILTR 89.

3.4.1 The judicial power

It was noted above that the doctrine of separation of powers is enshrined in the Constitution. The powers of the nation derive from the People (Article 6)[46], and those powers are then divided out between the parliament (Article 15);[47] the government (Article 28)[48] and the courts (Article 34). These three divisions approximate the classical legislative–executive–judicial division in the doctrine of the separation of powers. Article 34.1 of the Constitution outlines the purpose of the courts:

> Justice shall be administered in courts established by law by judges appointed in the manner provided by this Constitution, and, save in such special and limited cases as may be prescribed by law, shall be administered in public.[49]

This judicial function is limited to those matters that are justiciable, which Hogan and Whyte neatly encapsulate as establishing a system founded on "the exclusive administration of justice by a judiciary separate from the other arms of government (and immune from interference by them)".[50]

Lynham v Butler (No 2),[51] is often considered to be the founding principle of the doctrine of non-justiciability in this jurisdiction. The Constitution of the Irish Free State 1922, in Article 64, had preserved the existing structure of the judicial function as it operated under British rule. In respect of certain matters, the adjudicative power of the State was entrusted by statute to numerous *ex curia* tribunals whose decisions remained amenable to judicial review. One of these was the ascertainment of lands to be vested in the Land Commission.[52] *Lynham v Butler (No 2)*, was the first challenge

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[46] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 6.1: "All powers of government, legislative, executive and judicial, derive, under God, from the people, whose right it is to designate the rulers of the State and, in final appeal, to decide all questions of national policy, according to the requirements of the common good."

[47] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 15.2.1: "The sole and exclusive power of making laws for the State is hereby vested in the Oireachtas: no other legislative authority ahs power to make laws for the State."

[48] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 28.2: "The executive power of the State shall, subject to the provisions of this Constitution, be exercised by or on the authority of the Government."

[49] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 34.1.

[50] Hogan, Gerard and Gerry Whyte, eds, *JM Kelly's The Irish Constitution*, 4th ed (Dublin: Butterworths, 1994) at 609.

[51] *Lynham v Butler* (No 2) [1933] IR 74; (1933) 67 ILTR 75.

[52] Land Act 1923, s 40.

to the constitutionality of the exercise by these *ex curia* tribunals of the judicial adjudicative function, and it was framed in the form of a challenge to the constitutionality of the activities of the Land Commission.

In the Supreme Court, Kennedy, CJ took the opportunity to attempt to describe a definition of 'judicial power', characterising it as being (a) the determination, in accordance with the laws of the State, of all controversies of a justiciable nature that arise within the jurisdiction of the State; and (b) the exercise of the State's authority over persons and property for the purpose of determining such controversies, including the power to compel witnesses and the execution its decisions.[53] Kennedy CJ went on to find that adjudications made by ex curia tribunals, while being ancillary to it, were not an exercise of the judicial power. This portion of Kennedy CJ's decision in *Lynham v Butler* was later cited with approval in *Halpin v Attorney General*,[54] and *The State (McKay) v Cork Circuit Judge*.[55]

In his judgment, Johnston, J referenced both the constitutional jurisprudence of the United States and Blackstone's Commentaries as providing the grounding for the concept of non-justiciability. Johnston, J stated that, were the Court to take the separation of powers doctrine literally, it would mean that every last adjudication on any matter potentially capable of being adjudicated on by a judge in a court of law would be exclusively reserved to the judicial system. The Court held that this kind of 'watertight compartmentalisation'[56] would be impossible in practical application, and that a certain degree of fluidity is necessary in the concept in order for it to be workable. In other words, certain types of decisions exist, which in theory could be made by a court of law, but which are considered more appropriately adjudicated upon by the legislative or executive forums, and these are considered to be 'non-justiciable'.

Johnston, J also took the opportunity in *Lynham v Butler* to elaborate on the meaning of 'judicial power'. He characterised the Land Commission's functions as being primarily administrative, and that while that necessitated the Commission having

[53] *Lynham v Butler* (No 2) [1933] IR 74; (1933) 67 ILTR 75, IR at 100.
[54] *Halpin v Attorney General* [1936] IR 266; (1935) 69 ILTR 259.
[55] *The State (McKay) v Cork Circuit Judge* [1937] IR 650.
[56] *Lynham v Butler* (No 2) [1933] IR 74; (1933) 67 ILTR 75, IR at 121, paraphrasing Johnston J.

some ancillary quasi-judicial powers, these did not in any way amount to an exercise of 'judicial power'.[57] Johnston J, as Kennedy CJ had been, was clear to differentiate between 'exercising judicial power' and 'acting judicially'.[58]

With the introduction of the 1937 Constitution the question of administrative bodies engaged in adjudication was addressed again:

> Nothing in this Constitution shall operate to invalidate the exercise of limited functions and powers of a judicial nature, in matters other than criminal matters, by any person or body of persons duly authorised by law to exercise such functions and powers, notwithstanding that such person or such body of persons is not a judge or a court appointed or established as such under this Constitution.[59]

Hogan and Whyte posit that the result of the 1937 reformulation is that three distinct forms of 'judicial' activity are now explicitly recognised, but no greater degree of clarity as to the nature of 'judicial power' and its demarcation lines, was in fact achieved by the new provision. The three recognised forms of 'judicial' activity provided for in the 1947 Constitution, according to Hogan and Whyte, are:

1. The exercise of 'judicial power', only possible by judges in court;
2. Administrative bodies' ability to 'act judicially' without exercising 'judicial power'; and
3. The ability of certain fora to 'act in a limited judicial nature within the meaning of Article 37'.[60]

The authors' conclusion is one that had also been arrived at twenty years earlier, in *In re Solicitors Act 1954* by Kingsmill Moore J:

> From none of the pronouncements as to the nature of judicial power which have been quoted can a definition at once exhausted and precise be extracted, and probably no such definition can be framed.[61]

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[57] *Lynham v Butler* (No 2) [1933] IR 74; (1933) 67 ILTR 75, IR at 124.
[58] *Lynham v Butler* (No 2) [1933] IR 74; (1933) 67 ILTR 75, IR at 123.
[59] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 37.1.
[60] Hogan, Gerard and Gerry Whyte, eds, *JM Kelly's The Irish Constitution*, 4th ed (Dublin: Butterworths, 1994) at 617.
[61] *In re Solicitors Act 1954* [1960] IR 239, at 271.

The most authoritative decision on what constitutes an exercise of a judicial function is often considered to be that of Kenny J in *McDonald v Bord na gCon (No. 2)*.[62] In the High Court, Kenny J outlined five features he considered to be characteristic of an exercise of judicial power:

1. A dispute or controversy as to the existence of legal rights or a violation of the law;
2. The determination or ascertainment of the rights of parties or the imposition of liabilities or the infliction of a penalty;
3. The final determination (subject to appeal) of legal rights or liabilities or the imposition of penalties;
4. The enforcement of those rights or liabilities or the imposition of a penalty by the court or by the executive power of the State which is called in by the court to enforce its judgment;
5. The making of an order by the court which as a matter of history is an order characteristic of courts in this country.[63]

In *Re Philip Clarke*[64] the Supreme Court held that the power of the executive to order the compulsory detention of the mentally ill was not infringing on the judicial power, even though the decision to detain would amount to a deprivation of liberty. These decisions nonetheless remain amenable to judicial review, as will be discussed below.

3.4.2 A justiciable dispute

The first direct pronouncement on justiciability in this jurisdiction was laid down by the Supreme Court in *Philip Tormey v The Attorney General and Ireland*.[65] Referring to the full original jurisdiction of the High Court as expressed in Article 34.3.1°, Henchy, J stated:

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[62] *McDonald v Bord na gCon (No. 2)* [1965] IR 217; (1965) 100 ILTR 89.
[63] *McDonald v Bord na gCon (No. 2)* [1965] IR 217; (1965) 100 ILTR 89.
[64] *Re Philip Clarke* [1950] IR 235; (1949) 85 ILTR 119.
[65] *Philip Tormey v The Attorney General and Ireland* [1985] ILRM 375.

> At first view it might be thought that there is given to the High Court jurisdiction to determine 'all matters and questions', but that cannot be so, for in the nature of things there are matters and questions which are not amenable to determination by any court. They are not justiciable. Consequently, 'all matters and questions' must be read as confined to 'all justiciable matters and questions'. But even 'all justiciable matters and questions' expresses too widely the jurisdiction conferred by Article 34.3.1°, for other constitutional provisions show that an original jurisdiction in certain justiciable matters and questions shall, or may, be exercised by other courts, tribunals, persons or bodies.[66]

In other words, the 'full original jurisdiction' of the High Court is not a *carte blanche* to consider any and all grievances that may be addressed to it, as some grievances are not properly addressed to the courts system. It could not even be described as complete freedom to decide on all those grievances that are so properly addressed to the courts – as certain of those grievances are reserved to particular courts, tribunals, persons, or bodies. One such example might be the mandatory referring of certain personal injury suits to the Personal Injuries Assessment Board.[67] It would appear from this ruling that the decision as to what is or is not justiciable is one made on a case by case basis and that the primary criterion is whether or not the question is 'amenable to determination by any court'.

In *Duff v Minister for Agriculture*,[68] the Supreme Court held that the courts cannot review questions of government policy as there is no 'yardstick' by which the courts can review such decisions.[69] While this clearly states that certain matters are not amenable to determination by the courts, and are accordingly non-justiciable, it provides no guidance as to what those matters might be and therefore remains a contentious issue within this jurisdiction.

In general, any claim, which requires the courts to engage in an activity that appears to be a form of distributive justice, will be rejected by the courts as being non-justiciable. Thus in *O'Reilly v Limerick Corporation*[70] the applicant family were

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[66] *Philip Tormey v The Attorney General and Ireland* [1985] ILRM 375.
[67] Personal Injuries Assessment Board Act 2003, s 3.
[68] *Duff v Minister for Agriculture* [1993] 2 CMLR 969 (Supreme Court); [1994] 2 IJEL 247 (High Court).
[69] *Duff v Minister for Agriculture* [1993] 2 CMLR 969 (Supreme Court); [1994] 2 IJEL 247 (High Court).
[70] *O'Reilly and Ors v Limerick Corporation* [1989] ILRM 181.

unable to mount an argument for a right to the provision of housing as the petition was viewed as requiring the court to engage in distributive justice, which is an activity reserved to the executive. Similarly in *Sinnott v Minister for Education*;[71] *O'Donoghue v Minister for Health*;[72] and *TD v Minister for Education*[73] the court could not be cognisable of claims to a right to education if the claimant was older than the age fixed by the Executive as the cut-off point for 'primary education', as the Constitution made only the right to 'primary' education justiciable before the courts. The decisions in *NWHB v HW & CW*[74] adopted the same logic in respect of the justiciability of decisions to adopt the mandatory provision of certain medical tests and treatments.

By contrast, however, in *O'Donoghue v Legal Aid Board*[75] Kelly J rejected the arguments put forward on the part of the State that to order that the delay experienced by the applicant in receiving a certificate for legal aid constituted a breach of his constitutional rights would amount to the court engaging in distributive justice as it would represent the judiciary intervening in the executive's allocation of resources in respect of the legal aid programme:

> This case is not concerned with a claim for any form of mandatory relief against the State. The court is doing no more than what the courts have been doing since at least *Ryan v Attorney General* namely, ensuring that a right under the Constitution is protected and given effect. As was stated by Keane CJ in *Sinnott v Minister for Education* at page 631:-
>
> > 'That is not to say that where a plaintiff successfully claims that his constitutional rights have been violated by the State in the past and will continue to be so violated in the future (which is not the case here) unless the court intervenes, the courts are impotent when it comes to the protection of those rights.'[76]

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[71] *Sinnott (a minor suing by his mother and next friend) v Minister for Education, Ireland and the Attorney General* [2000] IEHC 21; [2001] IESC 63; [2001] 2 IR 545.
[72] *O'Donoghue v Minister for Health* [1996] 2 IR 20.
[73] *T.D. (a minor suing by his mother and next friend M.D.) v Minister for Education, Ireland and the Attorney General, the Eastern Health Board and by Order of the Minister for Health and Children* [2001] IESC 101; [2001] 4 IR 259.
[74] *NWHB v HW & CW* (2001) 3 IR 622.
[75] *O'Donoghue v Legal Aid Board* [2004] IEHC 413.
[76] *O'Donoghue v Legal Aid Board* [2004] IEHC 413.

The above case law on what does and what does not constitute a justiciable question has been controversial.[77] This controversy has been addressed in some detail in here. Langwallner, by way of example, has argued that the courts have been overly cautious in refusing to extend the ambit of justiciable questions to encompass disputes involving rights of a socio-economic character that may engage the State in distributive justice, on the basis that the courts' decisions regularly result in fiscal consequences for the executive even in the realm of classic civil and political rights and that any concerns about judicial activism can by allayed by issuing declarative relief only and reserving mandatory relief for only the most 'doubly exceptional' cases.[78] The prevailing judicial stance however remains one of reluctance to be seen to be engaged in decision-making that directs the executive in the distribution of resources for social or economic purposes.

Attention will now turn to the types of human rights claims commonly engaged by claimants in mental health litigation in Ireland.

3.5 Dignity claims

Dignity claims are founded on an argument either that a particular entitlement that will safeguard the claimant's dignity, or that freedom from being subjected to a certain treatment will avoid diminishment of the claimant's dignity.[79] Dignity is

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[77] *See* also Hogan, Gerard, "The Sinn Féin Funds Judgment Fifty Years On" (1997) 2 (9) *Bar Review* 375; McDermott, Paul Anthony, "The Separation of Powers and the Docrine of Non-Justiciability" (2000) 35 *Irish Jurist* 55; Ruane, Blathnaid, "The Separation of Powers and the Grant of Mandatory Orders to Enforce Constitutional Rights" (2000-1) 5 *Bar Review* 416; Hogan, Gerard, "Directive Principles, Socio-Economic Rights and The Constitution" (2001) 36 *Irish Jurist* (new series) 174; Gwynn Morgan, David, "'Judicial-o-centric' Separation of Powers on the Wane?" (2004) 39 *Irish Jurist* 162; Whyte, Gerry, "The Role of The Supreme Court in our Democracy: A Response to Mr Justice Hardiman" (2006) *Dublin University Law Journal* 1; Foley, Brian, "Diceyean Ghosts: Deference, rights, Policy and Spatial Distinctions" (2006) *Dublin University Law Journa*l 77; Keating, Alan and Lowry, Anthony, "The Separation of Powers – The Supreme Court's Approach to Affirmative Duties" (2003) 21 *Irish Law Times* 103 (Part I) and (2003) 21 *Irish Law Times* 118 (Part II); Whyte, Gerry, *Social Inclusion and the Law: Public Interest Law in Ireland* (Dublin: Institute of Public Administration, 2002) and Gwynn Morgan, David, *A Judgment Too Far? Judicial Activism and the Constitution* (Cork: Cork University Press, 2001).

[78] Langwallner, David, "Separation of Powers, Judicial Deference and the Failure to Protect the Rights of the Individual", *in* Carolan, Eoin and Doyle, Oran, eds., *The Irish Constitution: Governance and Values* (Dublin: Thomson Round Hall, 2008), 257-276.

[79] *See Re Philip Clarke* (1950) IR 235 and *The State (C) v Frawley* [1976] IR 365.

generally argued alongside other rights claims and in the Irish constitutional context, dignity claims have arisen frequently in cases concerned with the right to life.[80]

Dignity is a core concept of the international human rights documents, featuring in the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the International Covenant on Economic Social and Cultural Rights.[81] It is given explicit protection in the Preamble to the Irish Constitution:

> In the Name of the Most Holy Trinity, from Whom is all authority and to Whom, as our final end, all actions both of men and States must be referred,
>
> We, the people of Éire,
>
> Humbly acknowledging all our obligations to our Divine Lord, Jesus Christ, Who sustained our fathers through centuries of trial,
>
> Gratefully remembering their heroic and unremitting struggle to regain the rightful independence of our Nation,
>
> And seeking to promote the common good, with due observance of Prudence, Justice and Charity, so that the dignity and freedom of the individual may be assured, true social order attained, the unity of our country restored, and concord established with other nations,
>
> Do hereby adopt, enact, and give to ourselves this Constitution.[82]

Dignity has been described by O'Dowd as the most fundamental of all values under the Constitution.[83] Binchy argues that the reference to dignity in the Preamble represents the imposition of an obligation on the State to assure the dignity of individuals, an obligation he describes as "a stern task."[84] Binchy asserts that the precedents in the unenumerated rights cases of *McGee v Attorney General*[85] and *Norris v Attorney General*[86] demonstrate a judicial perception of dignity that "envisages a social scaffolding capable of supporting the individual fulfilment of

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[80] *See* for example *Re a Ward of Court* (No 2) [1995] IESC 1; [1996] 2 IR 73; [1995] 2 ILRM 401.
[81] *See* discussion in Chapter 4 of dignity in the international human rights documents and in the European Convention of Human Rights and European Social Charter.
[82] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Preamble.
[83] O'Dowd, John, "Dignity and Personhood in Irish Constitutional Law" *in* Quinn, Gerard, eds, *Justice and Legal Theory in Ireland* (Dublin: Oak Tree Press, 1994), 163-181.
[84] Binchy, William, "Dignity as a Constitutional Concept" *in* Carolan, Eoin and Doyle, Oran, eds., *The Irish Constitution: Governance and Values* (Dublin: Thomson Round Hall, 2008) 307-326, 310.
[85] *McGee v Attorney General* [1974] IR 284.
[86] *Norris v Attorney General* [1984] IR 36.

human potential."[87] This construction of dignity involves an understanding of dignity as a concept that informs personhood, rather than as an individual human right: it is a quality inherent in all people which is to be maximised in the recognition and protection of all other human rights, rather than a quality present or not depending on whether it has been sufficiently protected as a human right by itself. To this end, Binchy is somewhat critical of the Supreme Court decision in *Re a Ward of Court (No 2)*.[88] In that case Hamilton CJ held that while the right to life ranks first among all of the constitutionally protected rights, it can be subject to autonomy, self-preservation, privacy and dignity,[89] while Denham J described a "right to dignity" which she equated with a right to be treated with dignity.[90] Binchy considers this approach, whereby dignity is externalised from the person and is capable of being diminished or even removed entirely by the external actions of others, as inconsistent with the philosophy of the Constitution.[91]

As was noted in Chapter 2 in relation to dignity at the international human rights level, much jurisprudence involving the concept of dignity arises in the context of a primary claim under another right, with a violation of the applicant's dignity included as a facet of that primary human rights claim. Thus, many of the cases alleging breaches of a person's constitutional rights to privacy, or to bodily integrity, or to equality, feature a strong dignity argument as part of their submissions. Dignity as a constitutional right has been argued in a significant number of cases in respect of which written decisions have been issued by the superior courts.[92] A number of cases

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[87] Binchy, William, "Dignity as a Constitutional Concept" *in* Carolan, Eoin and Doyle, Oran, eds., *The Irish Constitution: Governance and Values* (Dublin: Thomson Round Hall, 2008) 307-326, 316.
[88] *Re a Ward of Court* (No 2) [1995] IESC 1; [1996] 2 IR 73; [1995] 2 ILRM 401.
[89] *Re a Ward of Court* (No 2) [1995] IESC 1; [1996] 2 IR 73; [1995] 2 ILRM 401, at 123.
[90] *Re a Ward of Court* (No 2) [1995] IESC 1; [1996] 2 IR 73; [1995] 2 ILRM 401, at 163.
[91] Binchy, William, "Dignity as a Constitutional Concept" *in* Carolan, Eoin and Doyle, Oran, eds., *The Irish Constittion: Governance and Values* (Dublin: Thomson Round Hall, 2008) 307-326, 317.
[92] A search of the British and Irish Legal Information Initiative (BAILII) website for the keyword "dignity", with results limited to judgments delivered by the superior courts of Ireland, yields a result of some 163 judgments. See <http://www.bailii.org> accessed 10 May 2011. Many of the cases returned in this search, however, do not involve the interpretation of the constitutional right to dignity. For example, the judgment may contain a quotation from another document that mentions dignity, but the judgment in the matter before the court does not address dignity as a constitutional concept. This occurs in *CC v Clinical Director of St. Patricks Hospital & Anor* [2009] IEHC 13 (20 January 2009) in which McMahon J refers to the dignity argument raised in the ECtHR decision in *Storck v Germany* Application No. 61603/00 (2005) 43 EHRR 96 but does not refer to dignity in the context of the Irish Constitution. Other cases returned by the search function concern the application of the concept of dignity under the Constitution in the context of the interpretation of criminal statutes, as in for example, *CC v Ireland & Ors* [2006] IESC 33 (23 May 2006).

are chosen here for discussion, on the basis of the strength of their reference to the concept of constitutional dignity, or for their treatment of constitutional dignity within the application of the mental health law regime.

In *In Re a Ward of Court (No. 2)*[93] the applicants was the committee of a ward of court who sought a permissive order from the court allowing for the cessation of the provision of artificial nutrition to the ward, who was in a persistent vegetative state. As was noted above, in granting the order sought Hamilton CJ held that while the right to life may in certain circumstances take second place to other constitutional rights including the right to dignity,[94] while Denham J outlined a number of specifically recognised constitutional rights including a "right to dignity" which may, in circumstances where they are being grossly or disproportionately interfered with, override even the right to life.[95]

In *Attorney General v X*[96] the Attorney General sought an injunction restraining a minor from travelling abroad to obtain an abortion, on the grounds that her doing so would infringe upon the right to life of her unborn child, as protected by Article 40.4.3 of the Constitution. The Supreme Court refused to grant the injunction sought, with O'Flaherty J holding that to grant the injunction would be to recognise a regime of restrictions of citizens' freedom of movement that would be "impossible to reconcile with a Constitution one of the primary objects of which, as stated in its Preamble, is to assure the dignity and freedom of the individual"[97] and Finlay CJ referring to the reliance placed on the reference to dignity in the Preamble to the Constitution in the decisions in *McGee v Attorney General*[98] and *State (Healy) v Donoghue.*[99]

In *McGee v Attorney General*[100] and in *Norris v Attorney General*[101] the constitutional right to dignity was cited in the context of the recognition of the unenumerated rights

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[93] *Re a Ward of Court* (No 2) [1995] IESC 1; [1996] 2 IR 73; [1995] 2 ILRM 401.
[94] *Re a Ward of Court* (No 2) [1995] IESC 1; [1996] 2 IR 73; [1995] 2 ILRM 401, at 123.
[95] *Re a Ward of Court* (No 2) [1995] IESC 1; [1996] 2 IR 73; [1995] 2 ILRM 401, at 163.
[96] *Attorney General v X* [1992] 1 IR 1.
[97] *Attorney General v X* [1992] 1 IR 1, § 168 (O'Flaherty, J).
[98] *McGee v Attorney General* [1974] IR 284.
[99] *The State (Healy) v Donoghue* [1976] IR 325.
[100] *McGee v Attorney General* [1974] IR 284.

to privacy and to bodily integrity. Dignity was also canvassed in the decision on the constitutional right to equality in *Quinn's Supermarket v Attorney General*[102] and in *Foy v An t-Ard Chláraitheoir & Ors*[103] in which the appplicant claimed that the failure of the State to facilitate a change to the entry pertaining to gender on birth certificates amounted to a violation of the constitutional rights including the rights to privacy, dignity, equality, and marriage. The High Court (McKechnie J) cited the decisions of the High Court in *McKinley v Minister for Defence*;[104] *In Re: Article 26 Offences Against the State (Amendment) Bill*[105] and *In Re Philip Clarke*[106] as authority that the courts have found that "the dignity of an individual is a value to be pursued" and cited the decision of Denham J in the Supreme Court in *In Re a Ward of Court (No. 2)* in holding that the State must accord to the right to dignity "the same entitlement as it must give, inter alia to the right of privacy." [107] McKechnie J held that while a right to dignity undoubtedly exists, it is not an unqualified and absolute right: while the lack of a procedure to amend the gender entry on one's birth certificate may certainly constitute an invasion of that person's right to dignity, the violation of the right was defensible in the interest of maintaining a system of registration dealing with births, deaths, and marriages.

Finally, a number of cases pertaining to the mental health law regime have referenced the concept of dignity at a constitutional level.[108] The landmark mental health law

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[101] *Norris v Attorney General* [1984] IR 36.

[102] *Quinn's Supermarket v Attorney General* [1972] IR 1.

[103] *Foy v An t-Ard Chláraitheoir & Ors* [2002] IEHC 116 (9 July 2002) (McKechnie, J).

[104] *McKinley v Minister for Defence* [1992] 2 IR 333.

[105] *In Re: Article 26 Offences Against the State (Amendment) Bill* [1940] IR 470.

[106] *In Re Philip Clarke* (1950) IR 235.

[107] *Foy v An t-Ard Chláraitheoir & Ors* [2002] IEHC 116 (9 July 2002), § 140 (McKechnie, J).

[108] A number of mental health cases appear on a search of the BAILII database for the keyword "dignity" which do not actually contain an analysis of dignity as a constitutional concept. These include *Han v President of the Circuit Court* [2008] IEHC 160 (30 May 2008); *TO'D v Kennedy & Ors* [2007] IEHC 129 (25 April 2007); *R v Clinical Director of St. Brendan's Hospital & Anor* [2009] IEHC 143 (24 March 2009); *SM v The Mental Health Commissioner & Ors* [2008] IEHC 441 (31 October 2008); *EJW (APUM) v Watters & Anor* [2008] IEHC 462 (25 November 2008) and *C v Clinical Director of St. Patrick's Hospital* [2009] IEHC 47 (06 February 2009) (Hedigan J), all of which make reference to the obligation in s 4 (3) of the MHA 2001 that decisions taken under the Act be in the patient's best interests and respect their constitutional right to dignity, but which do not otherwise refer to the constitutional right to dignity. The decision in *CC v Clinical Director of St. Patricks Hospital & Anor* [2009] IEHC 13 (20 January 2009) (McMahon J) refers to the dignity argument raised in the ECtHR decision in *Storck v Germany* but does not refer to dignity in the context of the Irish Constitution or in respect of s 4 of the MHA 2001. In *Blehein v St. John of God Hospital* [2002] IESC 43 (31st May, 2002) the applicant sought leave to litigate his claim that, *inter alia*, his

case in respect of the constitutional right to dignity is *In Re Philip Clarke.*[109] In that case, which concerned a challenge to the provisions pertaining to compulsory admissions to the Central Mental Hospital under the 1945 Act, O'Byrne J specifically addressed the interaction between the constitutional protection of dignity and the compulsory committal and treatment regime under the 1945 Act:

> The impugned legislation is of a paternal character, clearly intended for the care and custody of persons suspected to be suffering from mental infirmity and for the safety and well-being of the public generally. The existence of mental infirmity is too widespread to be overlooked, and was, no doubt, present to the minds of the draughtsmen when it was proclaimed in Art 40, 1, of the Constitution that, though all citizens, as human beings, are to be held equal before the law, the State may, nevertheless, in its enactments, have due regard to differences of capacity, physical and moral, and of social function. We do not see how the common good would be promoted or the dignity and freedom of the individual assured by allowing persons, alleged to be suffering from such infirmity, to remain at large to the possible danger of themselves and others.[110]

This passage from O'Byrne J's judgment has since been quoted with approval in *Croke v Smith*[111] and *Gooden v St. Otteran's Waterford Regional Hospital*[112] in relation to the 1945 Act; in *B v Mental Health (Criminal Law) Review Board & Ors*[113] in relation to the Criminal Law (Insanity) Act 2006 (dealing with forensic compulsory committals and treatment); and in *EH v St. Vincent's Hospital & Ors*[114] and *MR v Byrne & Ors*[115] in relation to the MHA 2001.

Finally, in *Maria (ET) v Clinical Director of the Central Mental Hospital & Anor*[116] the applicant claimed that her detention in a hospital that was unable to provide her with the specialised care she required amounted to a violation of her constitutional right, including to her right to dignity. In the High Court Clarke J held that an

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constitutional right to dignity had been infringed by the administration of psychiatric medication, but the Supreme Court (McGuinness J) upheld the High Court's refusal to grant leave to litigate.

[109] *In Re Philip Clarke* (1950) IR 235.

[110] *In Re Philip Clarke* (1950) IR 235, 247.

[111] *Croke v Smith* [1995] IEHC 6 (31st July, 1995).

[112] *Gooden v St. Otteran's Waterford Regional Hospital* [2001] IESC 14 (21 February 2001).

[113] *B v Mental Health (Criminal Law) Review Board & Ors* [2008] IEHC 303 (25 July 2008).

[114] *EH v St. Vincent's Hospital & Ors* [2009] IESC 46 (28 May 2009).

[115] *MR v Byrne & Ors* [2007] IEHC 73 (02 March 2007).

[116] *Maria (ET) v Clinical Director of the Central Mental Hospital & Anor* [2010] IEHC 378 (2 November 2010).

inability to provide specialised care in a particular approved centre did not of itself amount to a violation of the right to dignity, and further that the conditions of her detention were reasonably necessary within the context of her medical condition and as such did not violate her constitutional rights.[117]

3.6 Liberty Claims

Liberty claims are grounded on an argument for a right to be left in freedom to live where and as one pleases. In the mental health context any form of detention in a mental health facility may engage the right to liberty, even where the formal involuntary detention provisions are not utilised, if the patient in question feels their liberty has been constrained against their will or choosing. Liberty claims also arise where challenges are mounted to either the substance of an involuntary detention regime, or to its manner of implementation, or to schemes intended to monitor the behaviour of patients in the community.[118]

The right to liberty is protected under the Constitution by Article 40 providing for a range of 'Personal Rights'. These include the right to life protected by Article 40.3.2; the right to liberty protected by Article 40.4.1; and the rights to freedom of association (Article 40.6.1.iii) and of expression (Article 40.6.1.i); and the right to equality (Article 40.1). Of these, the right to liberty has featured most prominently in the courts' jurisprudence on issues pertaining to mental health care and psychiatric treatment. Article 40.4.1 also contains a fair procedures aspect, in the form of a *habeas corpus* type right to have one's detention reviewed by a High Court judge, and this is discussed below, together with the Article 38.1 protection of the right to due course of law in criminal trials.

In *King v AG*,[119] the applicant argued that section 4 of the Vagrancy Act 1824, which criminalised 'loitering with intent', had not survived the enactment of the Constitution as its provisions infringed the Article 38.1 right to fair procedures in the criminal

[117] See the further discussion of this judgment at § 3.7 below.
[118] *See* for example *Re Philip Clarke* (1950) IR 235; *MMcN & Anor. v The Health Service Executive* (2009) IEHC 236; and *MR v Byrne & Ors* [2007] IEHC 73; [2007] 3 IR 211.
[119] *King v AG* [1981] IR 233.

context; the Article 40.4.1 right to liberty; and the Article 40.3.1 umbrella personal rights provision. The Supreme Court upheld the applicant's argument in respect of Article 40.4.1, on the grounds that the Constitution mandates that no citizen should be deprived of their liberty save in accordance with fair procedures (under Article 38.1), and that the crime created by section 4 of the 1824 Act was too subjective to secure that protection for the citizen. The Vagrancy Act 1824, was a piece of legislation with a particularly strong social hygiene bent, and in this decision the Supreme Court reinforced the right of every citizen to expect not to be deprived of their liberty save in accordance with fair procedures, and not merely on the basis of perceived undesirable behaviour or lifestyle. The principle's application in this fashion led to the utilisation of 'deprivation of liberty otherwise than in accordance with law' in a number of mental health cases thereafter.

In *Re Philip Clarke*[120] the applicant sought to impugn section 165 of the Mental Treatment Act 1945 (the 1945 Act), as infringing on the Article 40.1 protection of the right to liberty, on the basis that the provision for involuntary detention of a patient on the grounds of public safety without any mechanism for review of the necessity of that detention, was unconstitutional. The Supreme Court rejected that argument, holding that the paternal character of the 1945 Act rendered the limitations therein on the right to protection from deprivation of liberty, other than in accordance with fair procedures, compatible with the Article 40.1 constitutional provision that the State may, in its enactments, have regard to differences of physical, moral and social capacity among citizens:

> The impugned legislation is of a paternal character, clearly intended for the care and custody of persons suspected to be suffering from mental infirmity and for the safety and well-being of the public generally. The existence of mental infirmity is too widespread to be overlooked and was, no doubt, present to the minds of the draughtsmen when it was proclaimed in Article 40.1 of the Constitution that, though all citizens, as human beings are to be held equal before the law, the State may, nevertheless, in its enactments, have due regard to differences of capacity, physical and moral, and of social function. We do not see how the common good would be promoted or the dignity and freedom of the individual assured by allowing persons, alleged to be suffering from such infirmity, to remain at large to the possible danger of themselves and others.

[120] *Re Philip Clarke* [1950] IR 235.

> The section is carefully drafted so as to ensure that the person, alleged to be of unsound mind, shall be brought before, and examined by, responsible medical officers with the least possible delay. This seems to us to satisfy every reasonable requirement, and we have not been satisfied, and do not consider that the Constitution requires, that there should be a judicial inquiry or determination before such a person can be placed and detained in a mental hospital.
>
> The section cannot, in our opinion, be construed as an attack upon the personal rights of the citizen. On the contrary it seems to us to be designed for the protection of the citizen and for the promotion of the common good.[121]

By contrast, in *RT v The Director of the Central Mental Hospital*, Costello P had found that s 208 of the 1945 Act was unconstitutional.[122] The reasons for the Court's conclusion centred on the nexus between transfers to the Central Mental Hospital under the 1945 Act where a detained patient committed a crime while in hospital, and the protections afforded by the criminal process where crimes were committed outside of hospital.[123] Costello P, however, was very careful to highlight the purpose of mental health legislation, and the importance of taking cognisance of that purpose in interpretation of the legislation:

> The right to liberty is, of course, not an absolute right and its exercise is in fact and in many different ways restricted by perfectly valid laws, both common law and statutory. Adjudication on a challenge to restrictive laws will be helped by considering the object and justification advanced in support of the law. It is obvious that if the object of the law is to punish criminal behaviour different considerations will apply than when the impugned law has a totally different object, such as the welfare of the person whose liberty is restricted.
>
> The reasons why the Act of 1945 deprives persons suffering from mental disorder of their liberty are perfectly clear. It does so for a number of different and perhaps overlapping reasons – in order to provide for their care and treatment, for their own safety, and for the safety of others. Its object is essentially benign. But this objective does not justify any restriction designed to further it. On the contrary, the State's duty to protect the citizen's rights becomes more exacting in the case of weak and vulnerable citizens, such as those suffering from mental disorder. So, it seems to me that the constitutional imperative to which I have referred requires the Oireachtas to be particularly astute when depriving persons suffering from mental disorder of their liberty and that it should ensure that such legislation should contain adequate safeguards against abuse and error in the interests of those whose welfare the legislation is designed to support. And in considering such safeguards regard

[121] *In re Philip Clarke* [1950] IR 235, at 247.
[122] *RT v Director of the Central Mental Hospital* [1995] 2 ILRM 354; [1995] 2 IR 65.
[123] *RT v Director of the Central Mental Hospital* [1995] 2 ILRM 354; [1995] 2 IR 65, at 79-80.

should be had to the standards set by the Recommendations and Conventions of International Organisations of which this country is a member.[124]

Costello P's interpretation of the purpose of mental health legislation, while still paternalist in character, amounted to a more sophisticated analysis of the need to strike a balance between paternalist protection of vulnerable people, and human rights maximisation of their liberty (and other rights). In a similar vein, in *Blehein v Minister for Health*[125] Denham J in the Supreme Court (in holding that s 260 of the 1945 Act placed unreasonable and disproportionate restrictions on the constitutional right to litigate proceedings before the courts) highlighted that where the constitutional right to liberty is at issue, any limitation on that right "should not be overbroad, should be proportionate, and should be necessary to secure the legitimate aim."[126]

However, *In re Philip Clarke*, and its deferential treatment of limitations on the right to liberty in the light of a paternalist attitude to mental patients, has become the foundation stone in the survival of the paternalist approach in the interpretation of mental health legislation even after the adoption of the MHA 2001. In *Croke v Smith (No 2)*[127] the Supreme Court, relying heavily on the paternalist principles espoused in *In Re Philip Clarke*, overturned the decision of Budd J in the High Court that the provisions of the Mental Treatment Act 1945 dealing with the reception and detention of a patient in respect of whom a reception order had been made consequent upon a recommendation had infringed the right to liberty provided for in Article 40.4.1.

In the High Court Budd J had also referenced the paternalist character of the 1945 Act and had highlighted the stress that the Oireachtas had in adopting that approach chosen to place on the therapeutic relationship between doctor and patient.[128] Budd J felt, however, that the instant case could be distinguished from that of *In re Philip Clarke*, on the basis that whereas *In re Philip Clarke* had dealt with the provisions of

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[124] *RT v Director of the Central Mental Hospital* [1995] 2 ILRM 354; [1995] 2 IR 65, at 78-79.
[125] *Blehein v Minister for Health and Children* [2004] IEHC 374; [2004] 3 IR 610 (High Court, Carroll J), and *Blehein v Minister for Health and Children* [2008] IESC 40; [2009] 1 IR 275; [2008] 2 ILRM 401 (Supreme Court, Denham J).
[126] *Blehein v Minister for Health and Children* [2008] IESC 40 (Supreme Court, Denham J); [2008] 2 ILRM 401; [2009] 1 IR 275, at 281.
[127] *Croke v Smith (No 2)* [1998] 1 IR 101 (Supreme Court); [1995] IEHC 6 (31 July 1995) (Budd J).
[128] *Croke v Smith* [1995] IEHC 6 (31 July 1995) (Budd J), at 89.

the Act dealing with the making of a recommendation for reception, *Croke v Smith* concerned the making of the reception order itself and thus related to the patients "detention of an infinite duration without automatic independent review".[129] Budd J reviewed a substantial number of precedents from other jurisdictions, and referenced the ECHR and the United Nations Principles. Ultimately, however, his decision was based on Irish constitutional precedents and in particular on the decision of Costello P in *RT v Director of the Central Mental Hospital*. In holding that the impugned provisions of the 1945 Act were unconstitutional, and in forwarding the case to the Supreme Court as a case stated, Budd J stated that:

> I have come to the conclusion that the effect of a chargeable patient receiption order under Sections 163, 171 and particularly 172, which allows for detention until removal or discharge by proper authority or death, without any automatic independent review, falls below the norms required by the constitutional guarantee of personal liberty. The State accordingly has failed to respect, and as far as practicable by its laws, to defend and vindicate the personal rights of the citizen, particularly the right to personal liberty. There are no adequate safeguards to protect the Applicant against an error in the operation of Section 172. ... In the absence of independent review of the decision to detain and the lack of an automatic review of long-term detention of a "white card patient", such as the Applicant, the provisions of Section 172 of the M.T.A. 1945, as amended, are repugnant to the Constitution.[130]

The Supreme Court overturned the High Court, reasserting the primacy of the paternalist approach from *In re Philip Clarke* as a justification for the severe curtailments of the right to liberty provided for by the 1945 Act, and without performing the same depth of constitutional rights analysis as had been evident in Budd J's decision. Quoting extensively from *In re Philip Clarke*, Hamilton CJ ultimately concluded that:

> the sections of the Act of 1945 which permit the detention of a citizen, who is of unsound mind and requiring care and treatment and has been so certified, after examination, by two separate medical practitioners, satisfy every reasonable requirement and do not constitute an attack upon the personal rights of the citizen.[131]

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[129] *Croke v Smith* [1995] IEHC 6 (31 July 1995) (Budd J), at 130.
[130] *Croke v Smith* [1995] IEHC 6 (31 July 1995) (Budd J), at 131.
[131] *Croke v Smith (No 2)* [1998] 1 IR 101 (Supreme Court) (Hamilton CJ), at 116.

Whereas Budd J had been significantly concerned about the lack of an automatic review mechanism by which detentions under the 1945 Act could be independently monitored, Hamilton CJ dismissed any necessity for such a mechanism on the basis that the compulsory detention provisions of the 1945 Act did not involve the administration of justice, and that they "do not constitute an attack upon the personal rights of the citizen but rather vindicate and protect the rights of the citizen concerned by providing for their care and treatment and are not repugnant to the Constitution on this ground."[132]

Sadly, the more nuanced approach of Costello P in *RT v Director of the Central Mental Hospital* and of Budd J in *Croke v Smith* in the High Court was not taken up even in the twilight of the 1945 Act. In fact just prior to the enactment of the Mental Health Act 2001, the Supreme Court in *Gooden v St Otteran's Hospital*[133] held that where a provision of the Mental Treatment Act was required to be interpreted in a purposive fashion, the relevant purpose should follow the "paternal character" of the legislation.[134]

Furthermore, in *LK v Naas General Hospital*[135] Clarke J, having outlined the necessary requirements for the conduct of an Article 40 *habeus corpus* hearing in relation to a detention under the 1945 Act, then turned to consider the question of whether the *habeus corpus* mechanism as provided for in *Croke v Smith (No. 2)* was sufficient to satisfy the requirements of the ECHR. Having identified that the precedents in *X v United Kingdom* and *Winterwerp v Netherlands* entitle a detained patient to "early and, indeed, regular, access to a body which carries on its business in a manner similar to a court.... for the purposes of contesting the validity of their detention"[136] Clarke J then concluded that:

> ...the type of inquiry identified in *Croke v Smith (No. 2)* [1998] 1 I.R. 101 arising under Article 40.4.2° goes even further than the requirements necessary to satisfy article 5(4) of the Convention... There could not,

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[132] *Croke v Smith (No 2)* [1998] 1 IR 101 (Supreme Court) (Hamilton CJ), at 115.
[133] *Gooden v St. Otteran's Hospital* [2001] IESC 14; [2005] 3 IR 617.
[134] *Gooden v St. Otteran's Hospital* [2001] IESC 14; [2005] 3 IR 617.
[135] *LK v Naas General Hospital* [2006] IEHC 196; [2007] 2 IR 465 (Clarke J).
[136] *LK v Naas General Hospital* [2006] IEHC 196; [2007] 2 IR 465 (Clarke J), at 483.

> therefore, be any question of the applicant having been denied access to a court so as to satisfy article 5(4) of the Convention.[137]

Indeed, the *Re Philip Clarke* paternalism in respect of the right to liberty still informs the philosophy adopted by the courts in addressing these issues under the Mental Health Act 2001. In *MMcN v HSE*,[138] two patients suffering from severe dementia had been involuntarily detained under the Mental Health Act 2001 but had subsequently had their admission orders revoked after their conditions improved with treatment and their treating psychiatrists came to the decision that they were no longer suffering from a mental disorder warranting involuntary detention under the MHA 2001. Both patients, however, remained in mental hospital on an ostensibly voluntary basis, although neither in fact realised that they were legally free to leave if they so desired. When their Mental Health Tribunal-appointed legal representative formed the opinion that the patients were not in a position to instruct her, and that therefore, they could not understand the basis of the detention, she brought a legal challenge on their behalf, seeking to clarify whether the circumstances of their detention on a voluntary basis amounted to an infringement of their rights to liberty, privacy and bodily integrity. Both patients suffered from more general medical problems and it was the evidence before the court that they remained in hospital for treatment for those problems, and that the treatment was provided in the psychiatric ward to minimise distress and trauma to the patients. The treating psychiatrists admitted that the patients would not have been allowed to leave the hospital alone and that, had they attempted to do so, they would have been detained on an emergency basis under section 23 of the MHA 2001. In the High Court, Peart J held that it is in best interests of mental health patients, even voluntary ones, not to allow them to leave hospital if a doctor believes a mental disorder is present. In other words, the deprivation of liberty was justifiable under the paternalist precedent from *Re Philip Clarke*.

A similar set of facts arose in *EH v St Vincent's Hospital & Ors.*[139] The applicant was present in a mental hospital on an ostensibly voluntary basis. She made an attempt to leave hospital and was detained on the basis of the emergency provisions in s 23(1) of

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[137] *LK v Naas General Hospital* [2006] IEHC 196; [2007] 2 IR 465 (Clarke J), at 483.
[138] *MMcN & Anor. v The Health Service Executive* [2009] IEHC 236.
[139] *EH v The Clinical Director of St Vincent's Hospital, Aideen Frehne and the Mental Health Tribunal*, Unreported, Supreme Court, 28 May 2009 (Kearns J), [2009] 3 IR 774; [2009] 2 ILRM 14; (2009) IESC 46.

the MHA 2001 which permits the regrading of a voluntary patient as an involuntary patient.[140] The applicant now challenged the validity of her involuntary detention on the basis that her voluntary detention, from which her involuntary detention under s 23 must necessarily flow, was unlawful on the basis of the decision in *HL v United Kingdom*. Her claim was rejected O'Neill, J in the High Court, and his decision was unanimously upheld in the Supreme Court. As in *MMcN v HSE*, the paternalist character of the MHA 2001 was of paramount importance in the decision to hold that the applicant's detention was lawful.[141]

These decisions appear to directly contradict the decision of the European Court of Human Rights in *HL v United Kindgom*,[142] discussed in detail at § 2.4.2 (a),[143] and the decision in *EH v St. Vincent's Hospital* in particular has been the subject of criticism by the Irish Human Rights Commission.[144]

A further issue that arises in respect of the protection of liberty under the Constitution concerns the mechanism by which an involuntary patient may appeal the decision of a Mental Health Tribunal to affirm an admission order or a renewal order under the

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[140] Section 23 (1) of the MHA 2001 reads as follows: "23.—(1) Where a person (other than a child) who is being treated in an approved centre as a voluntary patient indicates at any time that he or she wishes to leave the approved centre, then, if a consultant psychiatrist, registered medical practitioner or registered nurse on the staff of the approved centre is of opinion that the person is suffering from a mental disorder, he or she may detain the person for a period not exceeding 24 hours or such shorter period as may be prescribed, beginning at the time aforesaid."

[141] *EH v The Clinical Director of St Vincent's Hospital, Aideen Frehne and the Mental Health Tribunal*, Unreported, Supreme Court, 28 May 2009 (Kearns J), [2009] 3 IR 774; [2009] 2 ILRM 14; (2009) IESC 46, at 26-28.

[142] *HL v United Kingdom* (2004) Application No. 45508/99, (2004) ECHR 471.

[143] In *S.M. v. The Mental Health Commission, The Mental Health Tribunal and The Clinical Director of St. Patrick's Hospital, Dublin; and The Attorney General and The Human Rights Commission* [2008] IEHC 441, [2008 / 749 JR] the applicant argued successfully that the renewal order made by the Mental Health Tribunal in respect of her detention was unlawful, and that her right to liberty had been unlawfully restricted. However, this case hinged on a technical difficulty with the Tribunal's standard forms in that the prescribed form to be used by the treating psychiatrist only provided for one option in respect of the length of detention recommended. McMahon J held that this resulted in a disproportionate interference with the applicant's right to liberty, and declared her detention unconstitutional, but with a four week stay on the entry into force of the order for her release, in order to allow time for the prescribed form to be amended and a lawful renewal of the applicant's detention to be effected. *See* Mental Health Act 2008. McMahon J made reference to the amending legislation in his judgment in *S.M. – see S.M. v. The Mental Health Commission, The Mental Health Tribunal and The Clinical Director of St. Patrick's Hospital, Dublin; and The Attorney General and The Human Rights Commission* [2008] IEHC 441; [2009] IR 188, 213.

[144] Irish Human Rights Commission, *Policy Paper concerning the Definition of a "voluntary patient" under s.2 of the Mental Health Act 2001* (Dublin: Irish Human Rights Commission, February 2010), at 7.

2001 Act. In *TS v Mental Health Tribunal*[145] the applicant in judicial review proceedings sought a declaration that s 19(4) of the 2001 Act, in placing the burden of proof on the patient in appeal proceedings brought before the Circuit Court (to prove that he or she is not suffering from a mental disorder), was repugnant to Article 40.4.1 of the Constitution and contrary to Article 5(4) of the ECHR. O'Keeffe J in the High Court did not find favour in this argument, holding that s 19(4) merely followed the general proposition in appeal cases that it is up to the applicant to prove his or her case and that the ECtHR jurisprudence to date holding that the burden of proof should not rest on a patient to disprove mental illness could be distinguished on the basis that those cases concerned hearings at first instance rather than appeals. Whelan has argued convincingly that this decision is dubious and that O'Keeffe J's insistence that s 19(4) merely replicates the general proposition that an appellant in appeal cases must prove their case is not entirely accurate given that the section actually circumscribes the Circuit Court's jurisdiction in these appeals by requiring it to dismiss the appeal unless the patient appellant demonstrates that they are not suffering from a mental disorder.[146]

A discussion of the review requirements mandated by the fair procedures element of Article 40.4.1, including a discussion of the merits of the Irish constitutional jurisprudence on the use of habeas corpus applications in the mental health context, and on the use of judicial review in mental health cases, is provided below at § 3.8.

3.7 Autonomy, Bodily Integrity and Privacy Claims, and Freedom from Torture and Inhuman and Degrading Treatment or Punishment Claims

As was noted in Chapter 2, the category of 'autonomy, bodily integrity and privacy claims' could be encompassed within a 'dignity' categorisation or within the 'autonomy' principle under the CRPD. These types of claims are given a separate categorisation in this work in light of the primary importance of this grouping of rights in the development of the unenumerated rights doctrine in Irish constitutional

[145] *TS v Mental Health Tribunal*, High Court, unapproved, O'Keeffe J, October 24, 2008.
[146] Whelan, Darius, *Mental Health Law and Practice* (Dublin: Round Hall, 2009), at 262-263.

law. The 'freedom from torture and inhuman and degrading treatment and punishment', discussed in its own right in Chapter 2 owing to the significant body of ECHR jurisprudence on Article 3 claims in the mental health context, will in this Chapter be discussed together with the autonomy, privacy and bodily integrity claims.

Autonomy, bodily integrity, and privacy claims are grounded in arguments based on the concept of self-determination. These rights claims argue for an entitlement to make one's own choices about the direction and content of one's life, even where those choices might clash with the choices that a majority of others would make. In the mental health context, these types of claims arise in challenges to involuntary detentions or compulsory treatment, or in claims that challenge the treatment or day-to-day regime in a mental hospital or other mental health facility, or in claims that relate to the keeping and use of medical records.[147] Claims based on the right to freedom from torture and inhuman and degrading treatment concern unlawful actions of such a barbaric or inhuman nature that they go even beyond breaches of the rights to autonomy, or bodily integrity, or privacy. For a torture claim, the aggressor must have had an invidious or malevolent purpose in acting in the manner they did, but this element is not required for a claim of inhuman or degrading treatment or punishment. This means that the latter category of abuse has a broader scope and a more immediate application to mental health cases, as an allegation of inhuman or degrading treatment is capable of being made in respect of both individual actions, or in respect of the manner of administration of a regime or system. The right to freedom from torture and inhuman and degrading treatment or punishment has arisen only twice in a constitutional claim concerning mental treatment in Irish law.[148] The right has also been raised in its ECHR format in a constitutional challenge to the validity of the Mental Treatment Act 1945.[149]

The rights to autonomy, bodily integrity and privacy are recognised as unenumerated personal rights in the constitutional jurisprudence on Article 40.1. While the Constitution does not explicitly provide for a right to freedom from torture and

[147] *See* for example *MMcN v HSE* (2009) IEHC 236, *Re Philip Clarke* [1950] IR 235 and *The State (C) v Frawley* [1976] IR 365.
[148] *Blehein v. St. John of God Hospital* [2002] IESC 43 (31st May, 2002) and *The State (C) v Frawley* [1976] IR 365.
[149] *See Croke v Smith (No 2)* (1998) 1 IR 101 (Supreme Court); Unreported, High Court, 27 and 31 July 1995 (Budd J).

inhuman and degrading treatment or punishment, those rights have been successfully argued in cases concerned with autonomy, bodily integrity and privacy and are thus discussed in that context in this Chapter.

The right to bodily integrity was first recognised in *Ryan v AG*,[150] which concerned the validity of the State's policy of fluoridating the national mains drinking water supply. The Supreme Court recognised the existence of a right to bodily integrity, which right would encompass the right to make decisions about which substances to put into one's body, including fluoride. However, the Court held that the right to bodily integrity is not absolute, and that it may be limited in circumstances where the benefits accruing from the limitation of the right outweigh the infringement of it. In the instant case, the public benefits achieved through the fluoridation of the mains drinking water supply were considered to outweigh the injury to citizens' right to bodily integrity.

The jurisprudence on the right to bodily integrity has been significantly developed through a number of cases in the medical law sphere. In a case concerning a prisoner suffering from a very serious personality disorder, who challenged the validity of his detention in prison where the conditions of his detention were not suitable for his particular medical needs, and in another concerning an involuntary mental patient who was being detained in an institution unsuited to her medical needs, the question of the State's obligation to protect a lawfully detained person's right to bodily integrity and to freedom from torture and from inhuman and degrading treatment and punishment was considered.[151] Two further leading cases on bodily integrity grounded in medical law issues concerned the question of whether the parents of an infant can refuse to permit a routine medical test widely considered to be non-invasive to be performed on the child, on the grounds that it infringes on their personal conception of bodily integrity and in their eyes would amount to a violation of the child's constitutional right to bodily integrity;[152] and whether a hospital may cease to provide life-preserving medical treatment to a patient in a persistent vegetative state

[150] *Ryan v AG* [1965] IESC 1; [1965] IR 294.
[151] *The State (C) v Frawley* [1976] IR 365, and *Maria (ET) v The Clinical Director of the Central Mental Hospital and the Health Service Executive* [2010] IEHC 378, respectively, *see* discussion below.
[152] *NWHB v HW & CW* [2001] 3 IR 622.

where it is alleged that the treatment amounts to a gross or disproportionate interference with one's bodily integrity.[153]

In *The State (C) v Frawley*[154] the applicant brought a *habeas corpus* application before the President of the High Court seeking his release from imprisonment on the grounds that he was improperly detained in prison because he should have instead been detained in a specialist mental hospital equipped to deal with his particular needs. The applicant suffered from a personality disorder that manifested itself in a rejection of authority and repeated attempts at escape from detention, including dangerous climbing feats and the swallowing of sharp objects in order to secure a transfer to hospital for surgery. The applicant's actions had caused him serious injury and it was advised that any further surgeries to remove foreign objects would be extremely dangerous. As a result the prison authorities had placed the applicant in solitary confinement without a mattress, cutlery or a radio, and he was supervised closely during his recreation times. The prison authorities argued that these were the best conditions they were capable of providing, in circumstances where the type of specialist medical facility the applicant would require to treat his condition was not available in the State, and even if the State were to undertake to provide it, it would be a number of years before it would be operational. In refusing to order the applicant's release Finlay P recognised that one of the personal rights guaranteed under the general umbrella of 'personal rights' is a 'right to bodily integrity' and that the applicant's right to bodily integrity had been infringed by the conditions of his detention. However, that infringement was not sufficient to render the applicant's detention unlawful as the rigorous conditions of his detention were justified given the hazard he posed to himself. Finlay P further held that the State when imprisoning a person could not then expose their health to risk or danger without justification or necessity. However, the State could not be placed under an absolute obligation to provide the particular psychiatric unit that the applicant required. In this case the applicant's medical needs as distinct from his psychiatric ones were met at all times, and no violation of his right to bodily integrity had occurred:

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[153] *Re a Ward of Court* (No 2) [1995] IESC 1; [1996] 2 IR 73; [1995] 2 ILRM 401.
[154] *The State (C) v Frawley* [1976] IR 365.

> I do not see why the principle [of bodily integrity as an unspecified personal right] should not also operate to prevent an act or omission of the Executive which, without justification, would expose the health of a person to risk or danger... [To state that] the Executive has a duty to protect the health of persons held in custody as well as is reasonably possible in all the circumstances of the case seems to me no more than to state in a positive manner the negative proposition which I have above accepted. Therefore, I am satisfied that such a proposition is sound in law.[155]

In *Maria (ET) v The Clinical Director of the Central Mental Hospital and the Health Service Executive*[156] the applicant was an involuntary patient being detained in St. Brendan's Hospital in Grangegorman in Dublin. It was accepted by her psychiatrist in St. Brendan's and by the Clinical Director of the Central Mental Hospital that the treatment she required could be better provided in the Central Mental Hospital than in St. Brendans's. She remained in St. Brendan's, however, due to resourcing difficulties which meant that she could not be accommodated in the Central Mental Hospital. The applicant challenged the validity of her detention in St. Brendan's under s 3 of the 2001 Act, and sought declaratory relief that her detention constituted torture and inhuman and degrading treatment or punishment under the Constitution and under Article 3 of the ECHR. Clarke J in the High Court felt that it did not fall within the power of the Court to declare that the failure on the part of the State to provide a particular type of medical care could amount to torture and inhuman or degrading treatment or punishment:

> It may be argued that the availability of treatment, for instance a particular operation, is due to the failure to adequately resource medical facilities. To make such a case is to assume a heavy burden and one that requires a court to become convinced that decisions leading to the complained of situation are amenable to judicial review of administrative action in the sphere of medical treatment. Issues as to the proper priority of resources are ones that should be properly left to the competent authorities that are charged with taking an overall view as to priorities and standards. That is very different to the case by case approach by a court which ill fits with the debate and analysis that is required in the allocation of resources in the provision of health care to a community.[157]

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[155] *The State (C) v Frawley* [1976] IR 365, 372.
[156] *Maria (ET) v The Clinical Director of the Central Mental Hospital and the Health Service Executive* [2010] IEHC 378.
[157] *Maria (ET) v The Clinical Director of the Central Mental Hospital and the Health Service Executive* [2010] IEHC 378, at § 15.

Clarke J then proceeded to find that the conditions of the applicant's detention, although admitted by her treating psychiatrist not to be ideal, were also not unreasonable in the circumstances where scarce resources prevented her transfer to a more suitable institution and where although better treatment would be available in the Central Mental Hospital the conditions of treatment and confinement in St. Brendan's were mandated by her condition. Once again referring to the paternalist philosophy underpinning the mental health legislation, the Court concluded that while the applicant's "constitutional rights have been severely circumscribed, this has been done in accordance with the paternal jurisdiction of the State to care for the severely ill" and that the steps taken were "reasonably necessary within the context of the condition" that had necessitated the detention in the first place.[158]

In *NWHB v HW & CW*[159] the parents of an infant refused to allow Health Board staff to perform the 'heel prick' or PKU test for certain metabolic disorders on the child. The Health Board then sought the guidance of the High Court as to whether it was obliged under the Child Care Act 1991 to seek a District Court order compelling the parents to allow the test to be done, or authorising the test to be done notwithstanding the parents' refusal to give their consent. The High Court ruling, subsequently upheld by the Supreme Court, was that the infant's parents' decision not to allow the test did not amount to a dereliction of their duties toward their son such as mandated the State under Article 42.5 of the Constitution to seek compulsory orders in the courts. The parents' arguments before the Court in defence of their decision to refuse the test were grounded in the unenumerated rights to autonomy, privacy and bodily integrity together with the rights of the family under Article 41. In a classic expression of the 'right to be let alone' philosophy underpinning the common law formulation of privacy, and of the 'right to make 'bad' decisions' philosophy underpinning autonomy, the Supreme Court recognised the rights of parents to make decisions in accordance with their particular views on bodily integrity, and to refuse to permit the routine medical test being performed on their child, even where that decision would be considered unreasonable by the majority of the population and even by the court itself, provided that they are not acting in gross dereliction of their duties as parents

[158] *Maria (ET) v The Clinical Director of the Central Mental Hospital and the Health Service Executive* [2010] IEHC 378, at § 24 (vi).
[159] *NWHB v HW & CW* [2001] 3 IR 622.

such as would justify the State in intervening in the rights of the family, which it was felt they were not.

In *Re a Ward of Court (No 2)*[160] a ward of court who was in a near-permanent vegetative state after suffering a series of heart attacks during a routine surgery some twenty years previously was being sustained through an artificial feeding tube. The committee of the ward sought the court's guidance on whether or not it would be lawful for them to direct the hospital providing the medical care to withdraw the ward's artificial nutrition, the hospital having indicated that it would not be prepared to accord with such a direction, believing it to be an unlawful course of action in violation of the ward's constitutional right to life. The Supreme Court (with Egan J dissenting) upheld Lynch J's decision in the High Court to permit the withdrawal of artificial nutrition. Hamilton CJ did so on the basis that the while right to life ranks first among all of the constitutionally protected rights, it can be subject to the other personal rights, and in the instant case the best interests of the ward were not served by the continuation of artificial nutrition. Denham J perceived the case as presenting a conflict between the 'most treasured' right, the right to life, and the rights to privacy and bodily integrity. She stated *obiter* that where a gross or disproportionate interference to a person's privacy, autonomy, bodily integrity or dignity occurs, that the duty to protect those rights may override the duty to protect the right to life.

In *EJW (APUM) v Watters*[161] the applicant was an involuntary patient admitted to a mental hospital under the provisions of the MHA 2001. In accordance with the Mental Health Tribunal provisions under the Act, she was appointed a legal representative. However, both the applicant's medical carers and the legal representative formed the view that the applicant did not have the requisite capacity to authorise the release of her medical records to her legal representative. The question before the court was whether the hospital would be violating the applicant's right to privacy and particularly to the confidentiality of her medical records if it were to release those records to her legal representative without her express consent. In the uncertain position that prevailed, the legal representative would be required to wait until the first sitting of the Mental Health Tribunal in order to obtain an order from the

[160] *Re a Ward of Court* (No 2) [1995] IESC 1; [1996] 2 IR 73; [1995] 2 ILRM 401.
[161] *EJW (APUM) v Watters and Ors* [2008] IEHC 462.

Tribunal for the release of her records, and it was argued that the applicant's right to fair procedures would be compromised if her legal representative could not have sight of the medical records well in advance of the Tribunal sitting. Peart J, relying on section 4 of the MHA 2001, held that the best interests of the patient required that her legal representative have access to the medical records at the earliest possible opportunity and that the paternalistic character of the mental health law regime required that her legal representative must protect her interests at the Tribunal, which would necessitate his having access to her medical file in advance of the Tribunal. The Court accordingly issued a declaration that the disclosure of the patient's medical records where she lacked the capacity to consent to that disclosure would not violate her right to privacy and to confidentiality.[162]

3.8 Fair procedures Claims

The vast majority of mental health cases in Ireland take the form of challenges to the validity of a compulsory detention, and are mounted on the basis of a fair procedures argument, often in the form of a *habeas corpus* application. While these cases could theoretically fall within the 'liberty/freedom' categorisation, given their prominence in the Irish constitutional jurisprudence as the primary expression of rights language in mental health cases before the Irish courts, it was felt that the *habeas corpus* 'fair procedures claims' in that context merited an individual categorisation. Fair procedures claims arise where a person argues that their right to fair procedures within legal processes has been infringed. In the mental health context fair procedures claims arise where the applicant challenges the availability or manner of provision of the review mechanisms.[163]

The Article 38 right to 'fair procedures' has had most impact in the area of criminal law, where it has been utilised to introduce a wide range of 'fairness' provisions into both the pre-trial and trial stages of the criminal justice system. Article 38.1 provides that:

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[162] *EJW (APUM) v Watters and Ors* [2008] IEHC 462 (Peart J).
[163] *See* for example *M v Kennedy, Clinical Director of the Central Mental Hospital* [2007] IEHC 136.

> No citizen shall be tried on any criminal charge save in due course of law.

This provision has been interpreted to mean significantly more than a requirement that courts merely follow the promulgated laws – it requires that criminal trials be:

> conducted in accordance with basic concepts of justice... of ancient origin and part of the long established principles of the common law, or... of more recent origin and widely accepted in other jurisdictions and recognised in international conventions as a basic requirement of a fair trial... Furthermore, the Irish courts have developed a concept that there are basic rules of procedure which must be followed in order to ensure that an accused is accorded a fair trial and these basic rules must be followed if constitutional invalidity is to be avoided.[164]

Of obvious relevance to mental health here are issues around fitness to stand trial and pleas to charges that are founded on insanity. This area is now regulated by the Criminal Law (Insanity) Act 2006 which makes detailed provision on the establishment of an accused person's fitness to be tried[165] and establishes the defences of 'not guilty by reason of insanity'[166] and of 'diminished responsibility'.[167] The 2006 Act also establishes the Mental Health (Criminal Law) Review Board which reviews detentions of mental patients ordered by the courts under the Act.[168]

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[164] *Heaney v Ireland* [1994] 3 IR 593, 605 (Costello J.).
[165] Criminal Law (Insanity) Act 2006, s 4.
[166] Criminal Law (Insanity) Act 2006, s 5.
[167] Criminal Law (Insanity) Act 2006, s 6.
[168] An assessment of the merits and operation of the Criminal Law (Insanity) Act 2006 is beyond the scope of this work, but *see* further O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: FirstLaw, 2005), Chapter 7; Whelan, Darius, *Mental Health Law and Practice: Civil and Criminal Aspects* (Dublin: Thomson Round Hall, 2009) Part Three; Dwyer, Padraig, "Law of Insanity" (1996) 1(1) *Bar Review* 9; Whelan, Darius, "Fitness to Plead and Insanity in the District Court" (2001) 11(2) *Irish Criminal Law Journal* 2; Yeo, Stanley, "Rethinking the incapacities of insanity"(2001) 36 *Irish Jurist* 275; Robinson, Dara, "Crazy situation" (2003) 97(1) *Law Society Gazette* 12; Trager, P., "The Insanity Defence Revisited" (1998) 4 *Medico-Legal Journal of Ireland* 15; Mills, Simon, "Criminal Law (Insanity) Bill 2002: Putting the sanity back into insanity" (2003) 8 (3) *Bar Review* 101; Conway, Gerard, "Fitness to Plead in Light of the Criminal Law (Insantiy) Bill 2002" (2003) 13(4) *Irish Criminal Law Journal* 2; Barnacle, Deirdre, "Reform Of The Defence Of Insanity – The Criminal Law (Insanity) Bill 2002" (2003) 3 *UCD Law Review* 153; McGillicuddy, Tony, "The Criminal Law (Insanity) Act 2006" (2006) 11(3) *Bar Review* 95; Ní Raifeartaigh, Úna, "The European Convention on Human Rights and the Criminal Justice System" (2007) 7(2) *Judicial Studies Institute Journal* 18; Duggan, Diane, "Diminished Responsibility and the Insanity Defence" (2007) 12(6) *Bar Review* 248; Marry, Clodagh, "The Law of Insanity and Diminished Responsibility in Criminal Law versus the Meaning of Insanity within the Medical Profession: an Inevitable Conflict?" (2007) 7(1) *Hibernian Law Journal* 169; and McAuley, Finbar, "The Civilian Experience of the Insanity Defence" (1989) 24 (2) *Irish Jurist* 227.

Article 40.4 of the Constitution also provides significant fair procedures protections in the civil law context:

> 4. 1° No citizen shall be deprived of his personal liberty save in accordance with law.
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> 2° Upon complaint being made by or on behalf of any person to the High Court or any judge thereof alleging that such person is being unlawfully detained, the High Court and any and every judge thereof to whom such complaint is made shall forthwith enquire into the said complaint and may order the person in whose custody such person is detained to produce the body of such person before the High Court on a named day and to certify in writing the grounds of his detention, and the High Court shall, upon the body of such person being produced before that Court and after giving the person in whose custody he is detained an opportunity of justifying the detention, order the release of such person from such detention unless satisfied that he is being detained in accordance with the law.
>
> 3° Where the body of a person alleged to be unlawfully detained is produced before the High Court in pursuance of an order in that behalf made under this section and that Court is satisfied that such person is being detained in accordance with a law but that such law is invalid having regard to the provisions of this Constitution, the High Court shall refer the question of the validity of such law to the Supreme Court by way of case stated and may, at the time of such reference or at any time thereafter, allow the said person to be at liberty on such bail and subject to such conditions as the High Court shall fix until the Supreme Court has determined the question so referred to it.
>
> 4° The High Court before which the body of a person alleged to be unlawfully detained is to be produced in pursuance of an order in that behalf made under this section shall, if the President of the High Court or, if he is not available, the senior judge of that Court who is available so directs in respect of any particular case, consist of three judges and shall, in every other case, consist of one judge only.[169]

The discussion of the fair procedures rights in the Irish Constitution will focus on three areas in which there has been significant case law: (1) the requirement under the MHA 2001, section 4(2), that all patients are entitled to fair procedures within the MHA 2001 review mechanisms; (2) the uptake and availability of the *habeas corpus* application in mental health cases; and (3) the utilisation of judicial review proceedings in mental health litigation.

[169] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Articles 40.4.1–40.4.4.

3.8.1 Fair Procedures under the MHA 2001, section 4

The constitutional fair procedures protections under Article 40.4 are of enormous importance in the area of mental health law, as by virtue of section 4(2) of the Mental Health Act 2001 all detained patients are entitled to fair procedures within the Mental Health Tribunal system. In fact, the majority of cases in the realm of mental health law raising a contitutional challenge decided since the enactment of the new mental health care regime in Ireland under the Mental Health Act 2001 have focussed on the Article 40.4.1 rights to liberty and to fair procedures, as these rights are explicitly enshrined in section 4 of the Mental Health Act 2001.

Section 4(2) of the MHA 2001 explicitly mandates certain procedural protections which must be provided to all persons detained under the mental health regime.[170] Section 4(1) requires that a decision whether or not to involuntarily admit a person to a mental hospital must be taken in the 'best interests' of the person, with consideration also to be given to other persons who might stand to be at risk of serious harm if an admission were not made.[171] Section 4(3) mandates that when this decision is being made, the constitutional right of the person to privacy (which includes the rights to bodily integrity, dignity and autonomy under Irish law[172]) must be given due respect.[173] The courts have interpreted this 'best interests' principle as being equivalent to the traditional paternalist interpretation adopted in the past cases on the 1945 Act regime. Thus in *MR v Byrne & Ors*[174] O'Neill J affirmed the applicability of the explicitly paternalistic principles in *In Re Philip Clarke*,[175] *Croke*

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[170] Mental Health Act 2001 s 4(2): "Where it is proposed to make a recommendation or an admission order in respect of a person, or to administer treatment to a person, under this Act, the person shall, so far as is reasonably practicable, be notified of the proposal and be entitled to make representations in relation to it and before deciding the matter due consideration shall be given to any representations duly made under this subsection."

[171] Mental Health Act 2001 s 4(1): "In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made."

[172] *In Re a Ward of Court (No. 2)* [1996] 2 I.R. 96.

[173] Mental Health Act 2001 s 4(3): "In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy."

[174] *MR v Byrne & Ors* [2007] IEHC 73; [2007] 3 IR 211.

[175] *In Re Philip Clarke* [1950] IR 235.

v Smith and Ors,[176] and *Gooden v St Otterans* to the new legislation regime, and stated that:

> ... 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 of 1945, as of a paternal character, clearly intended for the care and custody of persons suffering from mental disorder.[177]

In particular, the Court in *MR v Byrne & Ors* was of the opinion that section 4 of the MHA 2001 clearly gave statutory expression to the paternalistic approach adopted in the case law on the 1945 Act.[178]

The jurisprudence on section 4 has not been of a particularly stringent or interventionist character. The courts have almost preferred to adopt an approach of identifying the limits of the rights to privacy and fair procedures in the mental health context by reference to the evidence of clinical judgment before it. This preference for a delimiting jurisprudence rather than an expansionist philosophy is a result of the strongly ingrained leaning towards a paternalist approach in mental health law. Murray has strongly criticised this judicial preference for the paternalist approach and has described it as "an inadequate response to the challenges of a rights-based model."[179]

Thus in the case of *MR v Byrne & Ors* already mentioned, where the Applicant sought to have the Respondents' decision to detain and treat him under the MHA 2001 declared unlawful on the grounds that it infringed his right not to be deprived of his liberty save in due course of law, O'Neill J expressed the view that:

> [it] cannot be overemphasised however that on a daily basis these provisions will have to be operated by clinical experts who within the broad framework set out above have to make clinical judgments, and I would like to stress that it

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[176] *Croke v Smith & Ors* [1988] 1 IR 101.
[177] *MR v Byrne & Ors* [2007] IEHC 73; [2007] 3 IR 211.
[178] *MR v Byrne & Ors* [2007] IEHC 73; [2007] 3 IR 211.
[179] Murray, Claire, "Reinforcing Paternalism within Irish Mental Health Law – Contrasting the Decisions in *EH v St. Vincent's Hospital and Others* and *SM v The Mental Health Commission and Others*" (2010) 32 *Dublin University Law Journal* 273.

> is not intended in this judgment to interfere in the proper realm of clinical judgment or to cut down or limit the proper scope of clinical judgment.[180]

Further, in *B v Director of the Central Mental Hospital and Anor*,[181] another case involving the judicial review of the Respondents' decision to detain and treat the Applicant under the MHA 2001, McGovern J stated that the "courts should not second guess psychiatrists and other members of the medical profession."[182] Also in that case, McGovern J described the mental health legislation as "paternalistic in character and … intended for the care and custody of persons believed to be suffering from mental illness and also for the safety and well being of the public at large."[183]

Similarly, in *M v Kennedy, Clinical Director of the Central Mental Hospital*[184] Peart J reiterated the courts' view that the appropriate course of action in cases where issues arise in relation to the interpretation to be given to a provision in the statutory regime is to heed the paternalistic character of the mental health legislation (although in the event he was not compelled to pronounce in that regard in the case before him).

The precedents in *Gooden v St Otteran*,[185] *Re Philip Clarke*,[186] and *MR v Byrne*[187] were endorsed a further time by Charleton J in *O D v Kennedy & Ors*;[188] by McMahon J in *M (S) v Mental Health Commission*[189] in finding that section 15 of the Mental Health Act 2001 is not unconstitutional on the basis that the court must give a purposive interpretation to the legislation, which is intended to be paternalist in character;[190] and by Hanna J in *JB v Mental Health (Criminal Law) Review Board & Ors*[191] in which the court stated that:

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[180] *MR v Byrne & Ors* [2007] IEHC 73; [2007] 3 IR 211.
[181] *B v Director of the Central Mental Hospital and Anor* [2007] IEHC 147.
[182] *B v Director of the Central Mental Hospital & Ors* [2007] IEHC 147.
[183] *B v Director of the CMH and Anor* [2007] IEHC 147.
[184] *M v Kennedy, Clinical Director of the Central Mental Hospital* [2007] IEHC 136.
[185] *Gooden v St. Otteran's Hospital* [2001] IESC 14; [2005] 3 IR 617.
[186] *In Re Philip Clarke* [1950] IR 235.
[187] *MR v Byrne & Ors* [2007] IEHC 73; [2007] 3 IR 211.
[188] *TO'D v Kennedy & Ors* [2007] IEHC 129.
[189] *M (S) v Mental Health Commission* [2008] IEHC 441.
[190] McMahon J did however find that the manner in which the relevant medical forms applicable to involuntary admission orders were not in compliance with the requirements of the Mental Health Act 2001, and accordingly declared them in their extant format to be invalid. The court then granted a four week stay on the operation of that order, thereby giving the Mental Health Commission time to review and amend the forms appropriately, and for authorised detention centres to complete the necessary paperwork in respect of patients involuntary detained on the extant invalid forms. *See* the analysis of this judgment, with commentary on its greater focus on a human rights approach to mental health law,

> A particular spirit drives the interpretation of statutes such as this which legislate in the area of mental health. This legislation is viewed as being paternalistic in nature… The statutory framework is designed to promote the care and well being of the applicant and persons in his position. It is both empocare and well being of the appl
> empowering and protective.[192]

Finally, the decisions of Peart J in the High Court in *MMcN v HSE*[193] and of O'Neill J in the High Court, and Kearns J in the Supreme Court in *EH v St Vincent's Hospital*,[194] held that it is in the best interests of mental patients, even voluntary ones, to not allow them to leave hospital if a doctor believes a mental disorder is present and that accordingly it is not appropriate for the courts to adjudicate on the validity of revocation orders.

The effect of these deferential judgments is to significantly neuter the fair procedures protections provided for in Article 40.4.1.

3.8.2 *Habeas corpus* applications in mental health cases

Habeas corpus is an ancient common law remedy by which a person detained at either criminal or civil law may challenged the legality of that detention. It is now guaranteed under the Constitution and is exercised by means of Article 40.4.2 applications.[195]

Mary Keys has completed the only empirical study of the use of *habeas corpus* applications in Ireland in the context of challenges to compulsory mental health admissions.[196] The results of this study were published prior to the enactment of the

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in Murray, Claire, "Reinforcing Paternalism within Irish Mental Health Law – Contrasting the Decisions in *EH v St. Vincent's Hospital and Others* and *SM v The Mental Health Commission and Others*" (2010) 32 *Dublin University Law Journal* 273.

[191] *JB v Mental Health (Criminal Law) Review Board & Ors* [2008] IEHC 303.

[192] *JB v Mental Health (Criminal Law) Review Board & Ors* [2008] IEHC 303.

[193] *MMcN & Anor. v The Health Service Executive* [2009] IEHC 236.

[194] *EH v The Clinical Director of St Vincent's Hospital, Aideen Frehne and the Mental Health Tribunal*, Unreported, Supreme Court, 28 May 2009 (Kearns J), [2009] 3 IR 774; [2009] 2 ILRM 14; (2009) IESC 46.

[195] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 40.4.2.

[196] Keys, Mary "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 24 *Dublin University Law Journal* 26.

MHA 2001, but have been reviewed by Claire Murray in a later paper published since the commencement of the MHA 2001 in its entirety.[197]

Keys' findings are of enormous importance. In a comparative analysis with *habeas corpus* challenges to unlawful detentions of accused persons in the State's prisons, Keys found that mental patients admitted to hospital under the involuntary patient provisions of the 1945 Act were five times less likely to utilise the *habeas corpus* mechanism to mount a challenge to their committal.[198] Keys concludes that "the lack of a 'rights culture' in psychiatric hospitals... [and] the lack of rights-based mental health legislation has had an impact on this situation"[199] and highlights the ECtHR jurisprudence that is critical of the *habeas corpus* mechanism as a means of review of compulsory mental health admissions and treatments.[200]

A number of *habeus corpus* applications before the courts have addressed procedural irregularities that arose in the early days of the implementation of the 2001 Act. Many of these centred on the provision in s 18 of the Act for the waiver of procedural irregularity; on the meaning to be given to 'responsible consultant psychiatrist'; and on the powers in ss 23 and 24 to detain a voluntary patient on an involuntary basis.

In *TO'D v Central Mental Hospital*[201] Charleton J considered the remit of s 18 of the 2001 Act where a procedural irregularity arose in respect of the date on which a renewal order was signed. Charleton J, relying on the decision of O'Neill J in *MR v Byrne & Ors*[202] held that s 18 refers to the totality of the orders made, and not at

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[197] Murray, Claire, "Safeguarding the Right to Liberty of Incapable Compliant Patients with a Mental Disorder in Ireland" (2007) 14(1) *Dublin University Law Journal* 279.

[198] Keys, Mary "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 24 *Dublin University Law Journal* 26. The precise figures were that 0.5% of persons committed to prison in 1998 and 1999 utilised the *habeas corpus* procedure to challenge their detention, whereas the corresponding figure for persons committed under the Mental Treatment Act 1945 involuntary committal mechanisms was 0.09%. It is perhaps also significant that of the *habeas corpus* applications that were brought by mental patients, 63% of them were brought by patients detained in the Central Mental Hospital.

[199] Keys, Mary "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 24 *Dublin University Law Journal* 26.

[200] Keys, Mary "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 24 *Dublin University Law Journal* 26 referring to *X v United Kingdom* (1980) Application No. 6998/75 (1981) 4 EHRR 181.

[201] *TO'D v Director of the Central Mental Hospital and the Health Service Executive, and the Mental Health Commission (Notice Party),* [2007] IEHC 129; [2007] 3 IR 689 (Charleton J).

[202] *MR v Byrne & Ors* [2007] IEHC 73; [2007] 3 IR 211.

minor matters such as typographical errors, and that where the substance of the order is sufficiently well justified the s 18 empowers a Mental Health Tribunal to overlook technical irregularities in accordance with the purposive approach of the Act which requires the Tribunal to act at all times in the patient's best interests.

In an *ex tempore* decision in *Q v St. Patrick's Hospital and the Mental Health Tribunal and the Mental Health Commission*[203] O'Higgins J interpreted s 24 of the 2001 Act, which provides for a power to involuntary detain a voluntary patient. The Court found that in order to invoke the powers provided for in s 24, the responsible consultant psychiatrist must be satisfied that the s 23 provisions, which are predicated on the patient indicating an intention to leave the approved centre, must be met. As in this instance the patient had indicated no intention to leave, the detention was found to be unlawful and the applicant's immediate release was ordered. The Court refused to apply the s 18 waiver of procedural irregularity, holding that while a purposive approach to the Act is required to be adopted, that in this instance to find otherwise than that s 24 had not been complied with would do violence to the section.

In *AMC v St. Luke's Hospital Clonmel*[204] Peart J considered the time period for the review of a patient's detention by Mental Health Tribunal. The Court held that the date from which the time period commences to run is the date on which a renewal order is signed, not the date on which it comes into effect. On this interpretation of s 18(2) of the 2001 Act the applicant had not received a MHT review of his detention within 21 days of the making of the order, and the Court ordered his release (subject to a stay to enable the approved centre to effect a fresh detention under the 2001 Act). A similar outcome was reached in the cases of *JD v Central Mental Hospital*[205] and in *AM v Central Mental Hospital*[206] where the renewal orders made did not specify the periods for which the detention was renewed, and the patient was not provided with a Mental Health Tribunal review within the time period required under the Act.

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[203] *Q v St. Patrick's Hospital, and the Mental Health Tribunal and the Mental Health Commission* (Notice Parties), Unapproved, *ex tempore*, High Court, 21st December 2006 (O'Higgins J).
[204] *AMC v St. Luke's Hospital Clonmel* [2007] 2 IR 814 (Peart J).
[205] *JD v Central Mental Hospital*, Unreported, ex tempore, High Court, 20th March 2007 (Laffoy J).
[206] *AM v Clinical Director of the Central Mental Hospital, and the Health Service Executive, the Mental Health Commission and the Mental Health Tribunal (Notice Parties)* [2007] IEHC 136; [2007] 4 I.R. 667 (Peart J).

In *MM v Central Mental Hospital*[207] Geoghegan J in the Supreme Court upheld the decision of Peart J in the High Court that the applicant's detention under the Act was not rendered unlawful by the fact that a consultant psychiatrist other than 'the consultant psychiatrist responsible for the care and treatment of the patient' has signed the renewal order which forms the basis for his current detention. The applicant had been first detained under the 1945 Act in a mental hospital in Cork but had thereafter been transferred to the Central Mental Hospital. In the eight years since his first detention the applicant's treating psychiatrist in Cork had remained in contact with the CMH regarding the applicant's care and treatment, and the psychiatrist in Cork had been the person who signed the relevant renewal orders under the 1945 Act originally and more latterly under the 2001 Act. As Peart J stated in the High Court, this approach was taken as it was believed that the psychiatrist in Cork was the person "most familiar with the applicant's condition and requirements for treatment and care, and therefore the person best positioned to make decisions in relation to whether the applicant should continue to be detained."[208]

Considering the overall scheme of the 2001 Act, Peart J stated that it was significant that the Oireachtas had chosen not to define the phrase 'responsible consultant psychiatrist', and that there was no requirement that the responsible consultant psychiatrist be a psychiatrist working at the institution in which the applicant was detained. The judge, contrasting the circumstances in this case with those in *WQ v Director of the Central Mental Hospital*[209] concluded that:

> ...in the absence of any express statutory definition of the phrase "the consultant psychiatrist responsible...." in the Act, a measure of discretion can be seen to exist in those involved in the care and treatment of the patient to consider and reach a view on who is the consultant best placed to be considered that person. That is not to say that simply any consultant with a modicum of knowledge about the patient's illness and care and treatment requirements could simply be chosen out of convenience to sign a renewal order. Clearly the consultant concerned must be one who is directly and fully involved in the patient's care and treatment, and if any mere convenient shortcut was made in this regard, which could be seen as having diluted the

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[207] *MM v Clinical Director of the Central Mental Hospital* [2008] IESC 31 (Geoghegan, J); [2008] IEHC 44 (Peart J).
[208] *MM v Clinical Director of the Central Mental Hospital* [2008] IEHC 44 (Peart J), § 4.
[209] *WQ v. The Director of the Central Mental Hospital*, Unreported, High Court, 15th May 2007 (O'Neill J).

> protections which the Act affords to such a patient, the Court would be bound to reach the obvious conclusion that the consultant who had signed the renewal order was not entitled under the Act to do so, as in fact occurred in the WQ case for the reasons appearing therein.[210]

The Supreme Court upheld the decision in the High Court, and laid particular stress on the point that for the purposes of the 2001 Act the responsible consultant psychiatrist did not necessarily need to be the psychiatrist responsible for the day-to-day care of the patient, as that person could vary relatively frequently along the course of the applicant's detention and indeed along the course of their interaction with the mental health services over a longer period of time. Referring to the decision in *JB v Director of the Central Mental Hospital*[211] Geoghegan J adverted to the risks that could be created by an overly strict approach to the interpretation of the term 'responsible consultant psychiatrist':

> Given that this is an act which in some instances, including this particular instance, is relevant to the important question of detention or release of patients potentially dangerous to themselves and/or to the public, it would be all wrong to give the legislation an interpretation which would leave it in doubt as to who would be entitled to sign a renewal order.[212]

As was noted by Peart J in the High Court, the same conclusion had been reached by O'Neill J in the earlier case of *WQ v Mental Health Commission, Central Mental Hospital, and the Mental Health Tribunal.*[213]

3.8.3 Judicial review proceedings in mental health cases

Judicial review is the process by which decisions taken by public bodies exercising a public function, which impact on the rights and obligations of persons, may be

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[210] *MM v Clinical Director of the Central Mental Hospital* [2008] IEHC 44 (Peart J), § 46.
[211] *JB v Director of the Central Mental Hospital*, Unreported, High Court, 15th June 2007 (McMenamin J).
[212] *MM v Clinical Director of the Central Mental Hospital* [2008] IESC 31 (Geoghegan, J), § 19.
[213] *WQ v Mental Health Commission, Central Mental Hospital, and the Mental Health Tribunal* [2007] IEHC 154; [2007] 3 IR 755 (O'Neill J). For summaries of the most significant judgments of the Superior Courts on the implementation of the 2001 Act between 1st November 2006 and 31st July 2009 – the period when the switch-over from the 1945 regime to the 2001 regime resulted in significant litigation around the procedural mechanisms for the administration of the new review structures – *see* Mental Health Commission, *Summary of Judgments delivered by the Superior Courts on the Interpretation of the Mental Health Act 2001* (Dublin: Mental Health Commission, 2009).

reviewed by the courts. As Hilary Delaney comments, the circumstances in which this type of review is performed by the Irish courts have increased significantly in recent decades and that a general move has occurred towards "requiring grounds of review as being available against all types of bodies, whether classified as judicial, quasi-judicial or administrative in nature."[214]

The nature of judicial review is summarised in the decision in *The State (Abenglen Properties Limited) v Dublin Corporation*:

> Today it is the great remedy available to citizens, on application to the High Court, when any body or tribunal (be it a court or otherwise), having legal authority to affect their rights and having a duty to act judicially in accordance with the law and the Constitution, acts in excess of legal authority or contrary to its duty.[215]

Judicial review functions as a supervisory function over the decisions of public bodies, and is operated by the High Court. Importantly, judicial review is a review of the manner in which the decision is made, not of the substance of the decision itself,[216] and focuses on three key elements:

1. Were the proper procedures followed?
2. Did the decision-making body have the jurisdiction to make the decision?
3. Were the correct legal principles in respect of compliance with the rule of law applied?

As Delaney states, the purpose of judicial review "is not to vindicate rights as such, but to ensure that public powers are exercised in accordance with basic standards of legality, fairness and rationality."[217]

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[214] Delaney, Hilary, *Judicial Review of Administrative Action: A Comparative Analysis,* 2nd edn (Dublin: Round Hall Sweet and Maxwell, 2008), 1.

[215] *The State (Abenglen Properties Limited) v Dublin Corporation* [1984] IR 381, 392.

[216] *See* the statement of Lord Brightman that "judicial review is concerned not with the decision, but with the decision making process" in *Chief Constable of the North Wales Police v Evans* [1982] 1 WLR 1155, 1173 and the discussion at Delaney, Hilary, *Judicial Review of Administrative Action: A Comparative Analysis,* 2nd end (Dublin: Round Hall Sweet and Maxwell, 2008), 5-7.

[217] Delaney, Hilary, *Judicial Review of Administrative Action: A Comparative Analysis* (Dublin: Round Hall Sweet and Maxwell, 2001), 6.

Decisions that have a public element are subject to judicial review, and as Gerard Hogan and David Gwynn Morgan comment, "[t]he islands of immunity which continue to remain above the waterline are few".[218] In assessing whether or not a particular decision qualifies as having a 'public element' the courts will consider the nature of the power invoked by the decision-maker, and the nature of that power. In *Geoghegan v Institute of Chartered Accountants in Ireland*[219] Denham J discussed the factors that are to be considered by the High Court in assessing whether or not a particular decision has a sufficient public element to qualify as being amenable to judicial review. That case concerned a decision taken pursuant to the disciplinary procedures of the Institute of Chartered Accounts. Denham J's factors for consideration – commonly referred to as 'the Geoghegan principles' – may be paraphrased as follows:

1. Whether the decision relates to a major profession important in the community specially connected with a judicial organ of government and with special responsibilities, thereby giving the decision a nexus with the judicial branch of government;
2. Whether the original source of the powers is legislative, thereby giving the decision a nexus with the executive branch of government;
3. Whether the functions of the decision-making body and its members come within the public domain of the State;
4. The character and method of the creation of the relationship between the applicant and the decision-making body;
5. The seriousness of the consequences of the decision for the applicant; and
6. Whether the proceedings of the decision-making body may be said to be subject to the rule of law, that is, that they are under an obligation to act fairly and in accordance with the rules of natural justice.[220]

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[218] Hogan, Gerard, and Morgan, David Gwynn, *Administrative Law in Ireland*, 3rd edn (Dublin: Round Hall Sweet and Maxwell, 1998), 678.
[219] *Geoghegan v Institute of Chartered Accountants in Ireland* [1995] 3 IR 86.
[220] *See* also *Eogan v University College Dublin* [1996] 1 IR 390; *Rafferty v Bus Éireann* [1997] 2 IR 424 and *Bane v Garda Síochána Representative Association* [1997] 2 IR 449.

Under these principles, and as held by the High Court in *JH v Russell*[221] decisions taken by the Mental Health Tribunals under the Mental Health Act 2001 fall subject to judicial review:

1. The decisions taken by the MHT relate to the deprivation of a person's liberty and to the administration of medical treatment to them without their consent, thereby engaging a significant number of constitutional rights and creating a nexus with the judicial branch of government;[222]
2. The source of the MHT's powers is the MHA 2001, thereby giving the decision a nexus with the executive branch of government;
3. The functions of the MHT are to regulate the legal regime in the State for the compulsory detention and treatment of mental patients, which comes within the public domain of the State;[223]
4. The relationship between the patient and the MHT is established by statute; and the MHT is required to make all decisions in the best interest of the patient;[224]
5. The decisions of the MHT involve serious restrictions on the patient's constitutional rights, in the form of restrictions on their rights to liberty (where compulsory detention orders are made) and to autonomy (where compulsory treatment orders are made); and
6. The MHT is required to comply with the rule of law.[225]

A small body of case law has begun to build up on the procedures of the MHT since the passing of the MHA 2001. The most significant of these are reviewed below, but first a brief discussion of the requirements of natural justice as provided for in the case law on judicial review will be undertaken.

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[221] *JH v Russell (Clinical Director of Cavan General Hospital); and the Health Service Executive and the Human Rights Commission (Notice Parties)* [2007] IEHC 7. *See* also *SM v. The Mental Health Commission, The Mental Health Tribunal and The Clinical Director of St. Patrick's Hospital, Dublin; and The Attorney General and The Human Rights Commission (Notice Parties)* [2008] IEHC 441.
[222] Mental Health Act 2001, s 48.
[223] Mental Health Act 2001, Long Title.
[224] Mental Health Act 2001, s 4.
[225] Mental Health Act 2001, s 48(6).

The leading constitutional case on what constitutes compliance with the rule of law is *Re Haughey*[226] in which the Supreme Court held that a Dáil Committee investigation into accusations made against a former government minister that he had facilitated the alleged illegal importation of arms into Northern Ireland was required to provide certain safeguards in order to comply with the constitutional requirement of fair procedures. Those safeguards are:

1. That he should be furnished with a copy of the evidence which reflected on his good name;
2. That he should be allowed to cross-examine, by his counsel, his accuser or accusers;
3. That he should be allowed to give rebutting evidence;
4. That he should be permitted to address, again by counsel, the Committee in his own defence.[227]

Under the precedent in *State (Creedon) v Criminal Injuries Compensation Tribunal*[228] a tribunal exercising quasi-judicial or judicial functions is required to give reasons for its decisions:

> ...to reject the application and when that rejection was challenged subsequently to maintain a silence as to the reason for it, does not appear to me to be consistent with the proper administration of functions which are of a quasi judicial nature.[229]

As was noted above, judicial review operates as a review of the manner in which the decision is made, and not as a review of the substance of the decision itself. Thus, errors of law or of jurisdiction are amenable to review, but errors of fact are not. The only exception to this rule is where an error of fact is so fundamental as to undermine the basis for the tribunal's jurisdiction to adjudicate. The test for this exception is

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[226] *Re Haughey* [1971] IR 217.
[227] *Re Haughey* [1971] IR 217, 264 (Ó'Dálaigh, CJ).
[228] *State (Creedon) v Criminal Injuries Compensation Tribunal* [1988] IR 51.
[229] *State (Creedon) v Criminal Injuries Compensation Tribunal* [1988] IR 51, at 55 (Finlay, CJ).

governed by the 'administrative unreasonableness' principles.[230] This test was explained clearly by Henchy J in *State (Keegan) v Stardust Compensation Tribunal*:

> I would myself consider that the test of unreasonableness or irrationality in judicial review lies in considering whether the impugned decision plainly and unambiguously flies in the face of fundamental reason and common sense. If it does, then the decision-maker should be held to have acted *ultra vires*, for the necessarily implied constitutional limitation of jurisdiction in all decision-making which affects rights or duties requires, *inter alia*, that the decision-maker must not flagrantly reject or disregard fundamental reason or common sense in reaching his decision.[231]

The 'administrative unreasonableness' test established in *State (Keegan) v Stardust Compensation Tribunal* was later modified in *O'Keeffe v. An Bord Pleanála*[232] to require of the impugned decision that:

1. It is fundamentally at variance with reason and common sense.
2. It is indefensible for being in the teeth of plain reason and common sense.
3. Because the court is satisfied that the decision-maker has breached his obligation whereby he "must not flagrantly reject or disregard fundamental reason or common sense in reaching his decision.[233]

Hogan and Morgan describe the courts' approach to the availability of judicial review of administrative decisions as involving a balancing act between, on the one hand, a reluctance to interfere in the decisions of inferior courts or expert tribunals, and on the other hand, a desire to ensure that do not go unchecked.[234] Delaney has traced the development of the Irish courts' attitude to judicial review in the last decade, and discerns a trend such that "an increasing number of administrative decision-makers are required to observe a growing range of procedural and even substantive safeguards in exercising their powers" and the influence of the principles of the principles of proportionality and legitimate expectations, and of the European

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[230] *See Associated Picture Houses Limited v Wednesbury Corporation* [1948] 1 KB 223; *State (Keegan) v Stardust Compensation Tribunal* [1986] IR 642; *Radio One Limerick v Independent Radio and Television Commission* [1997] 1 IR 291; *O'Keeffe v An Bord Pleanála* [1993] 1 IR 39.
[231] *State (Keegan) v Stardust Compensation Tribunal* [1986] IR 642, 658 (Henchy J).
[232] *O'Keeffe v. An Bord Pleanála* [1993] 1 IR 39.
[233] *O'Keeffe v. An Bord Pleanála* [1993] 1 IR 39, at 70.
[234] Hogan, Gerard, and Morgan, David Gwynn, *Administrative Law in Ireland*, 3rd edn (Dublin: Round Hall Sweet and Maxwell, 1998), 412.

Convention on Human Rights Act 2003 ('the ECHR Act 2003').[235] The ECHR Act 2003 requires the Irish courts to have regard to the provisions of the ECHR and to the jurisprudence of the ECtHR. Delaney points out that there is evidence of the Irish courts taking judicial notice (and even placing reliance on) ECHR provisions, and states that:

> ...given the relatively few areas of potential conflict and the increasingly rich jurisprudence which has emanated from the ECtHR, it is likely that the court's decisions, particularly in areas such as the protection of privacy rights, will take on added significance before domestic courts in this jurisdiction in the years to come.[236]

In this regard, the decision in *Meadows v Minister for Justice Equality and Law Reform*[237] – delivered subsequent to Delaney's commentary – is of interest. In *Meadows* the Supreme Court addressed the question of which test – the *Keegan* version of unreasonableness, or the stricter *O'Keeffe* formulation – was to be applied in cases involving human rights claims. Denham J held that the *O'Keeffe* version of the unreasonableness test was to be confined to technical or specialist areas only, and that where constitutional or ECHR rights at stake this must be factored into the analysis of the reasonableness of the impugned decision, which analysis must include an assessment of the proportionality of the decision in light of the human rights restrictions it may occasion:

> My conclusion is as follows. In determining the reasonableness of an administrative decision which affects or concerns constitutional rights the standard to be applied is that stated by Henchy J., in *The State (Keegan) v. Stardust Victims' Compensation Tribunal* [1986] I.R. 642. This has been set out previously in the judgment, but for clarity I restate it here:
>
> Henchy J. stated at p.658:-
>
> > "I would myself consider that the test of unreasonableness or irrationality in judicial review lies in considering whether the impugned decision plainly and unambiguously flies in the face of fundamental reason and common sense. If it does, then the decision-maker should be held to have acted ultra vires, for the necessarily

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[235] Delaney, Hilary, *Judicial Review of Administrative Action: A Comparative Analysis,* 2nd edn (Dublin: Round Hall Sweet and Maxwell, 2008), 28.
[236] Delaney, Hilary, *Judicial Review of Administrative Action: A Comparative Analysis,* 2nd edn (Dublin: Round Hall Sweet and Maxwell, 2008), 469.
[237] *Meadows v Minister for Justice Equality and Law Reform* [2009] IESC 3.

> implied constitutional limitation of jurisdiction in all decision-making which affects rights or duties require, inter alia, that the decision-maker must not flagrantly reject or disregard fundamental reason or common sense in reaching his decision."
>
> This test includes the implied constitutional limitation of jurisdiction of all decision-making which affects rights and duties. Inter alia, the decision-maker should not disregard fundamental reason or common sense in reaching his or her decision. The constitutional limitation of jurisdiction arises inter alia from the duty of the courts to protect constitutional rights. When a decision-maker makes a decision which affects rights then, on reviewing the reasonableness of the decision: (a) the means must be rationally connected to the objective of the legislation and not arbitrary, unfair or based on irrational considerations; (b) the rights of the person must be impaired as little as possible; and (c) the effect on rights should be proportional to the objective.[238]

The concept of proportionality was also invoked successfully in *Blehein v Minister for Health and Children*[239] in the context of a challenge to s 260 of the Mental Treatment Act 1945 ('the 1945 Act'). In *Blehein*, Denham J in the Supreme Court had held that the restrictions imposed on the applicant's right to litigate were, having had regard to the aim and purpose of the 1945 Act, disproportionate curtailments of his constitutional rights.[240]

Hogan and Morgan, writing a decade prior to the *Meadows* and *Blehein* decisions, had highlighted the potential in the principle of proportionality in the context of cases that engage issues pertaining to Article 40.1 of the Constitution[241] and had pressed for its adoption in preference to the principle of 'administrative reasonableness' on the basis that the proportionality principle provides for a more "structured, rational and objective analysis" of an impugned decision.[242] The potential of this concept for the development of a heightened form of judicial review that may be of utility to litigants seeking to judicially review the reasonableness of decisions pertaining to the allocation of resources in the context of healthcare is discussed at §5.5.3 below.

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[238] *Meadows v Minister for Justice Equality and Law Reform* [2009] IESC 3, at § 51 (Denham J).
[239] *Blehein v Minister for Health and Children* [2008] IESC 40; [2009] 1 IR 275; [2008] 2 ILRM 401 (Supreme Court, Denham J).
[240] *Blehein v Minister for Health and Children* [2008] IESC 40 (Supreme Court, Denham J); [2008] 2 ILRM 401; [2009] 1 IR 275, at 279. See the discussion at §§ 1.4.1 and 3.6 above.
[241] Hogan, Gerard, and Morgan, David Gwynn, *Administrative Law in Ireland*, 3rd edn (Dublin: Round Hall Sweet and Maxwell, 1998), 126.
[242] Hogan, Gerard, and Morgan, David Gwynn, *Administrative Law in Ireland*, 3rd edn (Dublin: Round Hall Sweet and Maxwell, 1998), 663.

A review of the publicly accessible Courts Services High Court litigation database[243] shows records of thirteen judicial reviews taken to date in relation to the decisions of Mental Health Tribunals. In two cases – *SM v. The Mental Health Commission, The Mental Health Tribunal and The Clinical Director of St. Patrick's Hospital, Dublin; and The Attorney General and The Human Rights Commission*[244] and *EJW (APUM) v Watters and Ors*[245] declaratory relief was granted. In four cases – *Tully v Clinical Director of St. John of God's Hospital and Anor*;[246] *O'Gorman v Mental Health Commission and Anor*;[247] *Doran v Mental Health Tribunal and Anor*;[248] and *Tully v Mental Health Commission and Anor*[249] – orders of *certiorari* were made. Three cases – *Gleeson v Brannigan and Ors*;[250] *Daly v Judge Buttimer and Ors*;[251] and *O'Loughlin v Clinical Director of St. Patrick's University Hospital and Anor*[252] – were struck out and in *O'Connell v Mental Health Tribunal*[253] the court refused to grant the relief sought. In the remaining three cases[254] the proceedings are still pending.

In *S.M.*[255] the applicant argued successfully that the order made by the Mental Health tribunal under section 15(3) of the MHA 2001, renewing her compulsory detention for a period 'not exceeding twelve months', was not an order permitted under the Act. The applicant was in the circumstance that her compulsory detention was under review for the third time, and her treating psychiatrist was applying for a third renewal of the compulsory detention order. In that situation, the form prescribed by the Mental Health Commission for use by the MHT did not provide any option for the

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[243] Available through the Courts Services website <http://highcourtsearch.courts.ie/hcslive/cslogin> accessed 1 September 2010.
[244] *S.M. v. The Mental Health Commission, The Mental Health Tribunal and The Clinical Director of St. Patrick's Hospital, Dublin; and The Attorney General and The Human Rights Commission* [2008] IEHC 441, [2008 No. 749 JR].
[245] *EJW (APUM) v Watters and Ors* [2008] IEHC 462.
[246] *Tully v Clinical Director of St. John of God's Hospital and Anor* (2009 / 618 JR).
[247] *O'Gorman v Mental Health Commission and Anor* (2008 / 226 JR).
[248] *Doran v Mental Health Tribunal and Anor* (2009 / 310 JR).
[249] *Tully v Mental Health Commission and Anor* (2008 / 86 JR).
[250] *Gleeson v Brannigan and Ors* (2008 / 620 JR).
[251] *Daly v Judge Buttimer and Ors* (2008 / 197 JR).
[252] *O'Loughlin v Clinical Director of St. Patrick's University Hospital and Anor* (2010 / 653 JR).
[253] *O'Connell v Mental Health Tribunal* (2008 / 174 JR).
[254] *Ryan (APUM) v Brannigan and Ors* (2007 / 814 JR); *S v Mental Health Tribunal* (2007 / 1562 JR); and *Redmond (APUM) v Daly, Clinical Director of St. Senan's Psychiatric Hospital and Ors* (2007 / 677 JR).
[255] *S.M. v. The Mental Health Commission, The Mental Health Tribunal and The Clinical Director of St. Patrick's Hospital, Dublin; and The Attorney General and The Human Rights Commission* [2008] IEHC 441, [2008 / 749 JR].

treating psychiatrist to apply for a detention other than one 'not exceeding twelve months'. The applicant argued that this rendered the MHT's decision arbitrary and disproportionate and that it was void for uncertainty and could not provide a legitimate basis for the deprivation of her liberty.

McMahon J agreed, holding that section 15 is required to be interpreted in such a manner as to maximise the benefit to the patient while minimising the degree of interference with her constitutional rights. Accordingly, compulsory detention under the Act should never be for a period longer than is necessary to achieve the purpose as set out under the Act (which McMahon J determined to be "to protect the involuntary patient and to give him/her public assurance that an external monitoring mechanism exists to ensure that the involuntary patient is being properly cared for and treated."[256]) As such, the Court held that the detention order as made was disproportionate to the aim of the detention as it did not permit for a shorter detention than twelve months. The Court ordered that there was no legal basis for the Tribunal's decision to renew the applicant's compulsory detention, and accordingly made an order quashing that decision and ordering the applicant's release. A stay of a period of four weeks was placed on this order, in which time the legislature passed amending legislation to facilitate the creation of forms which would permit applications for varying terms of detention.[257]

One additional precedent is of interest in the context of actions taken under the MHA 2001 that are amenable to judicial review. In EF v Clinical Director of St. Ita's Hospital[258] the applicant challenged the validity of her removal to the approved centre, and sought declarations: (a) that her removal to the mental hospital hospital was not effected in accordance with the procedures mandated under the MHA 2001; (b) that the decision by the clinical director of the hospital that her removal to hospital would be carried out by a third party was *ultra vires* the powers of the clinical director

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[256] *S.M. v. The Mental Health Commission, The Mental Health Tribunal and The Clinical Director of St. Patrick's Hospital, Dublin; and The Attorney General and The Human Rights Commission* [2008] IEHC 441; [2009] IR 188, 203.

[257] *See* Mental Health Act 2008. McMahon J made reference to the amending legislation in his judgment in *S.M. – see S.M. v. The Mental Health Commission, The Mental Health Tribunal and The Clinical Director of St. Patrick's Hospital, Dublin; and The Attorney General and The Human Rights Commission* [2008] IEHC 441; [2009] IR 188, 213.

[258] *EF v Clinical Director of St. Ita's Hospital* [2009] IEHC 253 (O'Keeffe J).

under the MHA 2001; and (c) that the manner in which the removal was effected violated her constitutional and ECHR rights to liberty, bodily integrity, and privacy, and was not effected with reasonable care or in accordance with law. The case revolved around the provision in s 13 (2) of the MHA 2001 that the clinical director of a mental hospital (or a consultant psychiatrist acting on his or her behalf) may, where a request is by the medical practitioner who is recommending the patient's admission, "arrange for the removal of the person to the approved centre by members of staff of the approved centre."[259] In the instant case, the clinical director had "outsource" the removal of the applicant to the approved centre and the removal was effected by a private limited company which specialised in the provision of this service.[260] The applicant's argument was that as the private limited company was not a 'member of staff of the approved centre', then her removal to the hospital was not done in accordance with the provisions of the Act and the decision of the clinical director to engage the private limited company to provide the service was *ultra vires* and therefore unlawful. O'Keeffe J agreed with the applicant's argument that the private limited company or its employees could not be considered members of staff of the approved centre and granted the declaratory relief sought.

3.9 Equality Claims

The right to equality enjoys explicit constitutional protection and may arise in the mental health context as an argument in relation to the standards of protection afforded to patients' right to liberty or to autonomy (particularly in respect of protections around the right to refuse consent to treatment); or as an argument for the provision of entitlements in respect of service provision. Equality and non-discrimination arguments may also arise in the mental health context under the employment law protections which prohibit discrimination on the grounds of disability, including mental illness.[261]

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[259] Mental Health Act 2001, s 13 (2).

[260] "Outsource" is the term adopted by O'Keeffe J in the judgment. See *EF v Clinical Director of St. Ita's Hospital* [2009] IEHC 253 (O'Keeffe J), § 36.

[261] *See* for example *Croke v Smith (No 2)* (1998) 1 IR 101 (Supreme Court); 27 and 31 July 1995, Unreported, High Court, Budd J; *O'Donoghue v Minister for Health* [1996] 2 IR 20 and *Sinnott (a minor suing by his mother and next friend) v Minister for Education, Ireland and the Attorney General* [2000] IEHC 21; [2001] IESC 63; [2001] 2 IR 545.

Article 40.1 of the Constitution provides as follows:

> 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.[262]

The meaning of the equality provisions in the Constitution has been the subject of significant volumes of academic commentary. Hogan and White borrow Feldman's categorisation of the international equality jurisprudence into process-focussed; outcome-focussed; 'classical liberalism' and 'equality of opportunity' approaches to equality,[263] but the authors opine that the Irish jurisprudence is "remarkably underdeveloped" and that "debate about the differing conceptions of equality has, to a large extent, passed Article 40.1 by..."[264] In a similar vein, Doyle has written that the Irish courts, in scrutinising alleged anti-discriminatory actions, have adopted a focus on the process by which an impugned decision has been arrived at, rather than on the outcome of that impugned decision; and that the depth of investigation of the impugned process of decision-making has erred on the side of allowing a broad latitude rather than adopting a strict scrutiny approach. [265]

Casey describes Article 40.1 as conferring no actual rights in itself, and states instead that Article 40.1 requires that such rights as are guaranteed, must be administered in an even-handed fashion.[266] In other words, the equality guarantee does not promise absolute equality in all circumstances, but rather it prohibits arbitrary, unreasonable or unjust discrimination.[267] The decision of Henchy J in *Dillane v Attorney General*, which concerned a differentiation between an ordinary common informer and a

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[262] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 40.1.
[263] Feldman, D, *Civil Liberties and Human Rights in England and Wales*, 2nd ed. (Oxford: Oxford Univeristy Press, 2002), 134.
[264] Hogan, Gerard and Gerry Whyte, eds, *JM Kelly's The Irish Constitution*, 4th ed (Dublin: Butterworths, 1994), 1323-1324.
[265] *See* the analysis of constitutional equality and the argument for a new conceptualisation of constitutional equality protections in Doyle, Oran J, *Constitutional Equality* (Dublin: Thomson Round Hall, 2004).
[266] Casey, J. *Constitutional Law in Ireland*, 3rd edn. (Dublin: Round Hall Sweet and Maxwell, 2000), 450.
[267] Casey, J. *Constitutional Law in Ireland*, 3rd edn. (Dublin: Round Hall Sweet and Maxwell, 2000), 452.

member of An Garda Síochána in the matter of an award of costs, is illustrative in this regard:

> When the State, whether directly by statute or mediately through the exercise of a delegated power of subordinate legislation, makes a discrimination in favour of, or against, a person or a category of persons, on the express or implied ground of a difference in social function, the courts will not condemn such discrimination as being in breach of Article 40.1 if it is not arbitrary, or capricious, or otherwise not reasonably capable, when objectively viewed in the light of the social function involved, of supporting the selection or classification complained of.[268]

This formulation of the threshold for breach of the equality guarantee is the kernal of the courts' 'process focussed' conception of equality as described by Doyle.

In *Murphy v Attorney General*, a case challenging the provisions of the Income Tax Act 1967, as they applied to married couples, Kenny J held that an inequality will not be set aside as unconstitutional "...if any state of facts exists which may reasonably justify it."[269] In other words, a differentiation may exist but once it is not 'unreasonable, unjust or arbitrary' (having been given the greatest benefit of the doubt), it will not fall foul of Article 40.1. The prohibition is on 'invidious' discrimination only, the problem therefore being that the definition of 'invidious' is set at such a high threshold that the vast majority of differentiations cannot hope to meet it. Casey has described *Murphy* as "the low-water mark of the equality guarantee."[270]

In *People (DPP) v Quilligan and O'Reilly (No. 3)* Finlay, CJ affirmed that separating people into classifications for the purposes of differential treatment is not of itself offensive to Article 40.1.[271] In *Draper v Attorney General*, a case challenging the fact that the postal vote is given to members of an Garda Síochána and members of the Defence Forces but not to people with a disability, the Supreme Court held that, the State was entitled to decide that the cost and risk involved in extending the postal vote was excessive and that thus there was no violation of the equality protection in Article

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[268] *Dillane v Attorney General* [1980] ILRM 167 (Supreme Court), Henchy J, 169.
[269] *Murphy v Attorney General* [1982] IR 241 (Supreme Court), Kenny J, 284.
[270] Casey, J. *Constitutional Law in Ireland*, 3rd edn. (Dublin: Round Hall Sweet and Maxwell, 2000), 456.
[271] *People (DPP) v Quilligan and O'Reilly (No 3)* [1993] 2 IR 205.

40.1.[272] Casey describes this as "another example of extraordinary deference to legislative judgment."[273] Similarly in *State (Hartley) v Governor of Mountjoy Prison*, (a case that Casey believes may be falling out of favour in more recent times[274]) O'Dálaigh, CJ held that:

> A diversity of arrangements does not effect discrimination between citizens in their legal rights. Their legal rights are the same in the same circumstances. This in fact is equality before the law and not inequality.[275]

The idea espoused by these precedents, that once legal rights are the same within a particular group or class there can be no invidious discrimination, was seriously questioned in the Supreme Court of Canada in *Andrews v Law Society of British Columbia*.[276] McIntyre, J in that case described the 'similarly situated test' as "seriously deficient in that it excludes any consideration of the nature of the law."[277]

In the arena of mental health law, in *State (H) v Daly*[278] the applicant had been found of unsound mind and transferred to the Central Mental Hospital until such time as he made a recovery from his condition. He argued that the provisions authorising the Minister for Justice to send an Inspector to examine any mental health patient, which required the Inspector to report on the legality of the detention of non Central Mental Hospital patients but did not require such a report on Central Mental Hospital patients, violated Article 40.1. Finlay, P held that while the Inspector was not 'required' to report on the legality of a Central Mental Hospital patient's detention, he could still do so if he wished, and that further the President of the High Court could direct the Inspector to examine the legality of a Central Mental Hospital patient's detention. Accordingly Finlay, P held that the discrimination in the legislation affected 'nothing of substance'[279] and as such did not breach Article 40.1.

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[272] *Draper v Attorney General* [1984] IR 277.
[273] Casey, J. *Constitutional Law in Ireland*, 3rd edn. (Dublin: Round Hall Sweet and Maxwell, 2000), 466.
[274] Casey, J. *Constitutional Law in Ireland*, 3rd edn. (Dublin: Round Hall Sweet and Maxwell, 2000), 469.
[275] *State (Hartley) v Governor of Mountjoy Prison*, Unreported, Supreme Court, 21 December 1967, (Ó'Dálaigh, CJ).
[276] *Andrews v Law Society of British Columbia* (1989) 56 DLR (4th) 1.
[277] *Andrews v Law Society of British Columbia* (1989) 56 DLR (4th) 1, 11-12.
[278] *State (H) v Daly* [1977] IR 90 (Finlay P).
[279] Casey, J. *Constitutional Law in Ireland*, 3rd edn. (Dublin: Round Hall Sweet and Maxwell, 2000), 470.

In *Re a Ward of Court (No. 2)*[280] the Supreme Court considered the question of whether a person could lose their rights to privacy and self-determination by virtue of incapacity, and held that to find such a loss of rights to be permissible would amount to an unjustified restriction of the Article 40.1 right to equality.[281]

3.10 Affirmative Rights Claims

The final type of rights claim that may arise in mental health cases are claims based on arguments for entitlements. A number of these types of rights claims have been brought in the past decade, utilising the constitutionally protected right to education to argue that the provision of certain mental health treatments or services are essential to the ability of the claimant to participate in education. Further claims utilising the right to education to argue that the provision of education is an essential component in the claimant's mental health treatment needs have been advanced, and claims that the failure to provide education (either to a minor, or to an adult who argues that by virtue of their mental disability they require ongoing educational services) is detrimental to their mental health to a degree sufficient to amount to a violation of human rights, have also been brought.[282]

Claims that mount an argument for a constitutional entitlement to the provision of a particular service have been advanced in the Irish courts in respect of health services and education, usually within the one set of proceedings. These proceedings have utilised the constitutionally protected right to education to argue that the provision of certain mental health treatments or services are essential to enable a minor applicant (being a person under the age of 18) to participate in education, or to argue that the provision of education is an essential part of the necessary services required to secure the applicant's mental health treatment needs. A number of cases have also sought to

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[280] *Re a Ward of Court* (No 2) (1996) 2 IR 79.
[281] *Re a Ward of Court* (No 2) (1996) 2 IR 79, 434 (O'Flaherty J). *See* also the judgments of Denham J and Hamilton CJ.
[282] *See* for example *O'Reilly and Ors v Limerick Corporation* [1989] ILRM 181; *O'Donoghue v Minister for Health* [1996] 2 IR 20 and *Sinnott (a minor suing by his mother and next friend) v Minister for Education, Ireland and the Attorney General* [2000] IEHC 21; [2001] IESC 63; [2001] 2 IR 545.

utilise the right to property in the form of a right to housing in order to secure a better standard of health for claimants who argue that their current housing situation is detrimental to their health to an extent that amounts to a violation of their constitutional right to bodily integrity.

3.10.1 Health

The right to education, and its unique position in the Irish Constitution as a justiciable socio-economic right, is discussed below. This section discusses the attempts that have been made by litigants in Ireland to secure pronouncements that other socio-economic rights, the rights to housing and to health in particular, are justiciable before the courts.

In *O'Reilly v Limerick Corporation*[283] the applicant family, who were members of the travelling community, sought to compel the respondent local authority to provide them with housing within their local authority halting site, in the form of a serviced halting site stand for their mobile home. They submitted that this obligation arose out of the provisions of the Housing Act 1966, and that the failure on the part of the Oireachtas to comply with it had resulted in a violation of their constitutional rights. Costello, J in the High Court dismissed the applicants' claim on the ground that their petition was non-justiciable. The court held that the applicants' petition was in effect asking the court to engage in an act of distributive justice, and that distributive as opposed to commutative justice is exclusively the domain of the government. Accordingly, for the court to grant the orders sought would be for the court to engage in a function properly reserved to the government and would infringe on the principle of the separation of powers.

In *FN v Minister for Education*[284] Geoghegan J in the High Court held that a child has a right under Article 40.3 as against its parents (and hence as against the State where the parents fail in their duty), to be fed, to be reared and educated, and to have the opportunity of working and realising his or her full personality and dignity as a

[283] *O'Reilly and Ors v Limerick Corporation* [1989] ILRM 181.
[284] *F.N. v Minister for Education* [1995] 1 IR 509 (Geoghegan J) (High Court).

human being. Geoghegan, J based this judgment on the earlier decision in *G v An Bord Uchtála* [285] and concluded that the State in this instance has a constitutional obligation to establish suitable arrangements for the treatment of troubled youngsters as soon as reasonably practicable, and that it was within the power of the courts to make mandatory orders compelling the State to perform this obligation.

The *Sinnott v Minister for Education*;[286] *O'Donoghue v Minister for Health*;[287] and *TD v Minister for Education*[288] cases are also discussed below in relation to the constitutional right to a free "primary" education. The applicants in these cases had put forward the argument that consequent upon their intellectual, physical, or mental disabilities, they would remain in need of education as young adults and perhaps throughout their lives, in order that they could maintain a basic standard of living and of good health. Following the reasoning of Costello J in *O'Reilly v Limerick Corporation*[289] the Supreme Court held that to make orders requiring the provision of education beyond the cut-off point decided by the government as to what constitutes 'primary' education, would be to engage the courts in an inappropriate exercise of an executive function. The court pronounced itself to be cognisable only of education claims coming within the realm of 'primary education' as defined by the government, and found all claims falling outside of that ambit to be non-justiciable.

The decision in *NWHB v HW & CW*[290] also addresses the question of the justiciability of claims relating to the provision of services designed to maximise good health. Murphy J obiter stated that there are no express provisions of the Constitution cognisable by the courts which require the State to provide medical services or social welfare of any kind for any of its citizens.[291] Hardiman J gave a detailed explanation of his reasons for holding that a claim seeking to compel the State to provide

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[285] *G v An Bord Uchtála* [1980] IR 32.
[286] *Sinnott (a minor suing by his mother and next friend) v Minister for Education, Ireland and the Attorney General* [2000] IEHC 21; [2001] IESC 63; [2001] 2 IR 545.
[287] *O'Donoghue v Minister for Health* [1996] 2 IR 20.
[288] *T.D. (a minor suing by his mother and next friend M.D.) v Minister for Education, Ireland and the Attorney General, the Eastern Health Board and by Order of the Minister for Health and Children* [2001] IESC 101; [2001] 4 IR 259.
[289] *O'Reilly and Ors v Limerick Corporation* [1989] ILRM 181.
[290] *NWHB v HW & CW* [2001] 3 IR 622.
[291] *NWHB v HW & CW* [2001] 3 IR 622, 729.

particular medical treatments, tests or services could not be cognisable before the courts in Ireland:

> The legislature, and not the courts, are in the best position to judge whether such an innovation is necessary, proportionate or desirable, whether there are countervailing considerations of a social or medical nature or otherwise; whether there exists sufficient consensus in the community to make legislation feasible or desirable and many other relevant considerations. Compulsory medical diagnosis or treatment in any form is, for the reasons identified in the judgment of the learned Chief Justice, a topic regarded with some unease throughout the civilised world. The degree to which this unease should be recognised, whether precautions can be taken to allay legitimate fears, and the fundamental question of whether the imperative behind the P.K.U. test or any other test is sufficient to justify coercion, are all matters best addressed legislatively. As McCarthy J. said in a completely different context in *Russell v. Fanning* [1988] I.R. 505 at p. 554:-
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> > I question how a court determines (a) a question of national policy; (b) what is the decision on it; (c) whether or not that decision is that of the people; (d) how did the people decide such a question; (e) how the requirements of the common good were taken into account.
>
> Moreover, if and when the legislature decides to introduce legislation of the relevant kind it will be for the courts to determine, if the occasion arises, whether such legislation is consistent with the provisions of the Constitution. If the court is called upon to make this decision, it will have the benefit of evidence and argument on a specific provision, probably in circumstances where the parties are more on a footing of equality from the point of view of resources than the present plaintiff and defendants. If the court itself imposed a novel obligation, the constitutionally envisaged arrangement whereby one organ of government makes law and another decides on its constitutionality, would be inhibited in its operation.[292]

Costello J's decision in *O'Reilly v Limerick Corporation*[293] has been cited in most of the subsequent decisions dealing with the justiciability of socio-economic rights claims. A decade after that decision Costello J may be considered to have reversed his position. In *O'Brien v Wicklow Urban District Council*[294] the applicants presented the same claim as had the applicants in *O'Reilly*. This time, however, Costello J held that the State did owe a duty to members of the travelling community living in an unauthorised and unserviced halting sites. The duty owed was to provide serviced halting sites, on the grounds that the failure to do so infringed the applicants'

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[292] *NWHB v HW & CW* [2001] 3 IR 622, 762.
[293] *O'Reilly and Ors v Limerick Corporation* [1989] ILRM 181.
[294] *O'Brien v Wicklow Urban District Council*, Unreported, High Court, 10 June 1994 (Costello J).

constitutional right to bodily integrity. In this way the judge found a means through the infringement of a civil and political right (the right to bodily integrity) to mandate the provision of a socio-economic right (housing). Costello J was cognisant of the fact that this decision was likely to be perceived as a reversal of his earlier stance:

> I don't think it is necessary to say whether I am now expressing a different view to the one which I expressed in the case of *O'Reilly and Ors. v Limerick Corporation.* In that case I was not considering the terms of Section 13 of the [Housing Act 1988]. Even, however, if the view which I am now expressing represents a change of views on my part, then I accept that my views have changed... I accept the argument that the plaintiffs have a constitutional right to bodily integrity which is being infringed by the conditions under which they are living.[295]

No comparable reversal in the area of health care, whereby a court has accepted that compulsory orders could be made against the State if conditions in the public provision of health services infringe a person's constitutionally protected civil and political rights, has as yet taken place.

3.10.2 Education

The remaining two rights recognised in this 'fundamental rights' section of the Irish Constitution are somewhat unique to Ireland. Article 41 recognises the family as the fundamental and primary unit of society and as being therefore protected;[296] and Article 45 recognises the existence of a duty on the part of the State to provide for free primary education.[297]

Article 41.1 provides:

> 1. The State recognises the Family as the natural primary and fundamental unit group of Society, and as a moral institution possession inalienable and imprescriptible rights, antecedent and superior to all positive law.

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[295] *O'Brien v Wicklow Urban District Council*, Unreported, High Court, 10 June 1994 (Costello J), 3-4.
[296] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 41.
[297] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 45. On the right to education in Irish law generally, see Farry, Michael, *Education and the Constitution* (Dublin: Round Hall Sweet and Maxwell, 1996); O'Mahony, Conor, *Educational Rights in Irish Law* (Dublin: Thomson Round Hall, 2006); and Glendenning, Dympna, *Education and the Law* (Dublin: Butterworths, 1999).

> 2. The State, therefore, guarantees to protect the Family in its constitution and authority, as the necessary basis of social order and as indispensible to the welfare of the Nation and the State.

The facts of *NWHB v HW & CW*[298] have been given in detail already. As noted above, the Supreme Court in this case upheld the High Court ruling that this was not such an exceptional case as would require State to intervene and usurp the rights of the family in order to protect the child's constitutional rights. Such a usurpation of the paternal function could only occur in circumstances of a parental failing for physical or moral reasons in their duties. Murphy J stated that:

> In relation to the education of their children the relationship between the State and the family is clearly and expressly dealt with in Article 42. The corresponding rights and duties of the State in relation to matters of general medical welfare are unenumerated and ill defined but the subsidiarity of the State to the parents is clearly established. Clearly, it would be incorrect to suggest that the State could, or should, intervene merely because by doing so it could advance significantly the material interests of a child. If such a crude test were permitted then children of less well off parents might be given readily in fosterage to others who, it could be demonstrated, had the capacity to advance the material and, even, moral welfare of the child.[299]

Article 42 recognises the family as the primary educator of the family and mandates that the State shall further provide for a right to a minimum level of education. The right to education is of a socio-economic character, and by its insertion in the 'fundamental rights' portion of the text, the right to education is arguably elevated in the Irish Constitution to a level of protection generally not afforded to a socio-economic right. It remains however a matter of interpretation whether this placement of the socio-economic right to education within the 'civil and political rights segment' of the Constitution in fact amounts to an elevation of that right to the status of a justiciable enumerated right.

Conor O'Mahony has described the right to education as "one of the most fundamental of all human rights" and as "a prerequisite to the exercise of many other

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[298] *NWHB v HW & CW* [2001] 3 IR 622.
[299] *North Western Health Board v HW & CW* [2001] 3 IR 622, 732.

human rights" in the sense that if people are not aware of rights that they have then they cannot avail of them.[300] Article 42.4 of the Constitution provides:

> The State shall provide for free primary education and shall endeavour to supplement and give reasonable private aid to private and corporate education initiative, and, when the public good requires it, provide for other educational facilities or institutions with due regard, however, for the rights of parents, especially in the matter of religious and moral freedom.

In a number of cases applicants have attempted to mount an argument for the recognition of a constitutional right to certain health services where those health services are necessary to enable a child – or an adult with a disability – to avail of the right to education in Article 42.4. These cases frequently involve families seeking to compel the State to provide certain particular models of education that incorporate significant components considered to the State to be health services. Of particular contention has been the Applied Behavioural Analysis model of education for children with autism, which parents have sought to compel the State to provide on an exclusive basis, to the exclusion of the State's preferred programmes of education.

The Supreme Court pronounced authoritatively on these questions in *O'Donoghue v Minister for Education*;[301] *Sinnott v Minister for Education*;[302] and *T.D. v Minister for Education & Ors*.[303] All three of these cases concerned the provision of specialised education services for children or young adults with special educational needs. The applicants had put forward the argument that consequent upon their intellectual, physical, or mental disabilities, they would remain in need of education as young adults and perhaps throughout their lives, in order that they could maintain a basic standard of living and of good health but the Supreme Court rejected this argument as non-justiciable. In all three cases the court held that the right to provision for education extends only so far as a primary level education, and further that a primary education ends once a child attains the age of eighteen years, irrespective of the level of education then attained.

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[300] O'Mahony, Conor, *Educational Rights in Irish Law* (Dublin: Thomson Round Hall, 2006), § 2.05.
[301] *O'Donoghue v Minister for Health* [1996] 2 IR 20.
[302] *Sinnott (a minor suing by his mother and next friend) v Minister for Education, Ireland and the Attorney General* [2000] IEHC 21; [2001] IESC 63; [2001] 2 IR 545.
[303] *T.D. (a minor suing by his mother and next friend M.D.) v Minister for Education, Ireland and the Attorney General, the Eastern Health Board and by Order of the Minister for Health and Children* [2001] IESC 101; [2001] 4 IR 259.

These cases have been the subject of significant academic criticism.[304] O'Mahony has cited the recognition of the lifelong dimension to the right to education in the international human rights documents[305] and contrasted this unfavourably with the more restrictive approach taken in the Irish constitutional jurisprudence.[306] Michael Farry[307] notes the failure in *O'D v Minister for Health* to take account of the comparable entitlement argument put forward in *The State (C) v Frawley*, in which the State's obligation to provide specialised medical services was considered.[308] By contrast, in *FN v Minister for Education* the decision in *Frawley* was considered, and the obligation to provide the services sought was upheld.[309]

Dympna Glendenning has described Ireland's protections around the right to education as having seen "remarkable progress" in the twilight of the twentieth century.[310] However, she also points out that Ireland's human rights record falls "well short of international standards" in respect of the rights of people with disability and in particular those with severe and profound disabilities.[311]

The effects of the efforts to litigate affirmative constitutional rights claims to education and to health are discussed in more detail at § 5.5 below. In particular, the possibility of the utilisation of an increased decrease of judicial scrutiny of the reasonableness of resource allocation decisions is considered as an alternative means

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[304] See for example Ring, Mary Ellen, "A Right to an Education" (1997) 2 (6) *Bar Review* 219; O'Halloran, Barry, "Another brick in the wall?"(2000) 94 (9) *Law Society Gazette* 14; Craig, E. and Lundy, L., "Education Rights in the Bill of Rights" (2001) 52 *Northern Ireland Law Quarterly* 325; Quinlivan, Shivaun and Keys, Mary, "Official Indifference and Persistent Procrastination: An Analysis of Sinnott" (2002) 2(2) *Judicial Studies Institute Journal* 163; O'Mahony, Conor, "Education, Remedies and the Separation of Powers" (2002) 24 *Dublin University Law Journal* 57; Fergus W. Ryan, Fergus W., "Disability and the Right to Education: Defining the Constitutional 'Child'" (2002) 24 *Dublin University Law Journal* 96; O'Mahony, Conor, "A New Slant on Education Rights and Mandatory Injunctions?" (2005) 27 *Dublin University Law Journal* 363; O'Mahony, Conor, "The Right to Education and "Constitutionally Appropriate" Provision" (2006) 28 *Dublin University Law Journal* 422; and Flynn, Eilionóir, "Ireland's compliance with the Convention on the Rights of Persons with Disabilities: Towards a Rights-based Approach for Legal Reform" (2009) 31 *Dublin University Law Journal* 357.

[305] O'Mahony, Conor, *Educational Rights in Irish Law* (Dublin: Thomson Round Hall, 2006), §§ 6.04-6.09.

[306] O'Mahony, Conor, *Educational Rights in Irish Law* (Dublin: Thomson Round Hall, 2006), §§ 6.73-6.79.

[307] Farry, Michael, *Education and the Constitution* (Dublin: Round Hall Sweet and Maxwell, 1996), 41.

[308] *The State (C) v Frawley* [1976] IR 365. See the discussion at § 5.3.2 above.

[309] *FN v Minister for Education* [1995] 1 IR 509, Geoghegan J. (High Court).

[310] Glendenning, Dympna, *Education and the Law* (Dublin: Butterworths, 1999), 275.

[311] Glendenning, Dympna, *Education and the Law* (Dublin: Butterworths, 1999), 275.

to achieve the results as yet unsuccessfully sought by the affirmative rights claims litigation.

Conclusion

In this Chapter the different types of constitutional rights arguments that are of importance to mental health service users have been identified as involving seven specific types of rights claims: dignity claims (including right to life claims); liberty claims; autonomy, bodily integrity and privacy claims and freedom from torture and inhuman and degrading treatment and punishment claims; fair procedures claims; equality claims; and entitlement (to health or to education) claims.

An account has been provided of the ways in which these rights are established further how those rights are then protected, vindicated or limited by decisions and judgments made in the Irish courts, regarding the constitutional aspects of mental health claims.

The constitutional jurisprudence on these issues provides a clear picture of the vision held by the judiciary in Ireland of the scope of constitutional human rights protections in the area of mental health. In Chapter 2 the scope of the human rights protections envisaged by the international human rights instruments in the area of mental health was evaluated. In Chapter 5, the degree to which the Irish constitutional protections tally with the international human rights framework's expectations of rights protections in the area of mental health is assessed.

In the next chapter, a comparative study is undertaken. Two jurisdictions are chosen for analysis. The first, England, does not have a constitutional human rights framework but which shares a virtually identical set of international human rights obligations and a shared legal heritage with Ireland. The second, South Africa, is not a party to the ECHR and as such does not share in full Ireland's international human rights obligations, but, importantly, does have a constitutional bill of rights, which interestingly provides for a justiciable right to access to health care.

4. COMPARATIVE ANALYSIS OF HUMAN RIGHTS AND MENTAL HEALTH LAW: IRELAND, ENGLAND, AND SOUTH AFRICA

Introduction

In this Chapter a comparative account is given of the approaches taken by different jurisdictions to the adoption of international human rights norms in the area of mental health regulation. The move towards the adoption of a human rights approach to mental health regulation has occurred on both the global scale, at the United Nations level; and on a regional scale within Europe, through the jurisprudence of the European Court of Human Rights.

A comparative analysis of how other countries have approached this task is a useful device for this work to adopt in order to provide additional context for the audit performed in Chapter 5 of Ireland's efforts at adopting a human rights regime in this area.

Of course, there are many countries whose legal systems would be of interest to this work as comparator jurisdictions. Former Commonwealth countries such as Canada, Australia and India, share some degree of legal history with Ireland as a result of a shared experience of colonisation by England, and generally like Ireland have a constitutional document that protects human rights. Indeed, Canada has, like Ireland, seen a certain amount of litigation seeking the recognition of a justiciable right to health as a corollary of another right such as equality.[1] The continental European countries share Ireland's ratification of the European Convention on Human Rights,

[1] For an analysis of the limited degree of success of this litigation in Canada, *see* Friesen, Tamara, "The Right to Health Care" (2001) 9 *Health Law Journal* 205. On the Canadian mental health law regime in general, *see* Kaiser, H. Archibald, "Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State" (2009) 17(1) *Health Law Journal* 139, and Gordon, Robert M., and Verdun-Jones, Simon, N., "2. Impact of the Canadian Charter of Rights and Freedoms upon Canadian Mental Health Law: The Dawn of a New Era of Business as Usual" (1986) 14 *Law, Medicine and Health Care* 190.

but unlike Ireland have a completely different legal heritage in that they have a civilian or Roman law derived legal system, and thus they approach the absorption of human rights principles into their legal systems in an entirely different manner.[2] However, a comparative analysis of the mental health systems of all of the countries with which Ireland shares some influences or legal history is beyond the scope of this work. The countries that have been chosen as of most interest for comparative analysis are England and South Africa: England for its unique close legal history with Ireland and its shared experience of incorporation of the European Convention on Human Rights into a dualist common law legal system; and South Africa for its unusual constitutional protection for a justiciable right to health care, together with a new mental health law regime adopted at virtually the same moment as Ireland's recent mental health law reforms.

4.1 England

England shares a common law heritage with Ireland, and like Ireland does not recognise a justiciable right to health. England also shares Ireland's membership of the Council of Europe making both jurisdictions subject to the European Convention on Human Rights (ECHR) and subject to the jurisprudence of the European Court of Human Rights (ECtHR). In this respect England and the continental European countries have much in common in terms of comparisons with Ireland. However, the shared common law heritage that exists between Ireland and England (and in some instances, such as the surviving wardship regime in Ireland, even extends to a shared statutory framework) makes direct comparisons between the impact of the ECHR on mental health regulation in the two countries uniquely illuminative.

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[2] On the approach taken to the incorporation of international human rights norms into mental health law in various jurisdictions globally, *see* Gostin, Lawrence O. and Gable, Lance, "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health" (2004) 63(1) *Maryland Law Review* 20 and Rosenthal, Eric, and Sundram, Clarence J., "International Human Rights in Mental Health Legislation" (2002) 21 *New York Law School Journal of International and Comparative Law* 469. For a comparative analysis of the compulsory civil committal provisions in the mental health laws of nine different European countries, *see* Legamaate, John, "Involuntary Admission to a Psychiatric Hospital: Recent European Developments" (1995) 2 *European Journal of Health Law* 15. *See* also Dressing, Harald, and Salize, Hans Joachim, "Compulsory admission of mentally ill patients in European Union Member States" (2004) 39 (10) *Social Psychiatry and Psychiatric Epidemiology* 797.

Notably, England does not have a written constitution and this is a point of divergence in the English legal system and the Irish system. The Human Rights Act 1998 incorporates the ECHR into English law at a domestic level, and mandates that the courts must interpret domestic law "so far as it is possible to do so" in such a fashion as to ensure compliance with the Convention.[3] The courts are also required to 'take into account' the jurisprudence of the ECtHR but are not bound to follow it.[4] Where statutory provisions cannot be rendered compatible with the Convention, the higher courts have a discretion to issue a declaration of incompatibility[5] following which it is open to parliament (but not mandated) to amend the offending law.

Mental health regulation in England[6] is provided by three pieces of legislation: the Mental Health Act 1983,[7] the Mental Capacity Act 2005,[8] and the Mental Health Act 2007[9] which is an amending enactment that heavily modifies both the 1983 and the 2005 Acts. England also utilises the Mental Capacity Act Deprivation of Liberty Safeguards to augment the provisions in the Mental Capacity Act 2005.

As was noted at § 1.3.3 above, England has reformed its wardship regime and the 2005 Act as amended by the 2007 Act introduced new measures providing for guardianship, advance directives, and a new system regulating the provision of medical treatment to patients lacking capacity. This new system for capacity and guardianship is discussed first below, followed by an outline of the mental health law regime which will follow the same structure as that adopted in Chapter 1 for the discussion of the contemporary law on mental health in Ireland. An account will be

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[3] Human Rights Act 1998 (England), s 3(1). *See* Wadham, John, Edmundson, Anna, and Mountfield, Helen, *Blackstone's Guide to the Human Rights Act 1998* (Oxford: Oxford University Press, 2003) and Feldman, David, *Civil Liberties in England and Wales* 2nd edn. (Oxford: Oxford University Press, 2002), Chapter 4. On the impact of the Human Rights Act 1998 (England) on mental health law specifically, *see* Bowen, Paul, "Is this a Revolution? The impact of the Human Rights Act on Mental Health Law" (2004) February *Journal of Mental Health Law* 27 and Hale, Brenda, "The Human Rights Act and Mental Health Law: Has it Helped?" (2007) May *Journal of Mental Health Law* 7.

[4] Human Rights Act 1998 (England), s 2.

[5] Human Rights Act 1998 (England), s 4.

[6] For a more detailed account of mental health law regulation in England, *see* Bartlett, Peter and Sandland, Ralph, *Mental Health Law: Policy and Practice* 3rd ed. (Oxford: Oxford University Press, 2007).

[7] Mental Health Act 1983 (C. 20) (England). *See* also *Reference Guide to the Mental Health Act 1983* (London: The Stationery Office Limited, 2008).

[8] Mental Capacity Act 2005 (C. 9) (England). *See* also *Mental Capacity Act 2005: Explanatory Notes* (London: The Stationery Office Limited, 2005).

[9] Mental Health Act 2007 (C. 12) (England). *See* also *Mental Health Act 2007: Explanatory Notes* (London: The Stationery Office Limited, 2007).

given here of three key aspects of the provisions in the English mental health regime, and a comparative analysis of these provisions compared with their Irish equivalents will be undertaken. The three key areas chosen for analysis are:

1. The provisions regulating compulsory admission to a mental hospital;
2. The mechanisms by which reviews of compulsory admission and detention are conducted; and
3. The regulation of the administration of mental health treatments, particularly the administration of treatment without a patient's consent.

4.1.1 Capacity and Guardianship in England

The Mental Capacity Act 2005 (hereafter 'the 2005 Act') has been in force in England since 1 October 2007.[10] It introduced a modern system of guardianship to replace the wardship regime previously in place. The wardship regime was intended to deal with situations where decisions were required to be made on behalf of adults who did not have the requisite capacity to make those decisions, but its provisions had come to be seen as outmoded and no longer suitable for use in a legal system that had adopted a human rights approach to issues around legal rights generally and to capacity specifically.[11] The 2005 Act also introduced measures to regulate advance directives and give them force of law in England for the first time. The 2005 Act replaced the entirety of Part 7 of the 1983 Act, which had dealt with the management of the property and affairs of mental patients.[12] It also established a reconstituted Court of Protection to replace the previous Court of Protection, which had operated as an office of the Supreme Court in a similar fashion to how the Office of the Wards of Court functions in Ireland.

The 2005 Act is of particular interest to this work as Ireland continues to operate a wardship system that is very similar to the system that operated in England prior to

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[10] Mental Capacity Act 2005 (Commencement No. 1) Order 2006 (England).
[11] *See* for example the detailed critique in Bartlett, Peter, and Sandland, Ralph, *Mental Health Law: Policy and Practice,* 2nd ed. (Oxford: Oxford University Press, 2003), 599-615.
[12] Mental Health Act 1983 (England), sections 93-113, repealed by Mental Capacity Act 2005 (England), sch 7.

2007. The Law Reform Commission in Ireland in 2006 recommended significant reform of the Irish wardship system[13] and the proposed new guardianship and advance directives provisions bear many similarities to the new English system.[14]

The 2005 Act is not confined in its application to people with mental illness and it applies to anyone who has lost legal capacity to make decisions, whether that is a result of dementia, a brain injury, or an intellectual disability.[15] For the purposes of this work, the focus will be on its application to people who lose capacity – temporarily or permanently – as a result of the effects of mental illness. The 2005 Act commences with a statement of principles applicable to all actions done under the provisions of the Act, the most important of which may be said to be (a) that the Act operates at all times on the basis of a presumption that a person has capacity; (b) that all acts done under the Act are to be done in the best interests of the person who has lost capacity; and (c) that before any act is done under the legislation, consideration must be given to whether the same outcome can be achieved through the use of another mechanism which would be less restrictive of the person's rights and freedom of action.[16]

Denzil Lush has emphasised the human rights foundations of these principles, and their starting premise that everyone is "entirely autonomous" and that a "paternalistic intervention is only justified when all practicable steps to help a person made a decision have been taken without success…"[17]

The presumption of capacity and the requirement to take 'all practicable steps' to maximise a person's capacity are of vital importance in the context of a human rights

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[13] Law Reform Commssion, *Report: Vulnerable Adults and the Law* (LRC 83 – 2006) (Dublin: Law Reform Commission, 2006).

[14] These proposals have met with approval in some quarters – *see* for example Donnelly, Mary, "Legislating for Incapacity: Developing a Rights-Based Framework" (2008) 30 *Dublin University Law Journal* 395 – but have also been criticised as an unnecessary jettisoning of the wardship framework which it is agued is capable of modernisation and does not require complete dismantling – *see* O'Neill, Anne-Marie, *Wards of Court in Ireland* (Dublin: Bloomsbury Professional, 2005), 206-208.

[15] *See Mental Capacity Act 2005: Explanatory Notes* (London: The Stationery Office Limited, 2005), 1.

[16] Mental Capacity Act 2005 (England), s 1. For some analysis of the guiding principles as enacted, *see* Daw, Rowena, "The Mental Health Act 2007: The Defeat of an Ideal" (2007) November *Journal of Mental Health Law* 131, 133.

[17] Lush, Denzil, "The Mental Capacity Act and the new Court of Protection" (2005) May *Journal of Mental Health Law* 31, 34.

approach to capacity, and are described by Gordon Ashton as part of the 'bringing home' of human rights by the Human Rights Act 1998.[18] The Act requires that any interference with a person's capacity and with their freedom to make decisions even where those decisions might be considered unwise should be minimised.[19] The Act applies to both permanent and temporary losses of capacity,[20] and defines capacity in relation to a person's ability to make a particular decision at a particular time, rather than on the basis of an abstract ability to make decisions generally:

> 2.— (1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.[21]

This definition adopts the functional model of capacity (whereby evaluations of capacity are on a function-by-function basis, and a finding that a person lacks capacity in relation to *one* type of decision does not result in a loss of legal capacity to make *all* decisions) rather than on the status model (where a finding that a person lacks capacity resulted in a total loss of legal capacity) that was used in the earlier capacity regime.[22] Section 3 of the 2005 Act, which defines an inability to make a decision, reinforces the functional approach to capacity in the Act:

> 3.— (1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable-
>
> (a) to understand the information relevant to the decision,
>
> (b) to retain that information,
>
> (c) to use or weigh that information as part of the process of making the decision, or
>
> (d) to communicate his decision (whether by talking, using sign language or any other means).[23]

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[18] Ashton, Gordon, "Will the New Court of Protection Damage Your Mental Health?" (2007) May *Journal of Mental Health Law* 19, 20.

[19] *Mental Capacity Act 2005: Explanatory Notes* (London: The Stationery Office Limited, 2005), 4.

[20] Mental Capacity Act 2005 (England), s2 (2).

[21] Mental Capacity Act 2005 (England), s 2 (1).

[22] *Mental Capacity Act 2005: Explanatory Notes* (London: The Stationery Office Limited, 2005), 4. For an account of these different models of capacity in an Irish context, *see* Law Reform Commission, *Report: Vulnerable Adults and the Law* (LRC 83 – 2006) (Dublin: Law Reform Commission, 2006), 25-28 and 44-47. *See* also Ashton, Gordon, "Will the New Court of Protection Damage Your Mental Health?" (2007) May *Journal of Mental Health Law* 19, 20.

[23] Mental Capacity Act 2005 (England), s 3(1).

The limbs of the test in section 3(1) are strongly resonant of the capacity test laid down in *Re C (Adult: Refusal of Treatment)*[24] in which the House of Lords held that a court in evaluating a mental patient's capacity (in this instance, to refuse surgery to treat a gangrenous infection) must have regard to the patient's ability to understand and retain the information given to him about the 'nature, purpose, and effects' of the proposed treatment.[25] The steps in the section 3(1)-(3) test for decision-making ability are cumulative – if a person cannot meet all three limbs of the test, then they do not have capacity to make the decision under scrutiny.[26]

The 2005 Act requires that anyone who makes decisions on behalf of another person who lacks capacity must act in that other person's best interests.[27] No definition of 'best interests' is given, this being a matter to be determined by reference to the 'relevant circumstances' (which are defined as those circumstances of which the decision-maker is aware, and which could reasonably be considered to be relevant[28]), although the Explanatory Notes to the Act point out that the best interests principle requires an objective evaluation of what is in the person's best interests, and that it does not amount to a substituted judgement ('what would they have wanted?') test.[29] The decision-maker is required however to have regard to statements the person may have made in the past in relation to their wishes, and to their religious beliefs, cultural values and lifestyle choices.[30] Section 4(4) requires that the person on whose behalf the decision is to be made should be involved in the decision-making process notwithstanding their lack of capacity to make the decision.[31]

Sections 9-14 of the 2005 Act introduce a scheme by which people may create a 'lasting power of attorney'. The previous regime of 'enduring powers of attorney' is

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[24] *In Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819.
[25] *In Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819, 824 (Thorpe J).
[26] *Mental Capacity Act 2005: Explanatory Notes* (London: The Stationery Office Limited, 2005), 5.
[27] Mental Capacity Act 2005 (England), s 4.
[28] Mental Capacity Act 2005 (England), s 4(11).
[29] *See Mental Capacity Act 2005: Explanatory Notes* (London: The Stationery Office Limited, 2005), 6.
[30] Mental Capacity Act 2005 (England), s 4(6). The Explanatory Notes on s 4(6) state that where there are written statements that are "well-thought out and considered", these should "carry particular weight for the purposes of best interests determinations." *See Mental Capacity Act 2005: Explanatory Notes* (London: The Stationery Office Limited, 2005), 7.
[31] Mental Capacity Act 2005 (England), s 4(4).

replaced by these new provisions.[32] A lasting power of attorney operates to confer on another person (the 'donee') the ability to make decisions pertaining to one's personal welfare, property, and other legal affairs when the donor no longer has capacity to make those decisions himself.[33] A donee must perform their decision-making duties in accordance with the principles established in section 1 (the functional model of capacity) and in the donor's best interests as is required by section 4.[34]

Of particular interest to this work are the provisions in sections 24-26 of the 2005 Act in respect of advance decisions to refuse medical treatment. Section 24 defines the circumstances in which an advance decision may be made:

> 24.— (1) "Advance decision" means a decision made by a person ("P"), after he has reached 18 and when he has capacity to do so, that if-
>
> (a) at a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and
>
> (b) at that time he lacks capacity to consent to the carrying out or continuation of the treatment,
>
> the specified treatment is not to be carried out or continued.[35]

Section 26 sets out the effect of valid advance decisions, providing that they have the same effect in law as a contemporaneous refusal of treatment made by a person with capacity to make that decision.[36] A clinician who carries out or continues a treatment will not incur criminal or civil liability for their actions unless they carry out or continue treatment despite being satisfied of the existence of a valid advance decision refusing that treatment.[37] By the same token, no liability can arise where treatment is withheld or withdrawn on foot of the contents of an advance directive that is reasonably believed to be both valid and applicable to the treatment in question.[38] Where there is doubt over the existence, validity, or applicability of an advance

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[32] Enduring powers of attorney created under the Enduring Powers of Attorney Act 1985 (England) prior to the enactment of the Mental Capacity Act 2005 (England) are preserved by s 66(1)(b) and are administered under the scheme established by the 2005 Act.
[33] Mental Capacity Act 2005 (England), s 9(1)(a).
[34] Mental Capacity Act 2005 (England), s 9(4).
[35] Mental Capacity Act 2005 (England), s 24(1). The formalities for completing a valid advance decision, and the circumstances within which amendments made by made to an advance decision, are set down in s 25.
[36] Mental Capacity Act 2005 (England), s 26(1).
[37] Mental Capacity Act 2005 (England), s 26(2).
[38] Mental Capacity Act 2005 (England), s 26(3).

decision in respect of a particular treatment, guidance may be sought from the Court of Protection[39] and while the decision of the Court of Protection is pending treatment may be administered to prevent a serious deterioration in the patient's condition or to sustain their life.[40]

Section 28 of the 2005 Act deals specifically with mental health treatments:

> 28.— (1) Nothing in this Act authorises anyone-
>
> (a) to give a patient medical treatment for mental disorder, or
>
> (b) to consent to a patient's being given medical treatment for mental disorder,
>
> if, at the time when it is proposed to treat the patient, his treatment is regulated by Part 4 of the Mental Health Act.
>
> (1A) Subsection (1) does not apply in relation to any form of treatment to which section 58A of that Act (electro-convulsive therapy, etc.) applies if the patient comes within subsection (7) of that section (informal patient under 18 who cannot give consent).
>
> (1B) Section 5 does not apply to an act to which section 64B of the Mental Health Act applies (treatment of community patients not recalled to hospital).
>
> (2) "Medical treatment", "mental disorder" and "patient" have the same meaning as in that Act.

Section 28 in effect excludes all mental health treatments provided under the compulsory treatment regime in Part 4 of the 1983 Act from the scope of the provisions of the 2005 Act.[41] As a result, advance decisions and lasting powers of attorney are of no effect in respect of compulsory mental health treatment.

Part 2 of the 2005 Act establishes a Court of Protection[42] and an office of The Public Guardian[43] to deal with issues arising under the Act. Among its functions the Court of Protection makes declarations of capacity or incapacity in respect of individual

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[39] Mental Capacity Act 2005 (England), s 26(4).
[40] Mental Capacity Act 2005 (England), s 26(5).
[41] *Mental Capacity Act 2005: Explanatory Notes* (London: The Stationery Office Limited, 2005), 16.
[42] Mental Capacity Act 2005 (England), ss 45 to 56.
[43] Mental Capacity Act 2005 (England), ss 57 to 60.

decisions;[44] makes declarations as to the lawfulness of a proposed act done or proposed to be done to an individual;[45] appoints deputies to make decisions in relation to capacity;[46] and resolves issues around advance care directives including powers of attorney and including making decisions on the validity of advance decisions.[47] The Office of the Public Guardian among its functions maintains registers of lasting powers of attorney and registers of court appointed deputies (people appointed to make specified types of decisions on behalf of others who are found to lack the capacity to make the decisions in question[48]) and may direct Court of Protection visitors to visit people detained under the 2005 Act.[49] These new systems are intended to be more accessible and to safeguard the human rights of people who lack capacity to make their own decisions.[50]

The Mental Health Act 2007 (the 2007 Act) made significant amendments to the 1983 Act, and these amendments are traced at 4.1.2 below. The primary purpose of the 2007 Act however was to introduce protections into the 2005 Act for compliant incapacitated patients who come into contact with the mental health law regime. These are set out in section 50 of the 2007 Act, which inserts new sub-sections into section 4 and 16 of the 2005 Act, and in the new Schedule A1 to the 2005 Act. The 2007 Act also introduced the Deprivation of Liberty Safeguards in England and Wales, and these are of significant interest to this thesis as comparable measures are contemplated in Ireland in the course of reform of Irish law on capacity.

The 2007 Act was introduced in the wake of the European Court of Human Rights (ECtHR) decision in *HL v United Kingdom.*[51] That case challenged a decision of the House of Lords in which that court had held that a 'compliant incapacitated patient' could be admitted to hospital and treated as an 'informal patient' under English mental health law. The Law Lords were divided in their findings as to whether or not the applicant patient had been 'detained' (which would have made him incapable of

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[44] Mental Capacity Act 2005 (England), s 47(1).
[45] Mental Capacity Act 2005 (England), s 15(1)(c).
[46] Mental Capacity Act 2005 (England), s 16(2)(b).
[47] Mental Capacity Act 2005 (England), ss 22, 23, and 26(4).
[48] Mental Capacity Act 2005 (England), s 16.
[49] Mental Capacity Act 2005 (England), s 58(1).
[50] Ashton, Gordon, "Will the New Court of Protection Damage Your Mental Health?" (2007) May *Journal of Mental Health Law* 19, 21.
[51] *H.L.* v *The United Kingdom* Application No. 44508/99, judgment delivered 5 October 2004.

being considered an informal patient), but they were unanimous in their finding that any detention that may have occurred (even if that detention occurred outside of the boundaries of the 1983 Act's provisions on involuntary admission and detention) was justifiable on the basis of the common law doctrine of necessity.[52]

The serious problem this judgment exposed in English mental health law in terms of the dual standard in the protections afforded to formally detained patients and compliant incapacitated patients – two groups that are factually in very similar situations but are legally in very different positions – has already been chronicled at §1.4.2 of this work. Commonly referred to as 'the Bournewood gap', the ECtHR held that this lacuna violated compliant incapacitated patients' rights under Articles 5(1)(e) and Article 5 (4) of the Convention and that the common law doctrine of necessity did not close the gap as the House of Lords had held it did, as it did not meet the Article 5 requirements as set down in *Winterwerp*.[53]

Between them the Mental Capacity Act 2005 and the Mental Health Act 2007 operate to introduce the Mental Capacity Act Deprivation of Liberty Safeguards (hereafter 'the Deprivation of Liberty Safeguards')[54] and close the 'Bournewood gap'. As was noted at §1.4.2 of this work, the Bournewood gap remains present in Irish law, and as such the Deprivation of Liberty Safeguards are of particular interest in the context of this work's audit of Irish mental health law's compliance with international human rights standards. The Deprivation of Liberty Safeguards require that whenever a compliant incapacitated person is proposed to be admitted to a hospital or care home other than as a detained mental patient under section 2 or section 3 of the 1983 Act, that an authorisation for the detention must be obtained from a supervisory body (the

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[52] *R* v *Bournewood Community and Mental Health NHS Trust ex parte L (Secretary of State for Health and others intervening)* [1998] 3 All ER 289. For an account of the different approaches taken in the judgments given in the House of Lords in *R v Bournewood*, see Morris, Fenella, "Mental Health Law After Bournewood: Some Legal and Practical Implications" (1999) February *Journal of Mental Health Law* 41.

[53] *H.L.* v *The United Kingdom* Application No. 44508/99, judgment delivered 5 October 2004.

[54] For general information on the Mental Capacity Act Deprivation of Liberty Safeguards *see* United Kingdom Department of Health, *What are the Mental Capacity Act 2005 Deprivation of Liberty Safeguards?* (London: Department of Health, 2008) <http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091867.pdf> accessed 5 January 2010 and Medical Protection Society, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards (MCA DOLS)*, (Medical Protection Society, March 2010) <http://www.medicalprotection.org/adx/aspx/adxGetMedia.aspx?DocID=27062,11288,127,9698,22,11,Documents&MediaID=8335&Filename=MPS0834+MCA+DOLS+2010_web.pdf&l=English> accessed 9 September 2010.

local health care trust or the local authority) which must appoint assessors to evaluate the necessity for the authorisation.[55] Patients subject to these authorisations have a capacity advocate appointed to safeguard their interests,[56] and may challenge the authorisation, which cannot remain in place without review for a period exceeding twelve months.[57]

Section 50 of the 2007 Act has the effect of giving statutory effect to the ECtHR decision in *HL v United Kingdom*.[58] Section 4A of the 1983 Act provides that it is never lawful to compulsorily detain a person in a hospital or a care home under the 1983 Act unless the detention is necessary to give effect to an order of the Court of Protection (which is a decision made under section 16(2)(a) of the 2005 Act[59]);[60] or is authorised by Schedule A1 of the Act.[61] All detentions effected under section 4A must comply with the conditions laid down in section 4B.[62] Section 4B permits a person to be compulsorily detained in a hospital or care home while a decision from the Court of Protection is sought in respect of an issue pertaining to that person is awaited[63] provided that a question arises about the authority to detain the person,[64] and the detention is effected in order (wholly or partly) to give life-sustaining treatment or do a vital act (which is defined as any act reasonably believed to be necessary to prevent a deterioration in the person's condition[65])[66], and the detention consists of the giving of that treatment or the doing of that vital act;[67] which treatment or act could not be given or done without the deprivation of liberty.[68]

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[55] Mental Capacity Act 2005 (England), ss 4A, 4B and 16A, as inserted by Mental Health Act 2007 (England), s 50.
[56] Mental Capacity Act 2005 (England), s 40, as amended by Mental Health Act 2007 (England), s 49.
[57] Mental Capacity Act 2005 (England), s 53.
[58] *HL v United Kingdom* (2004) Application No. 45508/99, (2004) ECHR 471.
[59] Mental Capacity Act 2005 (England), s 4A(4), as inserted by Mental Health Act 2007, s 50.
[60] Mental Capacity Act 2005 (England), s 4A(3), as inserted by Mental Health Act 2007, s 50.
[61] Mental Capacity Act 2005 (England), s 4A(5), as inserted by Mental Health Act 2007, s 50.
[62] Mental Capacity Act 2005, s 4A(2)(b), as inserted by Mental Health Act 2007, s 50.
[63] Mental Capacity Act 2005 (England), s 4B(1), as inserted by Mental Health Act 2007, s 50.
[64] Mental Capacity Act 2005, s 4B(2), as inserted by Mental Health Act 2007, s 50.
[65] Mental Capacity Act 2005 (England), s 4B(5), as inserted by Mental Health Act 2007 (England), s 50.
[66] Mental Capacity Act 2005 (England), s 4B(3)(a), as inserted by Mental Health Act 2007 (England), s 50.
[67] Mental Capacity Act 2005 (England), s 4B(3)(b), as inserted by Mental Health Act 2007 (England), s 50.
[68] Mental Capacity Act 2005 (England), s 4B(4), as inserted by Mental Health Act 2007 (England), s 50.

Schedule A1 of the 2005 Act[69] outlines the qualifying circumstances and legal procedural requirements necessary in order to obtain a Court of Protection authorisation to effect a detention in accordance with section 4A. Only when all of these requirements are satisfied may an incapacitated person be deprived of their liberty under the 2005 Act. The authorisation, once granted, operates to legitimise the detention of the incapacitated person. It does not authorise treatment without their consent, this being governed by the consent safeguards in the 2005 Act and the provisions of the mental health law regime.[70]

In order to obtain an authorisation under Schedule A1 a double test must be satisfied. First, the person it is proposed to detain must (a) be 18 years of age or older; (b) be suffering from a mental disorder within the definition set down in the 1983 Act as amended; and (c) lack the capacity to decide whether or not they should be a resident in the hospital or care home seeking the authorisation. Secondly, the proposed detention must be (a) in the best interests of the person; (b) necessary in order to prevent harm to that person; and (c) a proportionate response to both the likelihood of their suffering harm, and the seriousness of the harm in question.[71]

A Schedule A1 authorisation may not be sought in respect of persons already detained under the 1983 Act; and additionally may not be sought in respect of a person on leave of absence from detention; or a person subject to guardianship, a supervisory community treatment order, or conditional discharge if the deprivation of liberty sought in the authorisation would result in a violation of their conditions of their leave of absence, or guardianship, supervisory community treatment order, or conditional discharge.[72] An authorisation additionally may not be utilised in order to effect a

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[69] Mental Capacity Act 2005 (England), sch A1, as inserted by Mental Health Act 2007 (England), s 50(5).

[70] *Mental Health Act 2007: Explanatory Notes* (London: The Stationery Office Limited, 2007), 35.

[71] Mental Capacity Act 2005 (England), sch A1, pt 3, as inserted by Mental Health Act 2007 (England), s 50(5).

[72] In the Explanatory Notes to the 2007 Act the example is given of a person on a leave of absence from a 1983 Act detention who is subject to a requirement to reside in a particular place – an authorisation under sch A1 might result in their detention in another place and thereby violate the terms of their leave of absence and in such circumstances pt 3 of sch A1 would not permit the authorisation to be granted. *See Mental Health Act 2007: Explanatory Notes* (London: The Stationery Office Limited, 2007), 35.

detention for the purpose of providing treatment for mental disorder, the 1983 Act being the appropriate mechanism for detentions of this nature.[73]

Mental Health Alliance, in its review of the operation of the Deprivation of Liberty Safeguards has reported that use of the authorisation procedure has been significantly less than expected and that there have been wide variations in the implementation of the Safeguards.[74] It reports two consistent reasons for the lower than expected uptake of the authorisation procedure: first, a widespread misunderstanding that where acts are necessary in a person's best interests then they cannot amount to an unlawful deprivation of liberty and thus no need to seek an authorisation arises; and second, a lack of understanding of what circumstances actually amount to a 'deprivation of liberty' at law.[75] The 2007 reforms, however, have been controversial in England, with many commentators viewing them as a reactionary measure that has reasserted the primacy of a paternalist model of mental health law[76] or expressing concerns about the legitimacy of introducing a new form of detention under the 2005 Act that does not benefit from the full panoply of protections afforded to involuntary patients under the mental health law regime.[77]

Irish law on capacity has not kept pace with developments in England. A detailed and considered report from the Law Reform Commission in 2005 reviewed the current provisions in Ireland in respect to capacity and found that the introduction of a guardianship and advance care decisions regime to replace the wardship procedures was urgently required.[78] As is noted at §5.2.1 of this work, the failure in Ireland to

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[73] Mental Capacity Act 2005 (England), sch A1, pt 3, as inserted by Mental Health Act 2007 (England), s 50(5).

[74] Hargreaves, Roger, *Briefing Paper 1: Deprivation of Liberty Safeguards: an initial review of implementation* (London: Mental Health Alliance, 2010) 6 <http://www.mentalhealthalliance.org.uk/resources/DoLS_report_July2010.pdf> accessed 5 January 2011.

[75] Hargreaves, Roger, *Briefing Paper 1: Deprivation of Liberty Safeguards: an initial review of implementation* (London: Mental Health Alliance, 2010) 6 <http://www.mentalhealthalliance.org.uk/resources/DoLS_report_July2010.pdf> accessed 5 January 2011.

[76] *See* Daw, Rowena, "The Mental Health Act 2007: The Defeat of an Ideal" (2007) November *Journal of Mental Health Law* 131; and Gunn, Michael and Holland, Tony, "Some thoughts on the proposed Mental Health Act" (2002) December *Journal of Mental Health Law* 360.

[77] *See* Robinson, Robert, "Amending the Mental Capacity Act 2005 to provide for deprivation of liberty" (2007) May *Journal of Mental Health Law* 25; and Jones, Richard "Deprivations of Liberty: Mental Health Act or Mental Capacity Act?" (2007) November *Journal of Mental Health Law* 170.

[78] Law Reform Commission of Ireland, *Consultation Paper on Vulnerable Adults and the Law: Capacity* (Dublin: Law Reform Commission, 2005)

introduce a modern guardianship mechanism grounded on the functional model of capacity results in the utilisation of the extremely rights-invasive mental health law regime in situations where it is not necessarily the most appropriate avenue, and a guardianship regime could achieve the necessary protection of the incapacitated person without trammelling their rights beyond the minimum degree necessary for their protection. While there are many areas of convergence between the English and Irish mental health law regimes, the introduction of the Mental Capacity Act 2005 and the Mental Capacity Act Deprivation of Liberty Safeguards opens a chasm between the two jurisdictions in terms of human rights protections in the area of mental health. A Mental Capacity and Guardianship Bill was placed before the Dáil in February 2008 but has progressed no further since that date. While the Irish mental health regime continues to languish in contravention of the *HL v United Kingdom* decision from the European Court of Human Rights, England has introduced a modern regime providing for a system of guardianship and a framework for the recognition of advance care decisions. The Deprivation of Liberty Safeguards may have a less than expected degree of uptake than was initially expected, and remain subject to only cautious approval to date, but the replacement of the invasive and outdated wardship jurisdiction with a modern guardianship mechanism cannot but be viewed as a significant development in cultivating a human rights oriented approach in the area of capacity and mental health generally.

4.1.2 Legal Regulation of Mental Health Care in England

The Mental Health Act 1983 (hereafter 'the 1983 Act') is the core legislation governing compulsory detention and treatment for mental illness in England. In 2007 the 1983 Act was extensively updated and amended by the Mental Health Act 2007 (hereafter 'the 2007 Act'), which made a number of substantial changes to the mental health law regime as established under the 1983 Act.

As has already been noted, the impetus for the 2007 Act's changes was the successful European Court of Human Rights (ECtHR) challenge in the case of *HL v United*

<http://www.lawreform.ie/_fileupload/Reports/Report%20Vulnerable%20Adults.pdf> accessed 23 January 2011.

Kingdom[79] to the manner in which the 1983 Act's provisions dealt with the rights of incapacitated patients. The Strasbourg Court's judgment in that case led to the amendment of the 1983 Act regime's provisions in respect of, *inter alia*, the definition of a mental disorder; the test to be applied in considering the 'treatability' of a mental disorder; and the safeguards to be applied around the administration of particular treatments.[80] *HL v United Kingdom* is of significant importance in the context of Irish law on mental health as the mental health law regime in Ireland under the Mental Health Act 2001 bears many similarities to the regime as it existed in England under the 1983 Act. The issues raised by *HL v United Kingdom* have important consequences for mental health rights in the Irish context and these are addressed specifically at §§ 1.4.2 and 5.2.1 of this work.

Some of the most significant changes wrought by the 2007 Act to the regime as it existed under the 1983 Act include the following:

1. The introduction of a single definition of 'mental disorder' applicable throughout the entire Act, and the abolition of different categories of 'mental disorder';[81]
2. The introduction of a new 'appropriate medical treatment' test in the criteria for compulsory detention, replacing the previous 'treatability' test;[82]
3. The introduction of 'supervised community treatment orders' to provide for patients to live in the community while still subject to certain conditions under the 1983 Act;[83]
4. An extension of the categories of patients whose detentions are eligible for review by a Mental Health Review Tribunal, and amendments to the time periods within which patients' cases can be referred for review;[84] and

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[79] *H.L.* v *The United Kingdom* Application No. 44508/99, judgment delivered 5 October 2004.
[80] Note this is not an exhaustive list of the amendments made by the Mental Health Act 2007 (England), and the amendments highlighted for attention here are those considered of most interest to this work. For a more comprehensive account of the amendments made by the 2007 Act, *see Mental Health Act 2007: Explanatory Notes* (London: The Stationery Office Limited, 2007).
[81] Mental Health Act 1983 (England), s 1 as amended by Mental Health Act 2007 (England), s 1.
[82] Mental Health Act 1983 (England), s 3, as amended by Mental Health Act 2007 (England), s 4.
[83] Mental Health Act 1983 (England), ss 17A to 17G, as inserted by Mental Health Act 2007 (England), s 32.
[84] Mental Health Act 1983 (England), s 68, as amended by Mental Health Act 2007 (England), s 34.

5. The introduction of new safeguards around the use of electro-convulsive therapy.[85]

The 2007 Act's amendments were made after a lengthy process of review of the existing regime and the completion of a detailed and comprehensive report by a Committee (known as the Richardson Committee after its Chair, Professor Genevra Richardson) appointed specifically for that purpose.[86] However, many of the recommendations made by the Richardson Committee were diluted in the final draft of the Act as it was presented to parliament, and much of the academic commentary on the 2007 Act focuses on the loss of many of the forward looking human rights protections contained in the initial recommendations.[87] In this regard, while the introduction of mechanisms to formalise the position of compliant incapacitated patients is welcome, the 2007 reforms in England could not be said to represent an ideal model in the context of the broader question of the best way to achieve the incorporation of human rights standards into a mental health regime.

4.1.2 (a) Admission to a Mental Hospital

Section 3 of the 1983 Act provides for the compulsory detention and treatment of people who fall within the definition of a person suffering from a 'mental disorder':

> 3.— (1) A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as "an application for admission for treatment") made in accordance with this section.
>
> (2) An application for admission for treatment may be made in respect of a patient on the grounds that—

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[85] Mental Health Act 1983 (England), s 58A, as inserted by Mental Health Act 2007 (England), s 27.

[86] Department of Health (United Kingdom) *Report of the Expert Committee: Review of the Mental Health Act 1983*, (London: Department of Health, 1999) <http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4062614.pdf> accessed 23 January 2011.

[87] *See* for example the criticisms in Peay, Jill, "Reform of the Mental Health Act 1983: Squandering an Opportunity?" (2000) February *Journal of Mental Health Law* 5; Fennell, Philip, "Reforming the Mental Health Act 1983: Joined Up Compulsion" (2001) June *Journal of Mental Health Law* 5; Fennell, Philip, "The Mental Capacity Act 2005, the Mental Health Act 1983, and the Common Law" (2005) November *Journal of Mental Health Law* 163 and Daw, Rowena, "The Mental Health Act 2007: The Defeat of an Ideal" (2007) November *Journal of Mental Health Law* 131.

(a) he is suffering from [mental disorder] of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
[...]
(c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section[; and
(d) appropriate medical treatment is available for him.]

The definition of a 'mental disorder' is therefore the gateway to compulsory admission and treatment, and is of crucial importance. That definition is provided in section 1 of the 1983 Act. Its current text, following a number of amendments made by the 2007 Act, is as follows:

1.— (1) The provisions of this Act shall have effect with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters.

(2) In this Act—
"mental disorder" means any disorder or disability of the mind; and
"mentally disordered" shall be construed accordingly;
and other expressions shall have the meanings assigned to them in section 145 below.

(2A) But a person with learning disability shall not be considered by reason of that disability to be-

...

(b) requiring treatment in hospital for mental disorder for the purposes of sections 17E and 50 to 53 below,
unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part.

...

(3) Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of subsection (2) above.

(4) In subsection (2A) above, "learning disability" means a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning.[88]

As noted above, three significant amendments to section 1 were made by the 2007 Act. First, the section 1 definition of a mental disorder was originally split into four separate classifications – mental illness, psychopathic disorder, mental impairment

[88] Mental Health Act 1983 (England), s 1 as amended by Mental Health Act 2007 (England), s 1.

and severe mental impairment[89] – but is now a simplified unitary definition. Secondly, the requirement that where it is proposed to detain a person with a learning disability it must be demonstrated that that person be engaged in 'abnormally aggressive or seriously irresponsible conduct' originally also applied to people with personality disorders.[90] Since the 2007 Act amendments, a person with a personality disorder can be detained without any evidence of their engaging in abnormally aggressive or seriously irresponsible conduct. Thirdly, the provision in section 1(3) providing for the exclusion of dependence on alcohol or drugs from the definition of a mental disorder originally also excluded "promiscuity or other immoral conduct", and sexual deviancy.[91] This amendment makes the detention of sex offenders more straightforward that it would have been under the originally enacted text of section 1.

The provisions in the 1983 Act as amended pertaining to the definition of a mental disorder, and setting out the grounds for admission, at first blush do not appear to vary to any significant extent from the provisions in the Mental Health Act 2001 in Ireland. Both regimes require a medical diagnosis of a mental disorder coupled with associated behaviour that results in a risk to the person's own health or safety or to the health or safety of others.[92] The single most vital point of divergence is the 2007 Act amendment to simplify the definition by the removal of exclusions for social deviance and in this regard, the 2007 Act has been heavily criticised:

> The role of exclusions is to make clear what kind of behaviour, beliefs or life style should not be brought within compulsory powers, even if they fall within the definition of mental disorder. Human rights law requires the definition of

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[89] Mental Health Act 1983 (England), s 1(2) as amended by Mental Health Act 2007 (England), s 1(1)(2). For a useful annotated statute tracing these changes, *see* Care Quality Commission, *Mental Health Act 1983 Reproduced by Permission of Reed Elsevier (UK) Limited trading as LexisNexis* <http://www.cqc.org.uk/_db/_documents/Mental_Health_Act_1983_201005272747.pdf> accessed 2 January, 2011.

[90] Mental Health Act 1983 (England), s 1(2A) as inserted by Mental Health Act 2007 (England), s 2(1)(2). Mental Health Act 1983 (England), s 1(2) was repealed by the Mental Health Act 2007 (England), ss 1(1)(3)(c), 55, sch 11, Pt 1. For a useful annotated statute tracing these changes, *see* Care Quality Commission, *Mental Health Act 1983 Reproduced by Permission of Reed Elsevier (UK) Limited trading as LexisNexis* <http://www.cqc.org.uk/_db/_documents/Mental_Health_Act_1983_201005272747.pdf> accessed 2 January, 2011.

[91] Mental Health Act 1983 (England), s 1(3) as substituted by Mental Health Act 2007 (England), s 1(3). For a useful annotated statute tracing these changes, *see* Care Quality Commission, *Mental Health Act 1983 Reproduced by Permission of Reed Elsevier (UK) Limited trading as LexisNexis* <http://www.cqc.org.uk/_db/_documents/Mental_Health_Act_1983_201005272747.pdf> accessed 2 January, 2011.

[92] *See* discussion of Mental Health Act 2001, ss 3 and 8, at paras 5.2. and 5.3 below.

> mental disorder to be very clear in order for exercise of detention powers to be lawful. The use of exclusions is a standard feature of most common law jurisdictions in meeting that requirement by providing legal certainty; guaranteeing individual autonomy; and ensuring that the powers of detention are used no more than strictly necessary.[93]

The removal of the exclusions to the definition of a mental disorder broadens the net of people who may come within its parameters, and coupled with the changes to the 'treatability' requirement to permit 'containment' as a therapeutic measure in certain instances[94] this could be argued to amount to a reintroduction of an element of social hygiene into English mental health law and has been described by Fennell as "a reversal of the 20th Century trend in mental health legislation towards developing legal sub-categories of mental disorder, and attaching different admission criteria to each."[95] It is unlikely, however, that these changes bring English mental health law into conflict with the European Convention on Human rights, which has taken a very generous stance in the margin of appreciation it affords to the 'objective medical expertise' requirement laid down in the *Winterwerp v Netherlands* decision.[96]

A second slight divergence arises between the Irish and English mental health law regimes in respect of the requirement that treatment be available to an involuntarily detained patient at the institution in which they are detained for the mental disorder from which they suffer. Prior to the 2007 Act, the 1983 Act contained a 'treatability test' requirement that required that where a patient is admitted to a mental hospital for treatment, the treatment available at that hospital must be "likely to alleviate or prevent a deterioration of his condition."[97] The 2007 Act abolished the treatability test and replaced it with a requirement that patients admitted for treatment must have "appropriate medical treatment" available to them.[98] The 2007 Act also amended the definition of medical treatment from being treatment which is 'likely to be effective'

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[93] Daw, Rowena, "The Mental Health Act 2007: The Defeat of an Ideal" (2007) November *Journal of Mental Health Law* 131, 135.
[94] *See* Daw, Rowena, "The Mental Health Act 2007: The Defeat of an Ideal" (2007) November *Journal of Mental Health Law* 131, 140-141 and fn 60.
[95] Fennell, Philip, "Reforming the Mental Health Act 1983: Joined Up Compulsion" (2001) June *Journal of Mental Health Law* 5, 7.
[96] *Winterwerp v Netherlands* (1979) Application No. 6301/73, [1979] 2 EHRR 387, § 37. *See* the analysis of this issue in Pedler, Margaret, "Mental Health and Compulsion" (2000) February *Journal of Mental Health Law* 16.
[97] Mental Health Act 1983 (England), s 3, as enacted.
[98] Mental Health Act 1983 (England), s 3, as amended by Mental Health Act 2007 (England), s 4.

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."[99] This amendment was extremely controversial, with numerous commentators criticising it as weakening the criteria for compulsory admission to a mental hospital.[100]

In Ireland, the MHA 2001 sets a different threshold of treatment being available which is 'likely to benefit or alleviate the condition of the patient to a material extent.'[101] There is neither an 'appropriateness' nor an 'effectiveness' requirement in the Irish test.[102] However, the retention of the 'likely to benefit or alleviate' aspect of the treatment, which is a more stringent standard that that the treatment is 'intended to alleviate or prevent a worsening of the condition' places a higher threshold on the treatability aspect of the Irish definition of a mental disorder and accordingly on the grounds for admission. It should be noted that this commentary applies only to admissions effected under s 3(1)(b) of the MHA 2001. Admissions effected under s 3 (1)(b) are based on the likelihood of serious harm to self or others, and do not contain a treatability component.

4.1.2 (b) Review of Detention in a Mental Hospital

The 1983 Act introduced a comprehensive system for the review of decisions to compulsorily admit to hospital, detain, and treat people with mental disorders. These reviews are done by special courts convened at the hospital in which the patient is detained, and they were originally known as 'Mental Health Review Tribunals'. The 2007 Act introduced some changes to the system of review, including a change in the name of the review body to the 'Health and Social Care Chamber of the First-tier Tribunal'.[103] They remain frequently referred to as 'Mental Health Tribunals'.

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[99] Mental Health Act 1983 (England), s 3, as amended by Mental Health Act 2007 (England), s 4.
[100] Peay, Jill, "Reform of the Mental Health Act 1983: Squandering an Opportunity?" (2000) February *Journal of Mental Health Law* 5, 11; Hale, Brenda, "The Human Rights Act and Mental Health Law: Has it Helped?" (2007) May *Journal of Mental Health Law* 7, 12; and Fennell, Philip, "Reforming the Mental Health Act 1983: Joined Up Compulsion" (2001) June *Journal of Mental Health Law* 5, 11-12.
[101] Mental Health Act 2001, s 3(b)(ii).
[102] *See* discussion of Mental Health Act 2001, s 3, at § 5.2.3 (b) below.
[103] The Tribunals, Courts and Enforcement Act 2007 (England). *See* also the First-tier Tribunal and Upper Tribunal (Chambers) Order 2008 (England).

The Mental Health Review Tribunal (hereafter 'MHRT') panels are made up of a medical practitioner, a lawyer (in cases involving 'restricted patients', that is, patients who have been ordered to be detained for mental health treatment by the criminal justice system, this is usually a judge), and a lay person.[104]

Section 68 of the 1983 Act governs the referral of patients' cases to the MHRT. Hospital managers are required to automatically refer all cases of patients admitted under sections 2 or 3 of the Act, as well as patients transferred out of the guardianship regime and patients subject to community care orders, to the Mental Health Tribunal within specified time periods and at specified intervals.[105] Prior to the amendments introduced by the 2007 Act, patients subject to a section 2 admission, and patients on a community treatment orders, did not benefit from this automatic referral. The patient may also apply for a review, as may their nearest relative or the Secretary of State.[106] Under the amended 1983 Act, hospital managers are required to refer patients' cases to the MHRT within six months of their admission for assessment (section 2), or their detention for treatment (section 3), or their transfer from guardianship.[107] This requirement is satisfied if the patient or another appropriate person has made an application to the MHRT on their behalf within that six month time period.

Under the MHA 2001 in Ireland all involuntary admissions and detentions are notified to the Mental Health Commission, which then forwards the cases for review by a Mental Health Tribunal within 21 days of admission. The Tribunal may either discharge the patient or authorise the continued detention for an initial period of 72 days, and on a second review for a period of six months.[108] As Ireland does not have a guardianship or community treatment order regime, there is no mechanism for reviewing the situations of patients who would otherwise fall into these categories but

[104] Mental Health Act 1983 (England), s 65, as amended by Mental Health Act 2007 (England), s 38; Tribunals, Courts and Enforcement Act 2007 (England); First-tier Tribunal and Upper Tribunal (Chambers) Order 2008 (England).
[105] Mental Health Act 1983 (England), s 68, as amended by Mental Health Act 2007 (England), s 37.
[106] Mental Health Act 1983 (England), s 69, as amended by Mental Health Act 2007 (England), s 32.
[107] Mental Health Act 1983 (England), s 68, as amended by Mental Health Act 2007 (England), s 37.
[108] Mental Health Act 2001, s 17(1).

who frequently remain in mental hospitals as compliant incapacitated voluntary patients.[109]

The review mechanisms in England have received criticism for their failure to provide the Tribunals with a power to amend the conditions attached to community treatment orders.[110] Richardson and Machin, writing prior to the 2007 Act amendments, criticised the judicial review precedents on the validity of the decisions made by the Tribunals as favouring issues of welfare (interpreted paternalistically) over issues of patient autonomy.[111] This criticism was reiterated by Mullins, who, writing in 2000 in respect of the proposed changes which were ultimately adopted in the 2007 Act, stated that the arguments in favour of a foundation for a new (human rights based) mental health law were "ignored in favour or reliance on measure of 'risk' and 'safety'".[112] Overall, however, the Tribunal system in the English mental health law can be said to operate on a similar platform to that provided for in the 2001 Act, and it does provide an effective and overall human rights compliant means of review of detention for those patients who come within its remit.[113]

4.1.2 (c) Regulation of the Administration of Mental Health Treatments

S 57 of the 1983 Act as amended by s 34 (1)(2) of the 2007 Act provides for the regulation of the administration of mental health treatments. S 57 applies to (a) psychosurgery and (b) any other treatments designed by Regulation by the Secretary

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[109] *See* discussion at § 5.3 below and the comments of this author in Quirke, E, "Older People in Irish Mental Health Law" in O'Dell, E., ed., *Older People in Modern Ireland: Essays on Law and Policy* (Dublin: FirstLaw, 2006), 268. *See* also Keys, Mary, "Capacity – Whose Decision is it Anyway?" *Law and Mental Health Conference, Law Faculty, National University of Ireland Galway* 17th November 2007 <http://www.nuigalway.ie/law/documents/mental_health/Keys%20Talk.doc> accessed 10 January 2011.

[110] Daw, Rowena, "The Mental Health Act 2007: The Defeat of an Ideal" (2007) November *Journal of Mental Health Law* 131, 144.

[111] Richardson, Genevra and Machin, David, "A Clash of Values? Mental Health Review Tribunals and Judicial Review" (1999) February *Journal of Mental Health* Law 3, 11. Note the authors were writing prior to the commencement of the Human Rights Act 1998.

[112] Mullins, Mark, "The New Mental Disorder Tribunal" (2000) February *Journal of Mental Health Law* 29, 38.

[113] Hale, Brenda, "The Human Rights Act and Mental Health Law: Has it Helped?" (2007) May *Journal of Mental Health Law* 7, 13-15.

of State.[114] For these regulated treatments, it is necessary to obtain consent from the patient, and in addition certification from an independent physician and two lay persons appointed under the Act to assess the patient's capacity to consent to the treatment, together with a certification from the patient's treating psychiatrist that the treatment is appropriate for the patient.[115] Before certifying the appropriateness of the treatment, the treating psychiatrist is required to consult with a nurse and with another person professionally connected with the patient's care but who is not a registered medical practitioner; and additionally to consult with an independent consultant psychiatrist.[116]

The 2007 Act also amended the provisions in s 58 of the 1983 Act relating to the administration of certain types of treatments to mental patients. S 58 (1)(b) requires a consultant psychiatrist to obtain a second independent opinion before the administration of medication to a patient beyond a period of three months. No treatment may be administered under s 58 without the consent of the patient, or alternatively without the certification by an independent registered medical practitioner that the patient is unable to understand the nature, purpose and effects of the proposed treatment and that the proposed treatment is appropriate for the patient.[117]

S 58 also reforms the provisions in English law on the administration of electroconvulsive therapy (ECT) (also frequently known as electroshock therapy) through the insertion of a new section 58A to deal specifically with ECT. S58A provides that ECT cannot be given to any patient "capable of understanding the nature, purpose and likely effects of the treatment" without their consent.[118] Where the patient is not capable of consenting, the ECT must be certified by a registered medical practitioner as being an "appropriate" treatment and additionally the ECT

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[114] Mental Health Act 1983 (England), s 57 (1) as amended by the Mental Health Act 2007 (England), s 34. Under the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008, Regulation 27 (1), the administration of hormones for the purposes of reducing the male sex drive is specified as a regulated treatment for the purposes of s 57 (1).

[115] Mental Health Act 1983 (England), s 57 (2) as amended by the Mental Health Act 2007 (England), s 34.

[116] Mental Health Act 1983 (England), s 57 (3) as amended by the Mental Health Act 2007 (England), s 34.

[117] Mental Health Act 1983 (England), s 58 (3) as amended by the Mental Health Act 2007 (England), s 28.

[118] Mental Health Act 1983 (England), s 58A, as inserted by Mental Health Act 2007 (England), s 27.

must not conflict with an advance decision made by the patient that the registered medical practitioner considers 'valid and applicable', or with a decision made by a donee, a deputy, or the Court of Protection.[119] In circumstances where ECT is to be administered to a child, the treatment must always be certified as appropriate, even where the child is considered to have capacity to consent and is willing to give that consent.

In Ireland, the MHA 2001 mandates that ECT may not be administered without a patient's consent, unless the patient's consultant psychiatrist and a second consultant psychiatrist 'approve' the programme of ECT.[120] There is no requirement that the treatment be 'necessary' or 'appropriate', and no requirement that the consultant psychiatrists reach their conclusion to approve of the treatment independently of one another.[121]

The English mental health law's mechanisms on consent to treatment possibly provide for stronger protection in the event of a treatment being administered to a patient compulsorily, in particular in the instance of compliant incapacitated patients. These provisions are of interest as a comparison with the Irish approach to this issue in light of the problems with Part 4 of the 2001 Act as were outlined at § 1.4.2 above.[122]

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[119] Mental Health Act 1983 (England), s 58A ss (2) to (5), as inserted by Mental Health Act 2007 (England), s 27.

[120] Mental Health Act 2001 s 59(1)(b) for electro-convulsive therapy and s 60(1)(b) for the administration of medication.

[121] *See* discussion of Mental Health Act 2001, s 59, at § 5.3.2 below.

[122] Significant discussion of the English common law precedents pertaining to consent to treatment generally and in relation to mental health treatments more particularly is provided at § 1.4.2. above and at § 5.3.3 below. There is also a sizeable body of academic literature on the question of consent to treatment in England. See for example, Bartlett, Peter, and Sandland, Ralph, *Mental Health Law: Policy and Practice*, 2nd ed. (Oxford: Oxford University Press, 2003), Chapter 7; Hoggett, Brenda M., *Mental Health Law* (London: Sweet and Maxwell, 1996), Chapter 5; Mason, Kenyon and Laurie, Graeme, *Mason & McCall Smith's Law and Medical Ethics* 7th edn (Oxford: Oxford University Press, 2005), Chapter 10; Fenwick, Helen, *Civil Liberties and Human Rights*, 3rd ed. (London: Cavendish Publishing Limited, 2004), Chapter 12; Davies, M., *Medical Law* 2nd edn (London: Blackstone, 1998), Chapter 5; Cheng, Wilson, and Shah, Parag, "Making decisions on behalf of children: parents' rights under the new mental health legislation" (2010) 40 (Sep) *Family Law* 973-977; Richardson, Genevra, "Mental capacity at the margin: the interface between two Acts" (2010) 18 (1) *Medical Law Review* 56-57; Heywood, Rob, "Medical disclosure of alternative treatments" (2008) 68 (1) *Cambridge Law Journal* 30-32; Williams, Rebecca, "Deception, mistake and vitiation of the victim's consent" (2008) 124 (Jan) *Law Quarterly Review* 132-159; Maclean, Alisdair, "Autonomy, consent and persuasion" (2006) 13 (4) *European Journal of Health Law* 321-338; Davies, Rhys and Dawson, Keith, *Consent to medical treatment* (London: Mind, 2009); British Medical Association, *Consent, rights and choices in health care for young people* (London: BMJ Books, 2001); General Medical Council, *Consent:*

4.2 South Africa

South Africa's mental health law regime is but one year younger than Ireland's Mental Health Act 2001, and like the Irish regime it is intended to introduce a human rights framework into the area of mental health regulation. While South Africa is not a party to the European Convention on Human Rights, like Ireland it is a party to the United Nations human rights framework and this forms a common international human rights language that is shared between South Africa and Ireland. In this much, South Africa and Canada are similar in their points of comparison with Ireland. However, South Africa has a distinctive constitutional provision which makes it a particularly interesting jurisdiction for comparative purposes: South Africa recognises a justiciable constitutional right to health.

South Africa's legal system is a hybrid model incorporating elements of indigenous legal principles; the English common law; and Dutch civil law. The procedural rules of litigation and the law of evidence are strongly influenced by the common law, while detailed codified provisions governing contract, delict (torts), family law and so on demonstrate the influence of the Dutch civilian system with its roots in Roman law.[123]

In 1993, when the apartheid regime fell in South Africa, a new Constitution was drafted to underpin the new democratic society that was being constructed to replace the old regime. The structure and content of this new constitutional framework was crucial. As Klug states:

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patients and doctors making decisions together (London: General Medical Council, 2008); University of London Institute of Education, *Disabled people and consent to medical treatment and research* (London: University of London Institute of Education, 1993); University of London Institute of Education Social Science Research Unit, *Young people, psychiatric treatment and consent* (London: University of London Institute of Education, 1993); Hope, Paul, "Paternalism or power? Compulsory treatment under section 58 of the Mental Health Act 1983" (2006) May *Journal of Mental Health Law* 90-101, and Fennell, Phil, "Institutionalising the Community" *in* McSherry, Bernadette and Walker, Penelope, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), 13-50.

[123] For a brief introduction to the history and structure of the South African legal system, *see* Zweigert, Konrad and Kötz, Hein, 3rd ed. (Weir, Tony, transl.) *Introduction to Comparative Law* (Oxford: Clarendon Press, 1998), 231-235.

> While constitutional law was a peripheral part of law in the colonial and apartheid eras, since the achievement of democracy in 1994, the Constitution, and its interpretation by the Constitutional Court in particular, has become a central pillar in South African law.[124]

The South African Constitution is notable in its adoption of a number of socio-economic rights in its Bill of Rights, all of which are fully justiciable before the Constitutional Court. The philosophy underpinning the decision to include socio-economic rights as justiciable rights in the South African Constitution has been described by the South African Human Rights Commission as founded on concepts of humanity and dignity:

> Poverty and lack of access to basic means of living undermines the very humanity of people. In other words, basic elements like water, food and healthcare are essential for the realisation of decent and dignified humanity.[125]

Of most interest to this work is the right to have access to health care services. The discussion below will assess whether the inclusion of a justiciable right to access health care in South Africa has resulted in legal precedents that safeguard access to health care in a stronger way than has been the case before the courts in Ireland, where no justiciable right to health exists.

4.2.1 The South African Constitution

The new South African Constitution, adopted in 1994, is unusual in that it provides for fully justiciable socio-economic rights. As was noted in Chapter 2 of this work, socio-economic rights feature only in the 'Directive Principles' portion of the Irish Constitution, and any attempts to introduce enforceable socio-economic rights utilising arguments founded in the justiciable civil and political rights protections have been firmly rejected by the Supreme Court.[126] The concerns of the Irish judiciary

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[124] Klug, Heinz, *The Constitution of South Africa: A Contextual Analysis* (Portland, Oregon: Hart Publishing, 2010), 6.

[125] Pityana, Chairperson of the South African Human Rights Commission, from the Foreword to Seleoane, *Socio-Economic Rights in the South African Constitution: Theory and Practice* (Pretoria: Human Sciences Research Council, 2001), xv.

[126] *See O'Reilly and Ors v Limerick Corporation* [1989] ILRM 181, *Sinnott (a minor suing by his mother and next friend) v Minister for Education, Ireland and the Attorney General* [2000] IEHC 21; [2001] IESC 63; [2001] 2 IR 545, *O'Donoghue v Minister for Health* [1996] 2 IR 20, *T.D. (a minor*

in respect of socio-economic rights – focussing on the protection of the principles of democracy and of the separation of powers, and on the dangers of requiring judges to make decisions with fiscal consequences more properly confined to the realm of the executive branch of government – were also raised in the context of the introduction of the new Constitution in South Africa. Constitutional Court of South Africa Judge Kate O'Regan in a speech given at Trinity College Dublin referenced the significant debate in South Africa about the inclusion of jusiticiable socio-economic rights in the new Constitution,[127] before explaining the rationale for the approval by the Constitutional Court of the text of the new Constitution:

> Indeed during the certification process this Court was called upon to refuse certification of the constitutional text on the basis that it included socio-economic rights because to include such rights threatened the separation of powers. The Court rejected this argument noting that even first generation rights in a supreme Constitution have budgetary implications which can give rise to tensions between the legislature and courts.[128]

The approach taken in the South African Constitution has found favour with commentators in Ireland. McHugh is strongly supportive of the South African Constitutional Court's jurisprudence on socio-economic rights:

> The experience of the South African Constitutional Court in ensuring that the organs of State act reasonably in allocating resources and in implementing policy provides ample evidence that the courts have a valuable role to play in protecting individual rights such as the right to housing and appropriate healthcare, rights which can be regarded as pressing concerns of any individual…The unwillingness of the Irish courts to become involved in socio-economic matters may be less attributable to concern that this would overstep the boundaries of their constitutional role, than to an unstated belief that socio-economic rights do not merit judicial protection.[129]

Also approving of the South African approach, Whyte cites South Africa's adoption of socio-economic rights in its Constitution in support of his argument that the

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suing by his mother and next friend M.D.) v Minister for Education, Ireland and the Attorney General, the Eastern Health Board and by Order of the Minister for Health and Children [2001] IESC 101; [2001] 4 IR 259, and *NWHB v HW & CW* [2001] 3 IR 622.

[127] O'Regan, Kate, "Cultivating a Constitution: Challenges Facing the Constitutional Court in South Africa" (2000) 22 *Dublin University Law Journal* 1, n45.

[128] O'Regan, Kate, "Cultivating a Constitution: Challenges Facing the Constitutional Court in South Africa" (2000) 22 *Dublin University Law Journal* 1, 11-12.

[129] McHugh, Claire, "Socio-Economic Rights in Ireland: Lessons to be learned from South Africa and India" (2004) 4 *Hibernian Law Journal* 109, 142.

insertion of a guarantee for socio-economic rights into the Irish Constitution (presuming a referendum result in favour of the insertion) would not result in a distortion of democracy, and refers to the review of the South African Constitution by the Constitutional Assembly of the Republic of South Africa prior to its adoption as support for the position that there is "nothing objectionable in providing constitutional protection for a set of justiciable socio-economic rights designed to combat social exclusion."[130]

The South African Constitution provides for a right to health care services in three different sections.[131] Section 27 of Chapter 2 (the Bill of Rights section of the Constitution) is the core provision providing for a right to access to health care. Section 27 provides:

> 27. Health care, food, water and social security. – (1) Everyone has the right to have access to –
>
> (a) health care services, including reproductive health care;
>
> (b) sufficient food and water; and
>
> (c) social security, including if they are unable to support themselves and their dependants, appropriate social assistance.
>
> (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
>
> (3) No one may be refused emergency medical treatment.[132]

Section 27(2) provides for a duty on the State to protect the right to health care by means of 'progressive realisation'. As was noted at §2.7 of this work, progressive realisation requires governments to plan for the full implementation of rights and to institute policies to bring about that full implementation but is not a duty on governments to recognise rights immediately and in their entirety.[133] The Article 12

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[130] Whyte, Gerard, *Social Inclusion and the Legal System: Public Interest Law in Ireland* (Dublin: Institute of Public Administration, 2001), 55.

[131] Constitution of the Republic of South Africa 1996, Chapter 2: Bill of Rights, s 27 (general right to access to health care); s 28(1)(c) (right to basic health care services for all children); and s 35(2)(e) (right to adequate medical treatment for detainees and prisoners, to be provided at the State's expense).

[132] Constitution of the Republic of South Africa 1996, Chapter 2: Bill of Rights, s 27.

[133] Rosenthal, E., and Sundram, C.J., "International Human Rights in Mental Health Legislation" (2002) 21 *New York Law School Journal of International and Comparative* Law 469, 483-485.

right to health in the International Covenant on Economic, Social and Cultural Rights is also subject to progressive realisation.

Under section 7(2) of the Constitution the State is required to "respect, promote and fulfil" all of the rights in the Bill of Rights[134] and section 8 states:

> The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state. A provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right."[135]

The effect of these provisions is to make the right to health (along with all of the other rights in the Bill of Rights) fully justiciable before the South African courts.[136] The right to health is conceptualised as being linked with access to food, water and social security. It is not simply access to medical treatments – it includes access to the means that enable people to safeguard health in order to avoid illness and promote recovery if they do become ill.[137]

A number of high profile constitutional cases have revolved around the right to health in South Africa. In *Soobramoney v Minister for Health*[138] the Constitutional Court found that where a scarcity of resources prevailed, the State would be justified in limiting citizens' enjoyment of the constitutional right to health, in this instance in respect of access to expensive kidney dialysis treatment.[139] Chaskalon J found that the policy adopted by the State, while it meant that the applicant would be denied the

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[134] Constitution of the Republic of South Africa 1996, Chapter 2: Bill of Rights, s 7(2).
[135] Constitution of the Republic of South Africa 1996, Chapter 2: Bill of Rights, s 8(1).
[136] *See* Hassim, Adila; Heywood, Mark; and Berg, Jonathan, (eds.), *Health & Democracy: A guide to* human *rights, health law and policy in post-apartheid South Africa,* (South Africa: Siberink, 2007), Chapter 1 "A Background to Health Law and Human Rights in South Africa" para 1.2 <http://www.section27.org.za/2007/06/01/health-and-democracy/> accessed 10 January 2010.
[137] *See* Hassim, Adila; Heywood, Mark; and Berg, Jonathan, (eds.), *Health & Democracy: A guide to human rights, health law and policy in post-apartheid South Africa,* (South Africa: Siberink, 2007), Chapter 1 "A Background to Health Law and Human Rights in South Africa" para 1.2 <http://www.section27.org.za/2007/06/01/health-and-democracy/> accessed 10 January 2010.
[138] *Soobramoney v Minister of Health, Kwa-Zulu Natal,* 1997 (12) BCLR 1696 (CC). *See* Hassim, Adila; Heywood, Mark; and Berg, Jonathan, (eds.), *Health & Democracy: A guide to human rights, health law and policy in post-apartheid South Africa,* (South Africa: Siberink, 2007), Chapter 1 "A Background to Health Law and Human Rights in South Africa" para 19 <http://www.section27.org.za/2007/06/01/health-and-democracy/> accessed 10 January 2010.
[139] *Soobramoney v Minister of Health (Kwa-Zulu Natal)* (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997) <http://www.saflii.org/za/cases/ZACC/1997/17.html> accessed 10 January 2011.

treatment he sought, would ensure that overall more patients would benefit from the treatment in question, and was therefore reasonable:

> The state has to manage its limited resources in order to meet all these claims. There will be times when this requires it to adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society.[140]

The test of whether a particular approach to the allocation of resources in the provision of socio-economic rights was 'reasonable' was again adopted in *Government of the Republic of South Africa and Others v Grootboom and Others*[141] in which the Constitutional Court interpreted the phrase "reasonable legislative and other measures" in Article 27 (2). While upholding the *Soobramoney* precedent that the State is justified in times of hardship to limit the constitutional right to health, the Court held that measures that fail to include the objective of meeting the needs of the most vulnerable groups of society will not meet the 'reasonable measures' requirement.[142] Yacoob J described the threshold at which the minimal core obligation exists as "the floor beneath which the conduct of the State must not drop if there is to be compliance with the obligation."[143]

In *Minister of Health v Treatment Action Campaign*[144] ('the *Nevirapine* case') the Constitutional Court upheld a High Court order compelling the State to make an anti-retroviral drug (Nevirapine) available to all HIV positive pregnant women receiving health care in the public health sector.[145] Klug describes the *Nevirapine* decision as

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[140] *Soobramoney v Minister of Health (Kwa-Zulu Natal)* (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997) para 31 <http://www.saflii.org/za/cases/ZACC/1997/17.html> accessed 10 January 2011.

[141] *Grootboom and Others v Government of the Republic of South Africa and Others* (CCT38/00) [2000] ZACC 14 (21 September 2000) <http://www.saflii.org/za/cases/ZACC/2000/14.html> accessed 10 January 2011.

[142] *Grootboom and Others v Government of the Republic of South Africa and Others* (CCT38/00) [2000] ZACC 14 (21 September 2000) para 41 <http://www.saflii.org/za/cases/ZACC/2000/14.html> accessed 10 January 2011.

[143] *Grootboom and Others v Government of the Republic of South Africa and Others* (CCT38/00) [2000] ZACC 14 (21 September 2000) para 31 <http://www.saflii.org/za/cases/ZACC/2000/14.html> accessed 10 January 2011.

[144] *Minister of Health v Treatment Action Campaign (No. 1)* (CCT9/02) [2002] ZACC 16; 2002 (5) SA 703; 2002 (10) BCLR 1075 (5 July 2002) <http://www.saflii.org/za/cases/ZACC/2002/16.html> accessed 10 January 2011 and (No 2) (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) <http://www.saflii.org/za/cases/ZACC/2002/15.html> accessed 10 January 2011.

[145] *Minister of Health v Treatment Action Campaign (No. 1)* (CCT9/02) [2002] ZACC 16; 2002 (5) SA 703; 2002 (10) BCLR 1075 (5 July 2002) <http://www.saflii.org/za/cases/ZACC/2002/16.html>

building on the "central" decision in *Grootboom* and "placing the review of the reasonableness of government policy and implementation at the centre of its socio-economic rights jurisprudence."[146]

The attempts made by litigants in Ireland to secure access to health care on the basis of the Directive Principles of Social Policy in Article 45 of the Irish Constitution, or by arguing for an unenumerated right to access to health care, have been discussed in some detail in Chapter 3 of this work.[147] Most of these cases have sought to frame their submissions within the context of the right to education, which is justiciable in the Irish context. *NWHB v HW & CW*[148] however directly addresses the question of the justiciability of claims relating to the provision of services designed to maximise good health. Murphy J *obiter* stated that there are no express provisions of the Constitution cognisable by the courts which require the State to provide medical services or social welfare of any kind for any of its citizens.[149] Hardiman J gave a detailed explanation of his reasons for holding that a claim seeking to compel the State to provide particular medical treatments, tests or services could not be cognisable before the courts in Ireland:

> The legislature, and not the courts, are in the best position to judge whether such an innovation is necessary, proportionate or desirable, whether there are countervailing considerations of a social or medical nature or otherwise; whether there exists sufficient consensus in the community to make legislation feasible or desirable and many other relevant considerations. Compulsory medical diagnosis or treatment in any form is, for the reasons identified in the judgment of the learned Chief Justice, a topic regarded with some unease throughout the civilised world. The degree to which this unease should be recognised, whether precautions can be taken to allay legitimate fears, and the fundamental question of whether the imperative behind the P.K.U. test or any

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accessed 10 January 2011 and (No 2) (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) <http://www.saflii.org/za/cases/ZACC/2002/15.html> accessed 10 January 2011.

[146] Klug, Heinz, *The Constitution of South Africa: A Contextual Analysis* (Portland, Oregon: Hart Publishing, 2010), 140.

[147] *See* for example the cases of *O'Reilly and Ors v Limerick Corporation* [1989] ILRM 181, *F.N. v Minister for Education* [1995] 1 IR 509, Geoghegan J. (High Court), *G v An Bord Uchtála* [1980] IR 32, *Sinnott (a minor suing by his mother and next friend) v Minister for Education, Ireland and the Attorney General* [2000] IEHC 21; [2001] IESC 63; [2001] 2 IR 545, *O'Donoghue v Minister for Health* [1996] 2 IR 20, *T.D. (a minor suing by his mother and next friend M.D.) v Minister for Education, Ireland and the Attorney General, the Eastern Health Board and by Order of the Minister for Health and Children* [2001] IESC 101; [2001] 4 IR 259, *O'Reilly and Ors v Limerick Corporation* [1989] ILRM 181, *NWHB v HW & CW* [2001] 3 IR 622, and *O'Brien v Wicklow Urban District Council*, Unreported, High Court 10 June 1994, Costello J.

[148] *NWHB v HW & CW* [2001] 3 IR 622.

[149] *NWHB v HW & CW* [2001] 3 IR 622, 729.

other test is sufficient to justify coercion, are all matters best addressed legislatively. As McCarthy J. said in a completely different context in *Russell v. Fanning* [1988] I.R. 505 at p. 554:-

> I question how a court determines (a) a question of national policy; (b) what is the decision on it; (c) whether or not that decision is that of the people; (d) how did the people decide such a question; (e) how the requirements of the common good were taken into account.

Moreover, if and when the legislature decides to introduce legislation of the relevant kind it will be for the courts to determine, if the occasion arises, whether such legislation is consistent with the provisions of the Constitution. If the court is called upon to make this decision, it will have the benefit of evidence and argument on a specific provision, probably in circumstances where the parties are more on a footing of equality from the point of view of resources than the present plaintiff and defendants. If the court itself imposed a novel obligation, the constitutionally envisaged arrangement whereby one organ of government makes law and another decides on its constitutionality, would be inhibited in its operation.[150]

The fear of infringing on the separation of powers continues to prevent the Irish Supreme Court from being prepared to contemplate enforceable socio-economic rights. Without these rights even being cognisable before the Irish courts, there is no prospect of the introduction of any kind of *Soobramoney* or *Grootboom* reasonableness test to evaluate the government's commitment to the progressive realisation of a right to health as signed up to in the ICESCR. It is likely that the only means of effecting a change to the *Sinnott* line of precedents would be the introduction of a justiciable socio-economic right to health into the text of the Constitution by means of a constitutional referendum, as was suggested by Whyte in 2003.[151] There is little political will for such a proposal and the prospect of any such development is remote. Additionally, there is the possibility that a justiciable constitutional right to health care may not provide much 'value added' in the Irish context. In the recent decision in *Meadows v Minister for Justice Equality and Law Reform*[152] the Supreme Court held that in judicial review proceedings where the decision under review is of a nature that affects constitutional or ECHR rights, the court's analysis of the reasonableness of the decision must include an assessment of the proportionality of the decision. Proportionality in this context must be measured in

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[150] *NWHB v HW & CW* [2001] 3 IR 622, 762.
[151] Whyte, Gerard, *Social Inclusion and the Legal System: Public Interest Law in Ireland* (Dublin: Institute of Public Administration, 2001), 55.
[152] *Meadows v Minister for Justice Equality and Law Reform* [2009] IESC 3.

light of the human rights restrictions the decision in question may occasion. The possibility of utilising this 'proportional' version of reasonableness to argue for the review of decisions pertaining to the allocation of health care services is discussed at § 5.5 below.

The provision in the South African Constitution for a justiciable right to health is of significant importance in the context of mental health regulation, reinforcing the obligation under the International Covenant on Economic Social and Cultural Rights (ICESCR) for States to pursue progressive realisation of the right to health contained in Article 12 of the Convention. While the *Soobramoney* and *Grootboom* judgments limit the scope of analysis of the right to health to the reasonableness of government decisions on the availability of health services, this nonetheless represents a valuable administrative protection over and above the precedents from the Irish courts on similar issues.

4.2.2 Legal Regulation of Mental Health Care in South Africa

South Africa's mental health regime is contained primarily in the Mental Health Care Act 2002 (hereafter 'the 2002 Act').[153] The 2002 Act replaced the earlier Mental Health Act 1973 (hereafter 'the 1973 Act'). The 1973 Act has been described as having grown out of a 'public panic' following a conclusion made by a Commission of Inquiry into the murder of Prime Minister Verwoerd that many murders were committed by 'mentally disabled persons', and that as a consequence the 1973 Act was concerned more with issues of public safety than with patients' rights.[154] Among the provisions in the 1973 Act that were subjected to criticism were the compulsory admission criteria, which required only a 'reasonable suspicion' of a mental

[153] The text of the Mental Health Act (No. 17 of 2002) (South Africa) is available at <http://www.polity.org.za/article/mental-health-care-act-no-17-of-2002-2002-01-01> accessed 10 January 2011.

[154] McCrea, Natalie Latoya, "An Analysis of South Africa's Mental Health Legislation" (2010) *National Law Forum* <http://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1006&context=stusch_winners> accessed 10 January 2010.

disorder[155] and a lack of provisions providing for effective reviews of detentions and appeals against detention.[156]

After the adoption of the post-apartheid Constitution in 1996, reform of the 1973 Act's provisions was undertaken in order to ensure that the mental health law regime would comply with the constitutional requirements to respect the rights to equality;[157] dignity;[158] and freedom and security of person.[159] The Mental Care Act 2002 came into force in December 2004.[160] In common with the Mental Health Act 2001 in Ireland, the 2002 Act seeks to move towards community-based provision of mental health services and to put the legal regulation of mental health care onto a human rights based footing.[161]

Section 1 of the 2002 Act defines mental illness as "a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis."[162] Section 8 of the Act then proceeds to set out fundamental guiding principles applicable in the operation of the Act with regard to the rights and duties relating to mental health care users:

> 1) The person, human dignity and privacy of every mental health care user must be respected.
>
> 2) Every mental health care user must be provided with care, treatment and rehabilitation services that improve the mental capacity of the user to

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[155] *See* Burns, JK, "Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice" (2008) 98(1) *South African Medical Journal* 46-49. *See* also Kruger, A., *Mental Health Law in South Africa* (Durban: Butterworths, 1980).

[156] *See* Burns, JK, "Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice" (2008) 98(1) *South African Medical Journal* 46-49. *See* also Hayson, Nicholas, Strous, Martin, and Vogelman, Lloyd, "The Mad Mrs. Rochester Revisited: The involuntary confinement of the mentally ill in South Africa" (1990) 6 (3) *South African Journal on Human Rights* 341.

[157] Constitution of the Republic of South Africa 1996, Chapter 2: Bill of Rights, s 9.

[158] Constitution of the Republic of South Africa 1996, Chapter 2: Bill of Rights, s 10.

[159] Constitution of the Republic of South Africa 1996, Chapter 2: Bill of Rights, s 12.

[160] General Regulations, Notice No. R. 1467 published in Government Gazette No. 27117 dated 15 December 2004 (South Africa). *See* Department of Health, *Press Release: New Mental Health Care Act Promulgated'* (Johannesburg: South African Parliament, Department of Health, 14 December 2004) <http://www.doh.gov.za/docs/news/2004/nz1215.html> accessed 10 January 2011.

[161] *See* also the discussion of the evolution from a custodial to a treatment paradigm in Allan, Alfred and Allan, Marietje "The Right of Mentally Ill Patients to Refuse Treatment" (1997) 114 *South African Law Journal* 578.

[162] Mental Health Care Act 2002 (South Africa), s 1.

develop to full potential and to facilitate his or her integration into community life.

3) The care, treatment and rehabilitation services administered to a mental health care user must be proportionate to his or her mental health status and may intrude only as little as possible to give effect to the appropriate care, treatment and rehabilitation.[163]

The closest the Irish mental health law regime comes to enshrining this kind of human rights philosophy in its provisions is the direction in s 4 of the MHA 2001 to always act in the patient's best interests (to be balanced against the safety of others)[164] and with 'due regard' to 'the need to respect' their rights to dignity, bodily integrity, privacy and autonomy.[165] By comparison with the South African provision, the paternalist character of the Irish regime is strongly apparent.[166]

Involuntary admission, detention and treatment for mental illness is governed by section 33 of the 2002 Act together with the Mental Health Care Regulations 2003[167] and the General Regulations 2004.[168] An application for involuntary committal may be made by a family member but an admission will only proceed if two mental health care practitioners performing independent assessments of the patient find that involuntary care is necessary.[169] A person who is admitted as an 'involuntary mental health care user' must be provided with "care, treatment and rehabilitation at a health establishment if at the time of application, there is a reasonable belief that the mental health care user has a mental illness" and is likely to cause serious harm to their person or others.[170] Admission is for an initial period of 72 hours, after which a further review must occur.[171] The review may result in the patient continuing to be detained on an involuntary basis; or, if the review concludes that involuntary care is

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[163] Mental Health Care Act 2002 (South Africa), s 8.
[164] Mental Health Act 2001, s 4(1).
[165] Mental Health Act 2001, s 4(3).
[166] *See* also the discussion of the Mental Health Act 2001, s 4, and of the paternalist approach adopted in mental health cases by the Irish courts in Chapter 5 of this work, for example in the decision in *EH v The Clinical Director of St Vincent's Hospital, Aideen Frehne and the Mental Health Tribunal*, Unreported, Supreme Court, 28 May 2009 (Kearns J).
[167] Mental Health Care Regulations, Notice No. R. 24384 published in Government Gazette No. 7578 dated 14 February 2003 (South Africa).
[168] General Regulations, Notice No. R. 1467 published in Government Gazette No. 27117 dated 15 December 2004 (South Africa).
[169] Mental Health Care Act 2002 (South Africa), s 33(7).
[170] Mental Health Care Act 2002 (South Africa), s 33(7).
[171] Mental Health Care Act 2002 (South Africa), s 34.

not necessary it may result in their consenting to remain in hospital on a voluntary basis, or in their discharge, either completely or into outpatient care.[172] These provisions do not vary in substantial degree from the equivalent Irish provisions under the MHA 2001.

The 2002 Act also establishes Mental Health Review Boards to review admissions, detentions, and certain treatments for compliance with the provisions of the Act.[173] The Review Boards are composed of a magistrate, an attorney, and a mental health practitioner.[174] Unlike the Irish and English Mental Health Tribunals, there is no lay member of the panel. Where a hospital concludes at the expiration of the initial 72 hour period of involuntary detention provided for under section 34 that the patient requires further involuntary care and treatment, the hospital must make a request for approval of that further detention within seven days.[175] In a notable extra step that is not present in either Irish or English mental health law, where the Review Board concludes that the further detention is warranted, the case file is forwarded to the High Court for judicial review, and the Court will perform that review within one month.[176] Finally, sections 34 and 37 provide that periodic reviews of all patients' detentions and treatment must be undertaken and submitted to the Review Board in the form of an annual report – importantly, this protection applies to both voluntary and involuntary patients.[177] Voluntary patients in Ireland remain outside of the remit of the Mental Health Commission's inspection and review processes, despite calls from the Commission for the extension of its remit in order to be able to provide protection to these patients (and in particular to compliant incapacitated patients present in mental hospitals on an ostensibly voluntary basis) in addition to involuntary patients.[178]

The World Health Organisation in 2008 reviewed South Africa's mental health law regime and concluded:

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[172] Mental Health Care Act 2002 (South Africa), s 34(3).
[173] Mental Health Care Act 2002 (South Africa), s 18.
[174] Mental Health Care Act 2002 (South Africa), s 20.
[175] Mental Health Care Act 2002 (South Africa), s 34(3)(d).
[176] Mental Health Care Act 2002 (South Africa), s 34(7)(c).
[177] Mental Health Care Act 2002 (South Africa), ss 34 and 37.
[178] *See* Keys, Mary, *Mental Health Act 2001* (Dublin: Round Hall Sweet & Maxwell, 2002), 50.

> [the] Mental Health Care Act (2002) is consistent with international human rights standards, and is based on a thorough consultation process with a range of stakeholders. As a key instrument of reform (such as the development of mental health care within general health services and the facilitation of community-based care), the Act appears to be a highly appropriate and important milestone in the development of the mental health system in South Africa."[179]

The 2002 Act's inclusion of guiding principles founded on human rights concepts of dignity and reciprocity place South Africa's mental health law regime on a very different footing to the paternalist approach adopted in the Mental Health Act 2001 in Ireland. Significantly, the admission and treatment of voluntary patients in South Africa is subject to review, albeit at a significantly reduced level of intensity to that provided to involuntary patients. In Ireland, voluntary patients are not provided with any mechanism for review of their admission and treatment. Coupled with the lack of a human rights based guardianship regime, this leaves the compliant incapacitated patient in particular in a very vulnerable position.

Conclusion

The reform of mental health law in Ireland has resulted in significant improvements on the previous regime that was in place under the 1945 Act. However, a number of areas of difficulty still arise under the MHA 2001 in respect of patients' human rights and in this regard it may be said that two themes emerge from the comparative account in this Chapter of mental health regulation in other jurisdictions.

The first of these is the benefit that is accrued in terms of furtherance of the aims of the ICESCR of having a justiciable socio-economic right to health contained in the fundamental constitutional text of the legal system, as is the case in South Africa. The continued absence of any enforceable mechanism for evaluating the quality of the government decisions regarding the availability of health care services (as distinct

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[179] Lund C, Kleintjes S, Campbell-Hall V, Mjadu S, Petersen I, Bhana A, Kakuma R, Mlanjeni B, Bird P, Drew N, Faydi E, Funk M, Green A, Omar M, and Flisher AJ., *Mental health policy development and implementation in South Africa: a situation analysis. Phase 1 Country report.* (Cape Town: Mental Health and Poverty Project, 2008), 10 <http://www.who.int/mental_health/policy/development/SA%20Country%20Report%20-%20Final%20Draft%20Jan%202008.pdf> accessed 10 January 2011.

from the quality of individual treatment decisions, which is encompassed within the civil law of torts) leaves Irish law impoverished in this regard.

The second theme to emerge is the significant protection that is afforded to vulnerable patients by the introduction of a human rights based guardianship regime and legally enforceable guidelines around questions of capacity, as is the case in England. In particular for patients who lack capacity to make decisions concerning their admission and treatment for mental health problems, but who perhaps do not meet the other criteria for admission or who are compliant with their detention and their carers are reluctant to deploy the invasive provisions of the involuntary admission and treatment regime, a guardianship mechanism founded on a functional approach is of enormous value.

In the next Chapter an audit of the extent to which Irish constitutional, legislative, and common law provisions have succeeded in meeting the standards established by the international human rights provisions, and whether those international human rights provisions have in legal outcomes provided for meaningful substantive protections for mental health patients in Ireland, is evaluated.

5. An Audit of Irish Mental Health Law for Compliance with the International Human Rights Standards

Introduction

The reform of mental health law that has been undertaken in Ireland in the last decade has had as its stated purpose the intention of introducing a human rights grounded framework for the delivery of mental health care. The function of a human rights grounded mental health law is to ensure that the environment within which people with mental health disabilities are cared for operates in such a way as to safeguard service users' abilities to exercise and enjoy their human rights. This is achieved through the use of legal regulation that maximises dignity, autonomy, bodily integrity and privacy; while simultaneously minimising encroachments on liberty, and ensuring that where compulsion is used, fair procedures are adopted. The provision of equality safeguards and mechanisms for the presentation of affirmative claims are powerful rear guard fortifications to the front line civil and political protections.

This thesis seeks to evaluate the extent to which Irish mental health law succeeds in meeting these lofty goals. This audit of the protections in the area of mental health regulation in Ireland measures the provisions at the constitutional, statutory and common law levels against the international human rights norms to which Ireland is committed. The discussion is thematic, evaluating the successes and failures of the Irish legal framework in four areas:

1. Protection of the right to dignity;
2. Protection of the right to liberty including the provision of fair procedures where deprivations of liberty are effected;
3. Protection of the right to autonomy, including the rights to bodily integrity, privacy, and freedom from torture and inhuman and degrading treatment or punishment; and

4. Protection of equality safeguards and affirmative claims mechanisms by which a right to an entitlement to health care may be argued.

5.1 Dignity Claims (including Right to Life Claims)

Dignity is an essential element of the human condition, a quality that is inherent in all people and that the human rights philosophy of law strives to protect.[1] Dignity is not an isolated concept that may be argued as an individual rights claim. Dignity claims are made alongside another right claim, in the form of an argument that a failure to safeguard that right claim has led to a failure to protect the applicant's right to dignity.

Dignity claims in mental health law may arise in a multitude of contexts.[2] Most frequently, they are constituted as an argument for an entitlement to be treated in a particular way in order to safeguard one's dignity, or as an argument to an entitlement not to be subjected to a particular treatment, that it is argued would diminish one's dignity.[3]

5.1.1 Dignity Claims in International Human Rights

At the international human rights level, dignity features in all of the international human rights instruments. It is central to the core trinity of human rights documents that make up the United Nations Charter, appearing in Article 1 of the Universal Declaration of Human Rights (UDHR), and in the Preambles to both the International

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[1] Binchy, William, "Dignity as a Constitutional Concept" *in* Carolan, Eoin and Doyle, Oran, eds., *The Irish Constitution: Governance and Values* (Dublin: Thomson Round Hall, 2008) 307-326, 316.

[2] For example, in the context of challenges to compulsory detentions that are alleged to be unnecessary, or improperly effected; challenges to the administration of an unwanted medical treatment; challenges to a treatment regime in an institution; or in the form of claims seeking the provision of a particular service or facility or treatment. *See* Introduction, above.

[3] *See* Feldman, David, "Human Dignity as a Legal Value – Part 1 (1999) Winter *Public Law* 683; Rabkin, Jeremy, "What We Can Learn About Human Dignity from International Law" (2003-2004) 27 *Harvard Journal of Law and Public Policy* 145; Vorhaus, John, "On Degradation Part Two: Degrading Treatment and Punishment" (2003) 32 *Common Law World Review* 65; Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.

Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic Social and Cultural Rights (ICESCR).[4]

It is stated in the ICESCR that the recognition of economic, social and cultural rights is indispensable for a person's "dignity and free development of his personality"[5] and that the provision of education should be directed to the development of human dignity.[6] In the ICCPR respect for dignity is included as a requirement in the treatment of persons deprived of their liberty.[7] General Comment 21 on the ICCPR states that the right to dignity is 'fundamental' and 'universal.'[8]

Dignity as a guiding principle suffuses all of the rights contained in the Convention on the Rights of Persons with Disabilities (CRPD).[9]

These provisions of the international human rights framework on dignity are aspirational. They do not purport to create a 'human right to dignity' that may be litigated in its own right before the courts. What they do seek to achieve is to anchor the other rights provisions in a concept of humanity that is grounded on inherent dignity, and in this sense they allow dignity claims to 'piggyback' on the provisions providing for substantive protection of other human rights protections.

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[4] *See* United Nations, *Universal Declaration of Human Rights*, (1948) G.A. Res. 217A, U.N. GAOR, 3rd Sess. U.N. Doc. A/311, Article 1; United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Preamble; and United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3, Preamble.

[5] United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Article 22.

[6] United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3., Article 13.

[7] United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Article 10.

[8] United Nations Office of the High Commissioner for Human Rights, *General Comment 21 of the Committee on Human Rights: Replaces General Comment 9 Concerning Humane Treatment of Persons Deprived of Liberty* (Geneva: UNHCR, 1992) <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/3327552b9511fb98c12563ed004cbe59?Opendocument> accessed 24 May 2010, para 4.

[9] United Nations, *Comprehensive and Integral Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities*, G.A. Res. 168, U.N. GAOR, 56th Sess., 88th plenary meeting, U.N. Doc. A/56/583/Add.2 (New York: United Nations, 2001), Article 3.

5.1.2 Dignity Claims Under the Irish Constitution

A similar approach is taken to the concept of dignity at the Irish constitutional level. Dignity features in the Preamble to the Constitution which describes, as one of the purposes of the adoption of the Constitution, 'the assurance of the dignity and freedom of the individual.'[10] The protection of human dignity has been referenced in several Supreme Court judgments on the recognition and development of unenumerated personal rights. It has featured most prominently in cases on the right to privacy[11] and in cases on the right to life and to autonomy.[12] In *Re Philip Clarke*,[13] a mental health case, a right to dignity was argued as part of the right to fair procedures.

The right to dignity in these cases is presented as but one part of a mesh of human rights that are constitutionally protected, and the different rights in the mesh interweave in different ways in different cases. Thus in *Re a Ward of Court (No 2)* the right to life was held to be paramount, but it could be subject to the other constitutional rights of autonomy, self-preservation, privacy and dignity,[14] with dignity in this instance being equated with a right to be treated with dignity.[15] In that case, the treatment being provided to the ward of court, while it was aimed at the preservation of life, was found to infringe upon her dignity, and the withdrawal of that treatment was held not to be in violation of her constitutional rights. The right to 'treatment with dignity' was accorded sufficient status to enable it to trump the right to life.

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[10] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Preamble. The full text reads: "In the Name of the Most Holy Trinity, from Whom is all authority and to Whom, as our final end, all actions both of men and States must be referred, We, the people of Éire, Humbly acknowledging all our obligations to our Divine Lord, Jesus Christ, Who sustained our fathers through centuries of trial, Gratefully remembering their heroic and unremitting struggle to regain the rightful independence of our Nation, And seeking to promote the common good, with due observance of Prudence, Justice and Charity, so that the dignity and freedom of the individual may be assured, true social order attained, the unity of our country restored, and concord established with other nations, Do hereby adopt, enact, and give to ourselves this Constitution."

[11] *McGee v Attorney General* [1974] IR 284 and *Norris v Attorney General* [1984] IR 36.

[12] *Re a Ward of Court* (No 2) [1995] IESC 1; [1996] 2 IR 73; [1995] 2 ILRM 401 and *Attorney General v X* [1992] 1 IR 1.

[13] *Re Philip Clarke* (1950) IR 235.

[14] *Re a Ward of Court* (No 2) [1995] IESC 1; [1996] 2 IR 73; [1995] 2 ILRM 401, 123.

[15] *Re a Ward of Court* (No 2) [1995] IESC 1; [1996] 2 IR 73; [1995] 2 ILRM 401, 163.

By contrast, in *Re Philip Clarke*[16] the applicant's claim that the State's failure to provide for an automatic review mechanism when a person is subject to civil committal was a violation of his human dignity, was unsuccessful. The Supreme Court held that any infringement of the applicant's dignity that may have occurred as a result of the lack of a review procedure, was legitimate in the context of the constitutional provision that legislation may account for differences of physical, moral and social capacity among citizens. In the face of the prevailing paternalist attitude to mental health treatment, the applicant was unable to successfully argue that the civil committal regime amounted to an unacceptable restriction of the constitutional right to fair procedures, or that it had degraded him.

5.1.3 Audit of Irish Mental Health Law for Compliance with International Human Rights Standards: Dignity Claims

At the legislative level the right to dignity is protected in the Mental Health Act 2001 (MHA 2001), s 4(3), which provides that where decisions are made under the Act concerning the care or treatment of a person, including decisions to admit a person as an involuntary patient, that "due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy."[17]

This guiding principle, that is to be applied to all acts done under the Act, is in keeping with the spirit of the dignity provisions at the levels of both the international and the constitutional rights protections. The judicial interpretation that has been given to s 4, however, has been of a paternalist rather than a human rights character. It would not be unreasonable on first reading s 4(3) to interpret it as being intended to provide protection to patients from actions that infringe their dignity. However, in every case where it has been cited, any concerns raised under s 4(3) have been drowned out by the injunction in s 4(1) to make 'the best interests' of the person the paramount consideration in all decisions taken under the Act.

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[16] *Re Philip Clarke* [1950] IR 235.
[17] Mental Health Act 2001, section 4(3).

Thus in *MMcN v HSE*;[18] *MR v Byrne & Ors*;[19] *B v Director of the Central Mental Hospital and Anor*[20] and *M v Kennedy, Clinical Director of the Central Mental Hospital*[21] the infringements that occurred to the applicants' rights to liberty, dignity, bodily integrity, privacy, and autonomy were held to be defensible, as, in the view of the treating psychiatrists they were in the patients' 'best interests.' This judicial preference, for a paternalist rather than a human rights approach, to the application of s 4 has been the subject of much academic criticism.[22]

In certain aspects of the protection of the right to dignity Ireland may be said to be doing well. The protection of dignity in the Preamble to the Constitution is an important symbol of a commitment to its protection. The high profile accorded to dignity in the constitutional jurisprudence on the rights to life and autonomy, are evidence that it has a value within the Irish legal system that is greater than that of a concept of simply symbolic importance. Its inclusion in the MHA 2001, as an overriding principle to be respected in the consideration of all decisions to be taken under the Act, places it in a central position among the rights that underpin the new human rights focussed mental health law regime.

However, in one significant respect the protection given to dignity in Irish mental health law may not be adequate: the Irish courts continue to adopt a paternalist approach to the interpretation of the MHA 2001 and to rights claims generally in the area of mental health.

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[18] *MMcN & Anor. v The Health Service Executive* [2009] IEHC 236.
[19] *MR v Byrne & Ors* [2007] IEHC 73; [2007] 3 IR 211.
[20] *B v Director of the Central Mental Hospital and Anor* [2007] IEHC 147.
[21] *M v Kennedy, Clinical Director of the Central Mental Hospital* [2007] IEHC 136.
[22] *See* for example Murray, Claire, "Reinforcing Paternalism within Irish Mental Health Law – Contrasting the Decisions in *EH v St. Vincent's Hospital and Others* and *SM v The Mental Health Commission and Others*" (2010) 32 *Dublin University Law Journal* 273; Donnelly, Mary, "From Autonomy to Dignity: Treatment for Mental Disorders and the Focus for Patient Rights" (2008) 26 *Law in Context* 37 and Donnelly, Mary, "The Right of Autonomy in Irish Law" (2008) 14 (2) *Medico-Legal Journal of Ireland* 34 and the comments of this author in Quirke, Edel, ""The trajectory of Irish mental health law: whence and whither?", *UCD Legal Research Conference for Postgraduates*, 24th-25th November 2006; Quirke, Edel, "The HL v United Kingdom (Bournewood) precedent and the Mental Health Act 2001: implications for de facto detained patients in Ireland?", *30th International Congress of the International Academy of Law and Mental Health, University of Padua*, 25th-30th June2007 (the abstract for this publication may be seen at <http://www.ialmh.org/Padua2007/Revised%20final%20book.doc> accessed 20 January 2011)); and Quirke, Edel "Mental Health and Human Rights in the Irish Constitutional Framework" *National Disability Authority Lunchtime Seminars Series* 18th December 2008.

The constitutional jurisprudence varies greatly in the different conceptualisations of dignity that are adopted by the courts. It is frequently conceived of as being entirely ancillary to and dependant upon other rights, which, in the area of mental health renders it vulnerable. The prevailing judicial preference to adhere to the paternalist philosophy in the interpretation of mental health law is particularly problematic. The paternalist approach means that the rights upon which dignity claims depend – to liberty, autonomy, and fair procedures – will almost always be viewed through a lens that presents any infringements of those rights as defensible, because they occur within a context where they are well meant, and intended to be in the best interests of the patient. In this context, a mental health patient's right to dignity will always be subject to a conceptualisation of their needs as viewed through the eyes of their caregivers, rather than from their own standpoint.

5.2 Liberty and Fair Procedures Claims

The right to liberty could be said to be the cornerstone of the family of human rights.[23] In the area of mental health, the right to liberty is of enormous importance in the context of safeguarding people who are subject to legal regimes that provide for compulsory admission, detention, and treatment.

Liberty claims arise in mental health cases in the form of challenges to the legal basis for compulsion, or challenges to the manner of its utilisation.[24] In that context, the right to fair procedures regulates the methods by which deprivations of liberty are effected and reviewed.[25] Challenges to deprivations of liberty and challenges founded on the right to fair procedures form the majority of mental health cases taken before the courts in Ireland.

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[23] Glendon, Mary Ann, *Rights Talk: The Impoverishment of Political Discourse* (The Free Press: New York, 1993), see generally Chapter Three: 'The Lone Rights Bearer'. See also Murray, Claire, "Safeguarding the Right to Liberty of Incapable Compliant Patients with a Mental Disorder in Ireland" (2007) 29 *Dublin University Law Journal* 279; Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.

[24] *See* for example *Winterwerp v Netherlands* (1979) Application No. 6301/73, [1979] 2 EHRR 387 and *HL v United Kingdom* (2004) Application No. 45508/99, (2004) ECHR 471.

[25] See Cook, Timothy, "Substantive Due Process Rights of Mentally Disabled Clients" (1983) 7 (4) *Mental Disability Law Reporter* 346, Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.

5.2.1 Liberty and Fair Procedures Claims in International Human Rights

At the level of the international human rights framework, the right to liberty is protected by Article 9(1) of the ICCPR[26] and its particular application in cases of detention founded on a criteria of mental illness is stated explicitly in General Comment 8 on the Right to Liberty and Security of Persons (Art. 9).[27]

The right to liberty is also protected in Article 5 of the European Convention on Human Rights (ECHR), which requires that in circumstances where it is necessary to deprive a person of their liberty, that the detention must be effected in accordance with a procedure set down at law.[28] A substantial body of jurisprudence has developed on the Article 5(1)(e) provision in the ECHR that a deprivation of liberty may be effected in the context of detentions for mental health treatment and the parameters of these decisions are traced in the analysis at § 5.2.4(b) below.

The right to fair procedures at any hearing that is determinative of legal rights is enshrined in Article 14 of the ICCPR, and in Article 6 of the ECHR. These protections have been held to apply to decisions concerning a person's mental capacity or lack of mental capacity[29] and to decisions concerning the utilisation of guardianship measures.[30] Under the seminal decision in *Winterwerp v Netherlands* any curtailment of a person's right to fair procedures in the determination of their legal capacity, or any restriction of their right to liberty, must be done in furtherance of mental health legislation, must be legitimate and proportionate; grounded upon

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[26] United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Article 9(1).

[27] Human Rights Commission, *General Comment 8 on the Right to Liberty and Security of Persons (Article 9)* (Geneva: UNHCR, 1982) <http://www2.ohchr.org/english/bodies/hrc/comments.htm> accessed 28 August 2010, para 1.

[28] To meet the requirements of Article 5(1)(e), which deals specifically with deprivations of liberty in cases of mental illness, the European Court of Human Rights has held that the assessment of mental illness must be based on objective medical evidence, and the detention must be subject to an independent review mechanism. *See Winterwerp v Netherlands* (1979) Application No. 6301/73, (1979) 2 EHRR 387 and *Herczegfalvy v Austria* (1992) Application No. 10533/83, (1992) 15 EHRR 437, and *X v United Kingdom* (1980) Application No. 6998/75 (1981) 4 EHRR 181.

[29] *Osman v United Kingdom* (1998) Application No. 23452/94 (1999) 25 EHRR 245 and *Shtukaturov v Russia* (2008) Application No. 44009/05, judgment made final 27 June 2008.

[30] *Bock v Germany* (1989) Application No. 11118/84, (1989) 12 EHRR 247.

objective medical expertise; and there must be a means of independent legal review of the curtailment of rights available to the person whose rights are restricted.[31]

5.2.2 Liberty and Fair Procedures Claims under the Irish Constitution

In Irish constitutional law, the right to liberty is protected by Article 40.4.1 of the Constitution and has been the subject of extensive litigation.[32]

Article 40.4.1 also provides a constitutional right of *habeas corpus* entitling a person who has been deprived of their liberty by a legal process to have that detention reviewed by the High Court.

These cases provide that where a person is deprived of their liberty it must be effected in accordance with a valid legal procedure, and it must respect the principle of reciprocity (that the deprivation of liberty occasioned is proportionate to the purpose for which it is occasioned).[33]

As was noted at § 3.8 above, the vast majority of 'mental health cases' in Ireland take the form of challenges to deprivations of liberty on the basis of an argument that fair procedures were not followed in the exercise of compulsory committal procedures.[34] The right to fair procedures is protected in Article 38 of the Constitution and is supplemented by the *habeus corpus* mechanism provided for in Article 40.4.

5.2.4 Audit of Irish Mental Health Law for Compliance with International Human Rights Standards: Liberty and Fair Procedures Claims

In the statutory mental health law regime deprivations of liberty are regulated by section 8 of the MHA 2001. Deprivations of liberty are only permitted in

[31] *Winterwerp v Netherlands* (1979) Application No. 6301/73, (1979) 2 EHRR 387, § 75. See also *Ashingdane v United Kingdom* (1985) Application No. 8225/78, (1985) 7 EHRR 528.
[32] *See* for example *King v AG* [1981] IR 233; *Re Philip Clarke* [1950] IR 235; *Croke v Smith (No 2)* (1998) 1 IR 101 (Supreme Court); 27 and 31 July 1995, Unreported, High Court (Budd J).
[33] *See* Keys, Mary "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 24 *Dublin University Law Journal* 26.
[34] *See* for example *M v Kennedy, Clinical Director of the Central Mental Hospital* [2007] IEHC 136.

circumstances where the definition of a mental disorder under section 3 of the Act is met, and once a person has been detained under the MHA 2001 an automatic review process under section 18 of the Act is activated, which provides for an independent assessment of the validity of the detention.

An additional level of constitutional protection is provided at this juncture. Where a review tribunal finds that a patient's detention has been lawfully effected under the Act, it is open to the patient to bring judicial review proceedings in the High Court. Judicial review proceedings evaluate whether the review followed fair procedures, whether the reviewing body had the authority to make the decision that was made, and whether the reviewing body applied the correct legal principles and did not act unreasonably.[35]

In respect of the right to fair procedures, s 4 of the MHA 2001 provides that where actions are taken under the Act that may infringe a person's rights, those actions must be (a) taken in the 'best interests' of the person affected (s 4(1)); (b) fair procedures must be followed including the right to be notified of the proposed action and to make representations in respect of it (s 4(2)); and (c) 'due respect' must be given to the affected person's constitutional right to privacy (s 4(3)).

There are many positive features in the Irish constitutional and statutory frameworks in terms of the protection of the right to liberty and of the right to fair procedures. The right not to be arbitrarily deprived of one's liberty is given unequivocal protection on both a constitutional and a statutory level, and the courts are scrupulous in the review of cases where unlawful detentions are alleged. The requirements imposed – that detention must be in accordance with a procedure laid down at law, and that it must be for a legitimate reason that justifies the extent of the deprivation of liberty involved – are in accordance with the international human rights standards.

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[35] *See Geoghegan v Institute of Chartered Accountants in Ireland* [1995] 3 IR 86; *O'Keeffe v. An Bord Pleanála* [1993] 1 IR 39; and *Meadows v Minister for Justice Equality and Law Reform* [2009] IESC 3. In the context of a mental health case, *see S.M. v. The Mental Health Commission, The Mental Health Tribunal and The Clinical Director of St. Patrick's Hospital, Dublin; and The Attorney General and The Human Rights Commission* [2008] IEHC 441, [2008 No. 749 JR].

In the mental health context, the new mental health regime as established by the MHA 2001 represents a significant improvement on the regime under the Mental Treatment Act 1945 (the 1945 Act). Ireland now has a comprehensive system of regular and accountable reviews of the decisions to admit, detain, and treat mental health patients: the reviews do not need to be triggered by the patient; the review tribunal has the power to order the release of a patient it finds has been unlawfully detained; and its decisions are amenable to judicial review. These are all welcome improvements, which make great strides in bringing Irish law in respect of involuntary patients into compliance with the ECHR jurisprudence on mental health detentions.

However, the protection of liberty and of the right to fair procedures also falls short of the international human rights standards in two key respects. These are: (a) that the courts' paternalist approach to the interpretation of mental health law operates to restrict the success of claims on the basis of rights to liberty and autonomy; and (b) the lack of a modern framework for the assessment of capacity and for protecting the rights of people who suffer a loss of capacity.

5.2.4 (a) The paternalist model of interpreting mental health law

The paternalist approach to the interpretation of the mental health law regime was adopted in the cases taken challenging the provisions of the 1945 Act, and it was appropriate in that context given the expressly paternalist approach taken in that legislation to the regulation of mental health care.[36] However, the paternalist approach has been carried over into the interpretation of the MHA 2001.[37]

It is submitted that this is an inappropriate standpoint for the courts to adopt. While the 1945 Act was founded on a paternalist approach to the care of mental health patients, the MHA 2001 is expressly intended to introduce a human rights basis to

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[36] *See Re Philip Clarke* [1950] IR 235; *Croke v Smith (No 2)* [1998] 1 IR 101 (Supreme Court); 27 and 31 July 1995, Unreported, High Court (Budd J); and *Gooden v St. Otteran's Hospital* [2001] IESC 14; [2005] 3 IR 617.

[37] *MMcN & Anor. v The Health Service Executive* [2009] IEHC 236. For a broad overview of cases brought challenging aspects of the 2001 Act, *see* generally Mental Health Commission, *Summary of Judgments delivered by the Superior Courts on the Interpretation of the Mental Health Act 2001* (Dublin: Mental Health Commission, 2009).

mental health law in Ireland. The preservation of this paternalist philosophy has the effect of diluting the human rights protections provided in the MHA 2001, as it is utilised by the courts as a mechanism which mandates deference to the decisions of the medical profession in respect of admission, detention and treatment.

The problems of this approach are immediately evident in the context of compliant incapacitated patients, and in this area there is no doubt but that the MHA 2001 fails to accord with the jurisprudence of the European Court of Human Rights (ECtHR) in *HL v United Kindgom.*[38] The MHA 2001 does not require that patients who are present in a mental hospital as a voluntary patient be assessed, prior to their admission to hospital, to ensure that they have the requisite capacity to consent to their admission. In the challenges that have been brought by patients who sought to argue that they had been subject to an unlawful deprivation of liberty in the same manner as the applicant in *HL v United Kingdom*, the Irish courts have consistently fallen back to the default position of interpreting the MHA 2001 as a paternalist statute, and relying on that interpretation to justify detentions that might otherwise be considered unlawful on the basis of Article 5(1)(e). The rationale for that justification is that those detentions were effected with the patient's 'best interests' in mind.[39]

Unfortunately, the lack of protections for the right to liberty of compliant incapacitated patients resident in mental hospitals, is but once facet of the much broader problem that exists in respect of providing protection to people who lack capacity. The lack of a modern guardianship regime with clear guidelines on the requirements around capacity to consent to voluntary admission leaves an opening for potential abuses of mental health patients' rights to liberty and to fair procedures. A patient without capacity is not in a position to consent to admission, and yet no statutory obligation exists to require an assessment of capacity at the point of admission. A patient admitted on a voluntary basis also has no access to the system of

[38] *HL v United Kingdom* (2004) Application No. 45508/99, [2004] ECHR 471.
[39] See for example *MMcN & Anor. v The Health Service Executive* [2009] IEHC 236; *MR v Byrne & Ors* [2007] IEHC 73; [2007] 3 IR 211; *B v Director of the Central Mental Hospital and Anor* [2007] IEHC 147 and *M v Kennedy, Clinical Director of the Central Mental Hospital* [2007] IEHC 136.

Mental Health Tribunals to effect a review of their admission, detention, and crucially, their treatment.[40]

In respect of the right to fair procedures, the cases interpreting s 4 of the MHA 2001 have been disappointing. The paternalist purpose of the Act has been interpreted in the jurisprudence in a fashion that restricts of fair procedures protections, rather than maximising them.[41] It could even be said that the judiciary have used the paternalist approach as a 'brake' on the stringent application of fair procedures requirements, or even as a justification for failures in adhering to fair procedures. This approach has been the subject of academic criticism and has been described as "inadequate" in the context of a new human rights based mental health law regime.[42] As was noted at § 3.8 above, the effect of this interpretation of paternalism has been to neuter the protections afforded by Article 40.4 of the Constitution to people deprived of their liberty.

5.2.3 (b) The definition of a 'mental disorder' and the treatability requirement

The definition of a 'mental disorder' under section 3 of the MHA 2001, while narrower than its corresponding provision in English mental health law (discussed at

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[40] For similar critiques in the Australian context, and for an analysis of the merits of greater regulation of voluntary admissions and treatment, *see* McSherry, Bernadette, "Voluntary Treatment and the Role of the Law" *in* McSherry, Bernadette and Walker, Penelope, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), 379-396.

[41] *MR v Byrne & Ors* [2007] IEHC 73; [2007] 3 IR 211; *B v Director of the CMH and Anor* [2007] IEHC 147; *M v Kennedy, Clinical Director of the Central Mental Hospital* [2007] IEHC 136; *Gooden v St. Otteran's Hospital* [2001] IESC 14; [2005] 3 IR 617; *In Re Philip Clarke* [1950] IR 235; *MR v Byrne & Ors* [2007] IEHC 73; [2007] 3 IR 211; *TO'D v Kennedy & Ors* [2007] IEHC 129; *M (S) v Mental Health Commission* [2008] IEHC 441; *JB v Mental Health (Criminal Law) Review Board & Ors* [2008] IEHC 303; *MMcN & Anor. v The Health Service Executive* [2009] IEHC 236; *EH v The Clinical Director of St Vincent's Hospital, Aideen Frehne and the Mental Health Tribunal*, Unreported, Supreme Court, 28 May 2009 (Kearns J), [2009] 3 IR 774; [2009] 2 ILRM 14; (2009) IESC 46; *Q v St. Patrick's Hospital, and the Mental Health Tribunal and the Mental Health Commission* (Notice Parties), Unapproved, *ex tempore*, High Court, 21st December 2006 (O'Higgins J); *AMC v St. Luke's Hospital Clonmel* [2007] 2 IR 814 (Peart J); *JD v Central Mental Hospital*, Unreported, ex tempore, High Court, 20th March 2007 (Laffoy J); *MM v Clinical Director of the Central Mental Hospital* [2008] IESC 31 (Geoghegan, J); [2008] IEHC 44 (Peart J); and *WQ v. The Director of the Central Mental Hospital*, Unreported, High Court, 15th May 2007 (O'Neill J).

[42] Murray, Claire, "Reinforcing Paternalism within Irish Mental Health Law – Contrasting the Decisions in *EH v St. Vincent's Hospital and Others* and *SM v The Mental Health Commission and Others*" (2010) 32 *Dublin University Law Journal* 273.

§ 4.1.2 (a) above) may nonetheless be problematic in terms of its inclusion of intellectual disability within the definition of a 'mental disorder', and thus as a ground in its own right for admission to a mental hospital.

The definition in section 3 of a 'mental disorder' perpetuates uncertainty about the appropriate legal status of patients who suffer from mental illness symptoms as a result of a non-psychiatric illness; such as Alzheimer's disease, or some other cause; such as a brain injury. Nursing and care homes are not necessarily equipped to care for these patients; but neither should mental hospitals be used as pseudo care homes to nurse them. Concerns have been expressed that the admission requirements in the MHA 2001 may not be strict enough to prevent inappropriate or abusive utilisation of the compulsory admission and detention procedures in these contexts, resulting in violations of liberty and in some cases of the right to fair procedures.[43]

The involuntary admission criteria under the 1945 Act provided for admissions on a 'temporary' basis[44] or on a 'person of unsound mind' basis. [45] As was noted above, the detention provisions under the 1945 Act did not comply with the requirements of the ECHR, in particular with regard to the *Winterwerp* criteria that deprivations of liberty on Article 5(1)(e) mental health grounds must provide for an objective assessment of the existence of a mental illness of a kind or degree warranting confinement and treatment, and because they did not make any provision for review of admission, detention and treatment decisions.

Under the 1945 Act there were no definitions of 'mental illness', 'unsound mind', or 'treatment'. The MHA 2001 has provided definitions for these concepts. The term 'mental illness' is now subsumed into the broader term 'mental disorder' which encompasses 'severe dementia' and 'significant intellectual disability' as well as

[43] See for example the comments of this author in Quirke, E, "Older People in Irish Mental Health Law" in O'Dell, E., ed., *Older People in Modern Ireland: Essays on Law and Policy* (Dublin: FirstLaw, 2006), 268.
[44] The 'temporary patient' category was intended to cater for patients it was expected would require less than six months' treatment and for addicts – see section 163(2) of the Mental Treatment Act 1945.
[45] The 'person of unsound mind' detentions would envisaged to be of a longer duration Section 185 (4) of the Mental Treatment Act 1945.

'mental illness'.[46] 'Treatment' is also defined in the MHA 2001[47] while the phrase 'person of unsound mind' is now considered to be obsolete in the mental health context, although it continues to be used in wardship proceedings.

Under section 3(1) of the MHA 2001 a person may be involuntarily admitted to a mental hospital where they have a 'mental disorder', and the existence of a mental disorder is the only criterion for involuntary admission under the MHA 2001. The decision whether or not to involuntarily admit a person to a mental hospital must be taken in the 'best interests' of the person, with consideration also to be given to other persons who might be at risk of serious harm if an admission were not made.[48] When this decision is being made, the right of the person to privacy (which includes the rights to bodily integrity, dignity and autonomy under Irish law[49]) must be given due respect.[50]

These definitions, while representing welcome progress when compared with the complete omission of definitions of the grounds for detention in the 1945 Act, are not without difficulty. For example, the inclusion of 'intellectual disability' as a ground for involuntary admission is at odds with current psychiatric practice, which does view intellectual disability as a mental illness,[51] and is also in conflict with the social model of disability favoured in the Law Reform Commission's Report on Vulnerable Adults and the Law: Capacity.[52] Furthermore, the Reports of the Inspector of Mental Hospitals, and the Reports of the Inspector of Mental Health Services, include status reports on the progress in moving persons with intellectual disabilities out of mental hospitals.[53] In the MHA 2001 the government has passed legislation providing a

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[46] The new definitions contained in section 3(1) and section 3(2) of the Mental Health Act 2001 are in force by virtue of the Mental Health Act 2001 (Sections 1 to 5, 7, 31 to 55) (Commencement) Order 2001 (S. I. No. 90 of 2002).

[47] Under section 2 of the Mental Health Act 2001, treatment is defined as including 'the administration of physical, psychological and other remedies relating to the care and rehabilitation of a patient under medical supervision, intended for the purposes of ameliorating a mental disorder'.

[48] Section 4(1) of the Mental Health Act 2001.

[49] *In Re a Ward of Court (No. 2)* [1996] 2 I.R. 96.

[50] Section 4 (3) of the Mental Health Act 2001.

[51] See for example Inclusion Europe, *The Differences between Mental Illness and Intellectual Disability* (Brussels: Inclusion Europe) available online at http://www.inclusionireland.ie/downloads/TheDifferences.pdf (accessed 20 September 2010).

[52] Law Reform Commission of Ireland, *Consultation Paper on Vulnerable Adults and the Law: Capacity* (Dublin: Law Reform Commission, 2005) Chapter 1.

[53] The reports of the Inspector of Mental Hospitals (undertaken under the 1945 Act) are available online at the *Department of Health Publications* website at http://www.dohc.ie/publications/all.html

means to admit such persons into mental hospitals, contradicting the efforts of the Inspectorate and of the mental health services generally.[54]

Involuntary detentions under the MHA 2001 are governed by section 8 of the Act, which provides for important exclusions from the reasons for detention, to prevent the use of the Act as a form of social hygiene. Under section 8 (2), a detention may not be effected solely for the reason that a person suffers from a personality disorder, is socially deviant, or is addicted to drugs or to intoxicants. There remains, however, the possibility that the Act has not gone far enough to protect against this type of discrimination, particularly with reference to the provisions concerning dementia and intellectual disability. Both of these conditions are listed in section 3(1) of the MHA 2001 as constituting a mental disorder for the purposes of an involuntary detention, and they are defined under section 3(2) of the MHA 2001 as follows:

> 'severe dementia' means 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;
>
> 'significant intellectual disability' means 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.[55]

With regard to dementia, the definition appears to envisage two categories of dementia, which may serve as grounds to underpin an involuntary detention under the Act: 'severe dementia with severe psychiatric symptoms' and 'severe dementia with behaviour symptoms'. The latter of these two categories would appear to render it legitimate to involuntarily admit a person suffering from dementia, but who does not

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(accessed 9 September 2010). The reports of the Inspector of Mental Health Services (undertaken under the MHA 2001) are available at the Mental Health Commission website at http://www.mhcirl.ie/Inspectorate_of_Mental_Health_Services/AC_IRs/ (acessed 9 September 2010). See also Inclusion Ireland, *Press Statement: People with an intellectual disability still in psychiatric hospitals 25 years after Government said this must stop* (Inclusion Ireland: Dublin, May 2009) available online at http://www.inclusionireland.ie/Peoplewithanintellectualdisabilitystillinpsychiatrichospitals25yearsafterGovernmentpoli.htm (accessed 20 September 2010).

[54] This criticism of the MHA 2001 has been noted by this author in more depth in Quirke, E., "Older People in Irish Mental Health Law" *In* O'Dell, E., (ed.), *Older People in Modern Ireland: Essays on Law and Policy* (Dublin: Firstlaw, 2006) 268, at 278.

[55] Section 3 (2) of the Mental Health Act 2001.

exhibit psychiatric symptoms, to a mental hospital, on the basis of their dementia combined with challenging behaviours.

With regard to intellectual disability, there is no requirement to demonstrate the presence of any mental illness, rather all that is required is the presence of an impairment of intelligence combined with abnormally aggressive or seriously irresponsible conduct.

Both of these definitions, by not specifying the requirement of the existence of mental illness in addition to the other elements required, run the risk of being utilised in a manner that could be considered to amount to social hygiene.[56]

Involuntary admissions must also satisfy the requirement that the admission is 'likely to benefit or alleviate the condition of that [detained] person to a material extent'.[57] While the majority of mental patients can expect to experience relief from their symptoms, there are some disorders which are considered to be manageable rather than curable. Both dementia and Alzheimer's disease fall into this category of mental disorder.[58] Other conditions, such as personality disorders, are considered to be incurable and in some instances are even described as untreatable.[59]

While there is no requirement that an involuntary admission be likely to cure the patient's mental illness, and it is possible that 'management' of symptoms may be encompassed within the terms 'benefit' and 'alleviate', there is an argument to be

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[56] This criticism of the MHA 2001 has been noted by this author in more depth in Quirke, E., "Older People in Irish Mental Health Law" *In* O'Dell, E., (ed.), *Older People in Modern Ireland: Essays on Law and Policy* (Dublin: Firstlaw, 2006) 268, at 278-279. See also Whelan, Darius, *Mental Health Law and Practice* (Dublin: Round Hall, 2009), 79.

[57] Section 3 (1) (b) (ii) of the Mental Health Act 2001.

[58] For example, the *Diagnostic and Statistical Manual of Mental Disorders* has the following entry under the 'Treatment' heading for 'Dementia of the Alzheimer's Type': 'Although there is no cure for Alzheimer's, and various psychotherapies appear to be ineffective, there are ways to treat some of the symptoms of the disease: use of medication to treat cognitive decline and memory loss; appropriate activities such as exercise, recreation, and adult day care services appear to assist in the management of the patient.' American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR (Text Revision) (Diagnostic and Statistical Manual of Mental Disorders)*, 4th edn. (Arlington: American Psychiatric Publishing Inc., 2000).

[59] *See* for example the discussion of psychopathic personality disorders in *Hutchison Reid v United Kingdom*, Application No. 50272/99 [2003] ECHR 94 (20 February 2003). The ECtHR found that even though there was no possibility of the applicant's detention effecting a cure for his mental disorder, and that his mental disorder was not amenable to psychiatric treatment, that his detention was nonetheless justifiable under Article 5(1)(e) as his symptoms would worsen outside of the hospital environment.

made that in certain of these instances the mental hospital is in reality being asked to provide only nursing care, or worse, only accommodation. If this occurs then it means that patients are receiving care in a setting not designed to cater correctly for their needs and mental health resources are being used inappropriately.

This situation is tenable under the legislation[60] and is even explicitly provided for in s 3(1)(a), which provides for the admission of a person suffering from a mental disorder solely on the basis of there being a likelihood of them occasioning harm to themselves or to others, without any explicit requirement that they be in need of treatment for that mental illness. This is indefensible under the principle of reciprocity which underpins the legal rationale for justifiable deprivations of liberty.[61]

5.2.3 (c) The need for modern capacity and guardianship legislation

Also of serious concern in a review of liberty and fair procedures rights is the lack of any requirement on a mental hospital to check that a proposed voluntary patient is capable of consenting to the admission, or to any treatment administered while in hospital. The import of this is that there is no statutory requirement on a mental hospital to check that the admission is truly voluntary, and that the patient consequently is truly capable of consenting to the restrictions on their liberty that admission and treatment will entail. This lack of any requirement to check before admission that a voluntary patient has capacity to consent to treatment is particularly troubling, and as O'Neill has commented, the MHA 2001 "as a whole fails to provide adequate checks as to whether a patient has mental capacity to give voluntary consent to treatment on entry to hospital."[62]

Compounding the lack of a requirement to establish whether the proposed voluntary patient is capable of giving a voluntary consent to the admission, there is also no requirement to objectively establish that a proposed voluntary patient is suffering

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[60] There is no provision in the MHA 2001 which requires a mental hospital to provide treatment for a detained person. For more detailed discussion of the problems in this area, see O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005), 241.

[61] For discussion of the principle of reciprocity as it applies to mental health law in Ireland, see Keys, Mary, "Issues for the New Mental Health Act" (1997) 3 *Medico-Legal Journal of Ireland* 97, 98.

[62] O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005) 91.

from a mental illness. In *Winterwerp*[63] the European Court of Human Rights held that in order for an involuntary admission to be lawful under the ECHR, there must be an assessment at the point of admission finding that the patient was suffering from a mental illness of a nature and degree warranting confinement and treatment. While the requirement to certify that confinement is necessary would not be required in the context of a voluntary admission, as the patient is proposing their own admission and treatment, a requirement to certify that the patient is in fact suffering from a mental illness would protect patients' rights without imposing a substantial burden on medical personnel overseeing voluntary admissions.

Of course, *Winterwerp* is capable of being confined in its application to involuntary admissions and on this analysis would have no effect on voluntary admissions. That would be a legitimate interpretation of the *Winterwerp* precedent, but the introduction of a requirement to assess all patients for capacity at the point of admission would be of enormous value in the protection of patients' rights to liberty, and to autonomy. It is submitted that a requirement to assess capacity on admission would not result in any additional burden on the vast majority of clinicians within the mental health services, who perform such assessments as part of the clinical care of patients in any event, and that it would serve an important function in that it would prevent situations whereby compliant incapacitated patients 'fall between the cracks' and are admitted as voluntary patients but do not actually have the capacity to consent to their admission or to treatments administered to them.

The perils of the 'Bournewood gap' and the ECtHR jurisprudence on compliant incapacitated patients outlined in *HL v United Kingdom*[64] were discussed at § 2.4.2 above. While in England reforms have been undertaken to modernise the law on capacity and provide protection for compliant incapacitated patients (see § 4.1.1 above), grave concerns remain about Irish law in this area. The MHA 2001, by not requiring an assessment of capacity at the point of admission to hospital, perpetuates a situation whereby an adult incapable of giving consent, but compliant with hospital treatment, may nonetheless be classed as a voluntary patient. A number of cases that have come before the Irish courts on almost precisely the same issue as *HL v United*

[63] *Wintertwerp* v *The Netherlands* (1979) 2 EHRR 387.
[64] *H.L.* v *The United Kingdom* Application No. 44508/99, judgment delivered 5 October 2004.

Kingdom demonstrate that problems persist within the Irish mental health system around the admission and treatment of compliant incapacitated patients.[65]

One of these cases, *EH v St Vincent's Hospital & Ors*,[66] reached the Supreme Court. The applicant had been detained as an involuntary patient, but her involuntary detention order had been revoked by the Mental Health Tribunal. At that juncture the applicant was given a form notifying her of the change in her status from involuntary to voluntary patient. A fortnight thereafter, when the applicant made an attempt to leave the hospital, the medical staff present invoked section 23(1) of the MHA 2001 which permits the regrading of a voluntary patient as an involuntary patient.[67] The applicant now challenged the validity of her involuntary detention, on the basis that her voluntary detention had never in fact been voluntary, as she was a compliant incapacitated patient and as such should have been afforded the procedural safeguards mandated by *HL v United Kingdom*, and as provided to compliant incapacitated patients in England under the Mental Capacity Act 2005 (England) and the Mental Health Act 2007 (England). On this construction of events, as her ostensibly voluntary detention was therefore invalid, any regrading of it to an involuntary detention must also be invalid.

This argument was rejected by O'Neill, J in the High Court, whose judgment was unanimously upheld in the Supreme Court. The Court's judgment was delivered by Kearns, J who quoted with approval the following passage from the High Court judgment:

> It would seem to me that the definition [of a voluntary patient] 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

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[65] See for example *JB v Mental Health (Criminal Law) Review Board & Ors* [2008] IEHC 303; *MMcN & Anor. v The Health Service Executive* [2009] IEHC 236; and *EH v The Clinical Director of St Vincent's Hospital, Aideen Frehne and the Mental Health Tribunal*, Unreported, Supreme Court, 28 May 2009 (Kearns J).

[66] *EH v The Clinical Director of St Vincent's Hospital, Aideen Frehne and the Mental Health Tribunal*, Unreported, Supreme Court, 28 May 2009 (Kearns J).

[67] Section 23 (1) of the MHA 2001 reads as follows: "23.—(1) Where a person (other than a child) who is being treated in an approved centre as a voluntary patient indicates at any time that he or she wishes to leave the approved centre, then, if a consultant psychiatrist, registered medical practitioner or registered nurse on the staff of the approved centre is of opinion that the person is suffering from a mental disorder, he or she may detain the person for a period not exceeding 24 hours or such shorter period as may be prescribed, beginning at the time aforesaid."

> an admission order or a renewal order, including, in my view, the type of situation which has indeed arisen in this case, namely, 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. I say this, bearing in mind the clear linkage between the definition and sections 23 and 24, which are designed to cater *inter alia*, for mishaps or unexpected developments which result in there being no admission order or renewal order in respect of a patient who is suffering from a mental disorder which requires treatment as an involuntary patient who attempted to leave the approved centre.[68]

The Supreme Court then held that the meaning given to the term 'voluntary patient' by section 2 of the MHA 2001 does not require that the patient be a person who 'freely and voluntarily gives consent to an admission order', but rather that it means simply a person who is 'receiving care and treatment in an approved centre, who is not the subject of an admission order or a renewal order', and that in the context of the paternalist approach to be adopted to the interpretation of the provisions of the Act, the lack of any requirement to assess the capacity of the patient to give consent to the admission order was not a violation of the applicant's right to freedom and personal autonomy, either at a constitutional or at a Convention level.

This judgment has at its core a fundamental desire to protect the wellbeing of patients, as is expressed in Kearns, J's referencing of the need to respect the paternalistic character of mental health legislation and to safeguard the best interests of patients. It is founded on a deep concern that compliant incapacitated patients not be inappropriately discharged from care because they fall between the two stools of voluntary and involuntary admissions.

However, the effect of the judgment is to replicate in Irish law the situation condemned by the Strasbourg court in *HL v United Kingdom*. The Supreme Court defended this outcome in *EH* on the basis that the gap between the two involuntary detentions, when the applicant was treated as a voluntary patient, was legitimated on the basis of a need to allow some breathing room where mishaps or unexpected developments occur. It cannot be known, however, whether the section 23 regrading of *EH* as an involuntary patient would have taken place at all had she not attempted to

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[68] *EH v The Clinical Director of St Vincent's Hospital, Aideen Frehne and the Mental Health Tribunal*, Unreported, Supreme Court, 28 May 2009 (Kearns J).

leave the hospital. Had she remained in hospital, compliant with the detention, as HL did, would the second involuntary detention have been invoked at all?

It therefore remains unknown whether the Irish courts would be prepared to stand over a longer period of detention where a compliant incapacitated patient remains in hospital on a voluntary patient basis. The indications from *EH* are that they may – but such a position would be in direct conflict with the ECtHR ruling in *HL*. Furthermore, the Supreme Court did not consider that it could have declared the applicant's detention unlawful, but put a stay on her release to allow the Oireachtas time to pass legislation addressing the lacuna, as had been done in *SM v Mental Health Commission & Ors*.[69] Granted, the amendments required in *SM* were of a substantially less complex character than would be required to amend the 'Bournewood gap' that was exhibited in *EH*. However, the stalled Mental Capacity and Guardianship Bill 2008[70] might have provided the Oireachtas at least initial guidance.

It is expected that the proposed reform of capacity law in Ireland, to replace the outdated wardship mechanism with a modern system of guardianship, will provide valuable assistance in this area. As the law stands, however, the failure to amend the MHA 2001 to take account of the *HL v United Kingdom* precedent leaves Irish law in contravention of the ECHR. It also leaves Ireland unable to ratify the Convention on the Rights of Persons with Disabilities (CRPD), which requires a modern capacity regime based on a functional approach to capacity, rather than on a status based

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[69] *S.M. v. The Mental Health Commission, The Mental Health Tribunal and The Clinical Director of St. Patrick's Hospital, Dublin; and The Attorney General and The Human Rights Commission* [2008] IEHC 441, [2008 / 749 JR]. In that case, the forms made available to the treating psychiatrist when certifying the need for a third renewal of the applicant's involuntary detention order did not permit the Tribunal to certify renewal for anything other than a period 'not exceeding twelve months'. The Supreme Court held that the failure to allow the treating psychiatrist a range of options in relation to the nature of the detention order rendered the applicant's detention arbitrary and therefore not in accordance with law. The applicant's detention was declared unlawful, but a stay of four weeks was placed on the order to facilitate the Oireachtas in passing amending legislation to remedy the defect (in the form of the Mental Health Act 2008).

[70] For an interesting account from the perspective of the medical profession of the frustrations caused by the lack of clear legislative guidelines on the treatment of patients who consented to voluntary admission to a mental hospital but subsequently lose capacity to consent to treatment, see Dunne, R., Kavanagh, A., and McLoughlin, D., "Electroconvulsive therapy, capacity and the law in Ireland" (2009) 26 (1) *Irish Journal of Psychological Medicine* 3, available online at http://www.ijpm.org/content/pdf/423/Editorial.pdf (accessed 20 September 2010).

approach.[71] While Ireland was among the first countries to sign the CRPD, it now lags behind on ratifying the document[72] and chief among the reasons that Ireland has not yet ratified the CRPD, is the concern that our existing capacity laws are not in compliance with the requirements of the Convention.[73] Ratification, therefore, awaits reform of the law on capacity.[74]

The admission of people suffering from dementia and people with an intellectual disability to mental hospitals, and the position of compliant incapacitated patients, are areas which will hopefully be more sensitively addressed by the proposed modern capacity legislation, as they do not necessarily require the deployment of the more cumbersome and significantly more rights-invasive mental health law regime. The only alternatives under Irish law at present to the inclusion of these people within the definition of a 'mental patient' are: (a) to continue to permit them to reside in mental hospitals as compliant incapacitated patients, which is clearly in breach of the ECtHR decision in *HL v United Kingdom*, or (b) to admit them to wardship under the Lunacy Regulation (Ireland) Act 1871, which results in the complete removal of the person's

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[71] United Nations, *Comprehensive and Integral Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities*, G.A. Res. 168, U.N. GAOR, 56th Sess., 88th plenary meeting, U.N. Doc. A/56/583/Add.2 (New York: United Nations, 2001), Article 12.

[72] *See* United Nations Enable, *Convention and Optional Protocol Signatures and Ratifications* (New York: United Nations 2008-2009) for a regularly updated list of the signatures and ratifications of the Convention, available online at <http://www.un.org/disabilities/countries.asp?navid=12&pid=166> (accessed 10 October 2010). *See* also United Nations Enable, *Map of Signatures and Ratifications* (New York: United Nations 2008-2009), available online at <http://www.un.org/disabilities/documents/maps/enablemap.jpg> for a map depicting the same information (accessed 10 October 2010).

[73] See Irish Human Rights Commission, *IHRC calls for mental capacity legislation and review of Mental Health Act 2001 to protect rights of incapacitated persons and wards of court* (Dublin: Irish Human Rights Commission, 15 February 2010) available online at <http://www.ihrc.ie/newsevents/press/2010/02/> (accessed 13 October 2010). *See* also Department of Justice, *Press Release: Minister Ahern announces proposals for a Mental Capacity Bill* (Dublin: Department of Justice, 15 September 2008) available online at <http://www.justice.ie/en/JELR/Pages/Minister%20Ahern%20announces%20proposals%20for%20a%20Mental%20Capacity%20Bill> (accessed 13 October 2010), and Department of Justice, *Civil Law Reform: Proposed Legislation* (Dublin: Department of Justice) available online at < http://www.justice.ie/en/JELR/Pages/Civil_law_reform_proposed_legislation> (accessed 13 October 2010).

[74] Private members' bills containing proposals for a new capacity regime was placed before the Dáil in 2007 and again in 20088 but these proposals were never progressed further. The progress of the 2007 proposal may be viewed at < http://www.oireachtas.ie/viewdoc.asp?DocID=6969> (accessed 13 October 2010) and the progress of the 2008 proposal may be viewed at <http://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/bills/2008/1308/document1.htm> (accessed 13 October 2010)). The government published a scheme for proposed capacity legislation on 5 September 2008 and the text of the scheme may be viewed at <http://www.justice.ie/en/JELR/Pages/Scheme_of_Mental_Capacity_Bill_2008> (accessed 13 October 2008) and the text of the bill is available at

legal capacity and has been reported by the Law Reform Commission to be outmoded and in need of modernisation.[75]

As was noted at § 4.1.1, in England a modern system of guardianship has been introduced,[76] together with a series of reforms to the mental health legislation to integrate the new capacity provisions with the mental health law regime.[77] These reforms provide specific protection for compliant incapacitated patients, and provide recognition for advance directives pertaining to medical care. While the heads of a proposed Mental Capacity Bill have been published, legislation to modernise capacity regulation and protect these vulnerable patients has not to date been put before the Dáil.[78]

5.3 Autonomy, Bodily Integrity, and Privacy claims; and Claims based in the Right to Freedom from Torture and Inhuman and Degrading Treatment and Punishment

The rights to autonomy, bodily integrity, and privacy, together with the right to freedom from torture and from inhuman and degrading treatment or punishment, are founded on the concepts of self-determination and respect for a person's individual choices and a person's individual humanity.

These two groups of rights claims seek to protect an individual's freedom to make their own decisions free from compulsion, and to protect the right to even make controversial decisions with which others would not agree.

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[75] Law Reform Commission, *Report: Vulnerable Adults and the Law* (LRC 83 – 2006) (Dublin: Law Reform Commission, 2006).
[76] Mental Capacity Act 2005 (England).
[77] Mental Health Act 2007 (England) and Medical Protection Society, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards (MCA DOLS)*, (Medical Protection Society, March 2010) available online at http://www.medicalprotection.org/adx/aspx/adxGetMedia.aspx?DocID=27062,11288,127,9698,22,11,Documents&MediaID=8335&Filename=MPS0834+MCA+DOLS+2010_web.pdf&l=English (accessed 9 September 2010).
[78] Moloney, John, Houses of the Oireachtas (Seanad Debates) Vol. 207 No. 1 *Mental Capacity and Guardianship Legislation* 25 June 2008, 8 <http://debates.oireachtas.ie/seanad/2011/01/12/00008.asp#N2> accessed 24 January 2011.

While these types of human rights claims may take the form of challenges to an involuntary admission or detention under the mental health regime, or to the conditions of detention,[79] they are most frequently argued in cases brought challenging the administration of compulsory treatment.[80]

5.3.1 'Autonomy' and 'Degrading Treatment' Claims in International Human Rights

In the international human rights framework, the rights to autonomy, bodily integrity and privacy are given extensive protection. The right to privacy is protected in all of the core United Nations human rights documents, in the form of protection from arbitrary interference with one's privacy, family, or home; and a requirement that any legal procedure providing for an invasion of a person's right to privacy is necessary to protect an issue of public importance.[81] The CRPD states as one of its guiding principles the right to 'individual autonomy including the freedom to make one's own choices, and independence of persons.'[82] Similarly, Article 8 of the ECHR protects the right to privacy and permits the imposition of limitations on that right only if the limitation is 'necessary in a democratic society.'[83]

The right to freedom from torture and from inhuman and degrading treatment or punishment is protected in absolute terms in Article 10 of the ICCPR and its

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[79] *See* for example *MMcN v HSE* (2009) IEHC 236, *Re Philip Clarke* [1950] IR 235 and *The State (C) v Frawley* [1976] IR 365.

[80] *See* for example *Blehein v. St. John of God Hospital* [2002] IESC 43 (31st May, 2002) and *The State (C) v Frawley* [1976] IR 365.

[81] United Nations, *Universal Declaration of Human Rights*, (1948) G.A. Res. 217A, U.N. GAOR, 3rd Sess. U.N. Doc. A/311, Article 12; United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Article 17; United Nations, *Convention on the Rights of Persons with Disabilities* (New York: United Nations Secretariat Centre for Human Rights, 2008); (2006) G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611; 13 December 2006, 93 U.N.T.S. 3, Articles 22 and 23; and United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (New York: United Nations Secretariat Centre for Human Rights, 1991); (1991) G.A. Res. 119, U.N. GAOR, 46th Sess., U.N. Doc. A/46/49, Supp. No. 49, Annex, 188-92.

[82] United Nations, *Convention on the Rights of Persons with Disabilities* (New York: United Nations Secretariat Centre for Human Rights, 2008); (2006) G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611; 13 December 2006, 93 U.N.T.S. 3, Article 3.

[83] For the interpretation of Article 8 in the context of mental health cases, *see Herczegfalvy v Austria* (1992) Application No. 10533/83, (1992) 15 EHRR 437 and *JT v United Kingdom* (1997) Application No. 26494/95 (2000) ECHR 133.

applicability to mental health detentions has been specifically affirmed.[84] The right is also given explicit protection in non-derogable terms in Article 3 of the ECHR, and is reinforced by the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.

Under the UN framework, 'torture' is treatment administered with a malevolent intent on the part of the aggressor, whereas 'inhuman or degrading' treatment is any physical or mental treatment that is abusive, regardless of the intentions of the aggressor.[85]

The ECtHR defines torture as deliberate and particularly cruel inhuman and degrading treatment, of a kind that has a special stigma and causes very serious suffering, or that has an invidious purpose such as obtaining information, or a confession, or the infliction of punishment.[86] In *Herczegfalvy v Austria* the ECtHR recognised the rights of patients in psychiatric hospitals to the protection of Article 3 of the ECHR.[87] However, the precedent set in *Herczegfalvy* is open to the criticism that it adopts an overly deferential approach to the evaluation of mental health patients' claims of inhuman and degrading treatment. Under the test established in *Herczegfalvy*, a treatment that is provided with a therapeutic purpose can never amount to inhuman and degrading treatment. The chilling effect of this standpoint on the ECtHR case law involving allegations of inhuman and degrading treatment in mental health contexts has been described in detail at § 2.5.2 above.[88]

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[84] United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Article 10 (1). Articles 10 (2) and 10 (3) provide specific protection for persons deprived of their liberty under the criminal justice system. The right to freedom from torture and from inhuman and degrading treatment and punishment applies to mental health detentions and is non-derogable. *See* United Nations Office of the High Commissioner for Human Rights, *General Comment 21 of the Committee on Human Rights: Replaces General Comment 9 Concerning Humane Treatment of Persons Deprived of Liberty* (Geneva: UNHCR, 1992) <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/3327552b9511fb98c12563ed004cbe59?Opendocument> accessed 24 May 2010, para 4.

[85] United Nations, *Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, G.A. res. 3452 (XXX), annex, 30 U.N. GAOR Supp. (No. 34) at 91, U.N. Doc. A/10034 (1975) 9 December 1975, 297.

[86] *Greek Case* (1969) Report of 5 November (1969) 12 YB 1 and *Ireland v United Kingdom* (1971) Application No. 5310/71, (1978) 2 EHRR 25.

[87] *Herczegfalvy v Austria* (1992) Application No. 10533/83, (1992) 15 EHRR 437, para 82.

[88] *See* for example the decisions in *McFeeley v United Kingdom* (1980) Application No. 8317/78, decision of the Commission (1980) 20 DR 44; *Hilton v United Kingdom* (1976) Application No. 5613/72, decision of the Commission [1976] 4 DR 177; *Dhoest v Belgium* (1987) Application No. 10448/83, decision of the Commission (1987) 55 DR 5, (1987) 23 EHRR 97; *Storck v Germany* (2005)

5.3.2 'Autonomy' and 'Degrading Treatment' Claims Under the Irish Constitution

The Irish Constitution protects the rights to autonomy, bodily integrity and privacy, and to freedom from torture and inhuman and degrading treatment or punishment, within the unenumerated constitutional rights jurisprudence that has been developed from the personal rights protection in Article 40.3.[89]

In these cases the judiciary has given explicit support to the recognition of the rights of autonomy and to be treated with dignity under the Irish Constitution. In particular, in the decision in *The State (C) v Frawley* Finlay, P recognised the 'right to bodily integrity' as one of the personal rights guaranteed under the general umbrella of 'personal rights' in Article 40.3 in the context of a claim brought by a prisoner suffering from mental illness who was detained in prison, although his claim that the conditions of his detention amounted to a breach of his rights to autonomy and to freedom from torture and inhuman and degrading treatment or punishment, were not ultimately successful as the Court found that his sufferings were self-inflicted.[90]

5.3.3 Audit of Irish Mental Health Law for Compliance with International Human Rights Standards: 'Autonomy' and 'Degrading Treatment' Claims

As has already been noted, the MHA 2001 refers to the need to at all times give due regard to patients' rights to dignity, bodily integrity, privacy and autonomy.[91] This provides powerful support to patients' rights, requiring all persons making decisions

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Application No. 61603/00 (2005) 43 EHRR 96; *Hilton v United Kingdom* (1976) Application No. 5613/72, decision of the Commission [1976] 4 DR 177, (1978) 3 EHRR 104; *Winterwerp v Netherlands* (1979) Application No. 6301/73, (1979) 2 EHRR 387; *A v United Kingdom* (1980) Application No. 6840/74, (1980) 3 EHRR 131; and *Aerts v Belgium* (1998) Application No. 25257/94, (1998) 29 EHRR 50. *See* also Gostin, L.O., "Human Rights of Persons with Disabilities: The European Convention on Human Rights" (2000) 23 (2) *International Journal of Law and Psychiatry* 125.

[89] *Ryan v AG* [1965] IESC 1; [1965] IR 294; *The State (C) v Frawley* [1976] IR 365; *NWHB v HW & CW* [2001] 3 IR 622; *Re a Ward of Court* (No 2) [1995] IESC 1; [1996] 2 IR 73; [1995] 2 ILRM 401; and *EJW (APUM) v Watters and Ors* [2008] IEHC 462.

[90] *The State (C) v Frawley* [1976] IR 365, 372.

[91] Mental Health Act 2001, s 4(3).

in respect of patients who come within the remit of the Act, to consider the impact of their decisions on these particular human rights.

In respect of the administration of treatment to involuntary patients, the Act requires first and foremost that wherever possible, the treating psychiatrist should obtain the patient's consent to the treatment proposed.[92] Where it is not possible to obtain the patient's consent, the Act provides detailed procedures outlining the circumstances in which treatment may be administered without the patient's consent.[93]

These provisions are a significant improvement on the regime that applied prior to the enactment of the 2001 reforms, in which a presumption of incapacity applied to all mental health patients, and in respect of patients committed to hospital under the 'person of unsound mind' provisions, consent to treatment was not considered necessary for its administration. The detailed provisions contained in the MHA 2001 satisfy the requirements of the international human rights framework. They promote the right of the patient to have a say in the treatments they undergo, and provide safeguards around the administration of treatment without consent that are intended to ensure that treatment is provided for therapeutic purposes only.

While these are welcome developments, in a number of crucial respects the protection afforded to the rights to autonomy, bodily integrity, and privacy, and to freedom from torture and inhuman and degrading treatment or punishment under the MHA 2001 and at common law continue to lack sufficient rigour. The shortcomings of the regime may be broken down into three categories:

1. The continued utilisation of a paternalist model of interpretation in the evaluation of claims under the MHA 2001;
2. The exclusion from the consent protections in the MHA 2001 of voluntary and compliant incapacitated patients; and
3. The inclusion of 'unwillingness' to receive treatment as a justification for the administration of electro-convulsive therapy (ECT) to a patient who has refused to consent to the treatment.

[92] Mental Health Act 2001, s 56(a).
[93] Mental Health Act 2001, ss 57-60.

5.3.3 (a) The paternalist model of interpretating mental health law

The first of these categories has already been outlined in the analysis of the protection given to the rights to dignity and to liberty: the courts' paternalist approach to the interpretation of mental health law operates to restrict the success of claims on the basis of the rights to liberty and autonomy.

This approach to mental health cases was adopted in the interpretation of the 1945 Act, and was appropriate in that context given the expressly paternalist approach taken in that legislation to the regulation of mental health care,[94] and has been carried over into the interpretation of the MHA 2001.[95]

It is submitted that this is an inappropriate standpoint for the courts to adopt. While the 1945 Act was founded on a paternalist approach to the treatment and care of mental health patients, the MHA 2001 is expressly intended to introduce a human rights basis to mental health law in Ireland.

The preservation of this paternalist philosophy has the effect of diluting the human rights protections provided in the MHA 2001, as it is utilised by the courts as a mechanism which mandates deference to the decisions of the medical profession in respect of admission, detention and treatment.

5.3.3 (b) Regulation of consent to treatment for voluntary and compliant incapacitated patients

Significant discussion was made at § 1.4.2 above of the failure of the MHA 2001 to provide for a requirement to assess the capacity of a person applying to be admitted to a mental hospital on a voluntary basis. This means that there is correspondingly no

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[94] *See Re Philip Clarke* [1950] IR 235; *Croke v Smith (No 2)* [1998] 1 IR 101 (Supreme Court); 27 and 31 July 1995, Unreported, High Court (Budd J); and *Gooden v St. Otteran's Hospital* [2001] IESC 14; [2005] 3 IR 617.

[95] *MMcN & Anor. v The Health Service Executive* [2009] IEHC 236.

requirement under the Act to assess a voluntary patient's capacity to consent to treatment. Consequently the voluntary patient must rely on the provisions of the common law on consent to treatment, and where a voluntary patient is considered to be incapable of providing a valid consent to treatment under the common law rules, their physicians are then forced to either rely on the common law doctrine of necessity to justify the treatment administered, or to effect an involuntary detention of the patient under section 23 of the MHA 2001.

The common law provides a general rule that no medical treatment may be administered without a patient's consent, or it becomes in law a battery,[96] and this general rule applies equally to general medical and to psychiatric treatments. Davies describes the right of personal security as one of 'the immutable laws of nature'.[97] In Ireland, while it is imbued in the rights to privacy and dignity that a person should never be subjected to a medical treatment to which they have not given an informed consent, in fact, the doctrine of informed consent is a relatively recent concept and is as yet somewhat unclear and underdeveloped in Irish law.[98] Donnelly posits that informed consent is more of an ethical ideal than a strongly upheld legal principle: "although the legal understanding of informed consent owes something to the ethical ideal of informed consent, the vision enshrined in the law is a much impoverished vision."[99]

With the exception of the compelling ethical and legal questions surrounding the debate over the right to die, there can be no arena in which the meaning of informed consent is more disputed than in the involuntary treatment of mental health patients. In the realm of incapacitated patients who are not wards of court, the issue is rendered even more complicated by the commonly held but inaccurate view that family members can give consent on their behalf. This is not true of general medical treatment and neither is it true of mental health treatment.

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[96] *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914).
[97] Davies, M., *Medical Law*, 2nd ed. (London: Blackstone, 1998), 129.
[98] Law Reform Commission of Ireland, *Consultation Paper on Vulnerable Adults and the Law: Capacity* (Dublin: Law Reform Commission, 2005) paras 7.03 and 7.04, 166-167.
[99] Donnelly, M., *Consent: Bridging the Gap between Doctor and Patient* (Cork: Cork University Press, 2002), 34.

At common law it has been laid down that a valid consent to medical treatment contains three elements: (a) it must be voluntary; (b) it must be given by a patient with capacity to understand the nature and effects of the treatment; and (c) it must be given by a patient who has received appropriate information as to the details of the treatment.[100]

These principles are well understood in respect of their applicability to general medical treatment and their shortcomings have been well critiqued.[101] In the realm of psychiatric treatment, even setting aside the presence of statutory legitimisation of the administration of treatment without consent, the general rules on determining when a valid consent has been given are hopelessly inadequate. Yet, in the absence of statutory regulation of the position of the voluntary mental patient, the common law principles laid out above are the only rules which apply.

In respect of the first component of a valid consent, that is, the requirement that consent be voluntary, the applicable rule is laid down by Lord Donaldson in *In re T (Adult: Refusal of Medical Treatment)*:

> The real question in each such case is 'Does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself.'[102]

It is immediately obvious that concerns particular to mental health treatment may be raised. The environment of a mental hospital is inherently regimented and ordered for many reasons, not least among them therapeutic. Nonetheless, this may present an alien and intimidating atmosphere to the patient, which is exacerbated by the strength of statutory power wielded by the hospital staff. The stigma of being perceived as a 'crazy person' may lead to patients agreeing to treatment for a 'quiet life' (to borrow Lord Donaldson's phrase) rather than face prejudice. As such, sensitivity to the

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[100] *See* the decisions in *In Re C (Adult: Refusal of Medical Treatment* [1994] 1 All ER 819; [1994] 1 WLR 290 (High Court), *Walsh* v *Family Planning Services* [1992] 1 IR 496, *White v Fitzpatrick* (2007) IESC 51; [2008] 3 IR 551, and *Ryan and Fitzpatrick v FK and the Attorney General* (2008) IEHC 104; [2009] 2 IR 7.

[101] See Donnelly, M., *Consent: Bridging the Gap between Doctor and Patient* (Cork: Cork University Press, 2002) and Law Reform Commission of Ireland, *Consultation Paper on Vulnerable Adults and the Law: Capacity* (Dublin: Law Reform Commission, 2005), at §§ 7.03 and 7.04, 166-167.

[102] *In re T (Adult: Refusal of Treatment)* [1992] 4 All ER 749.

environmental factors surrounding a patient in a mental hospital, whether voluntary or involuntary, should be paramount when consent to mental health treatment is under scrutiny as to its voluntariness. The necessity for sensitivity to these issues was recognised by the ECtHR in its decisions in *Winterwerp*[103] and in *Herzcegfalvy*[104] but has not to date been given expression in the Irish case law on consent as it applies to voluntary mental health patients.

In *Freeman* v *Home Office (No. 2)*[105] the applicant, a prisoner serving a life term, complained that his consent to the administration of psychoactive medication was invalid. He based this claim on the fact that he felt he was not given enough information as to the nature of the treatment and its risks, and he also claimed that his consent was not voluntarily given due to the coercive nature of the prison environment. The court rejected his claim on both grounds. Brenda Hoggett describes the effect of this judgment as being that while a patient's free will may be overridden by a prison (or other coercive) environment, whether or not this in fact happened is a matter of fact to be decided on a case by case basis.[106] Peter Bartlett and Ralph Sandland, in discussing this judgment, draw attention to research which suggests that "the mere fact of being in hospital, assigned to the role of 'mental patient' is inherently coercive."[107] In the Irish context, Anne-Marie O'Neill interprets this case as being a warning to medical practitioners to "be especially careful to satisfy themselves that consent is freely given."[108]

The second component of a valid consent is that the patient must have capacity to give consent to the treatment that is proposed. The Law Reform Commission has identified two principles which may be considered central to Irish case law on determining capacity. First, the measure of capacity required is directly commensurate with the gravity of the decision involved. Second, a physician should

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[103] *Winterwerp v Netherlands* (1979) Application No. 6301/73, (1979) 2 EHRR 387.
[104] *Herczegfalvy v Austria* (1992) Application No. 10533/83, (1992) 15 EHRR 437.
[105] *Freeman* v *Home Office* [1984] QB 524.
[106] Hoggett, Brenda, *Mental Health Law*, 3rd edn. (London: Sweet and Maxwell, 1990), 208.
[107] Bartlett, Peter, and Sandland, Ralph, *Mental Health Law: Policy and Practice*, 2nd ed. (Oxford: Oxford University Press, 2003), 343.
[108] O'Neill, Anne-Marie, *Irish Mental Health Law* (Dublin: Firstlaw, 2005), 246.

not interpret a patient's capacity on the basis of any perceived ill consequences of the patient's decision.[109]

The cornerstone Irish case on consent to treatment is generally taken to be *In re a Ward of Court (No. 2)* In that case Denham J stated that the only exceptions to the requirement of obtaining consent to medical treatment, in the instance of an adult with capacity, were be (a) where the patient was unable to communicate and the treatment was necessary to treat an emergency; and (b) in the instance of the compulsory treatment of contagious diseases.[110] That case, however, concerned a ward of court, who has no legal capacity whatsoever by virtue of the wardship legislation.[111] As such, it was not necessary for the court to give consideration to the meaning of capacity to consent to treatment. As the Law Reform Commission has pointed out, this means that:

> Irish courts have not had the opportunity to set clear boundaries to the scope of the doctrine of necessity and its application to medical treatment of adults who lack capacity to consent but have not been made a ward of court.[112]

The leading Irish precedent on the administration of medical treatment in the absence of capacity to consent to that treatment is *Fitzpatrick and Ryan v FK and the Attorney General*.[113] In that case, the patient (FK) suffered a significant haemhorrage during childbirth. When the medical staff proposed a blood transfusion, which was necessary to save the patient's life, the patient refused the treatment on the grounds that her Jehovah's Witness faith did not permit her to accept blood transfusions. The hospital had prior to this point been unaware of the patient's faith, as she had previously informed the hospital that she was a Roman Catholic. The hospital at this point made an emergency *ex parte* application to Abbott J who granted an order permitting the hospital to "administer to the defendant, including all appropriate steps by way of restraint or otherwise, all appropriate medical treatment and other ancillary

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[109] Law Reform Commission of Ireland, *Consultation Paper on Vulnerable Adults and the Law: Capacity* (Dublin: Law Reform Commission, 2005) 174.
[110] *In Re a Ward of Court (No. 2)* [1996] 2 I.R. 96.
[111] Lunacy (Regulation) Ireland Act 1871.
[112] Law Reform Commission of Ireland, *Consultation Paper on Vulnerable Adults and the Law: Capacity* (Dublin: Law Reform Commission, 2005), 186.
[113] *Ryan and Fitzpatrick v FK and the Attorney General* (2008) IEHC 104; [2009] 2 IR 7.

procedures including blood transfusion and clotting agents."[114] At the *ex parte* hearing the plaintiff undertook to deliver statement of claim and the case ultimately came for hearing before Laffoy J a year later. Quoting from the decision of Denham J in *In re a Ward of Court (No. 2)* Laffoy J reiterated the importance of the principle that a competent adult is free to decline medical treatment.[115] The question for the court to consider, then, was whether FK had at the time of the refusal of the blood transfusion been competent to refuse the life-saving treatment. Laffoy J summarised the relevant English and Irish precedents on consent to treatment and formulated a six step test for the evaluation of capacity to consent to medical treatment:

1. There is a rebuttable presumption that an adult patient has capacity to make a decision to refuse medical treatment;
2. In determining whether a patient lacks capacity to refuse medical treatment whether by virtue of permanent cognitive impairment or by temporary factors the test is whether the impairments means that the patient cannot at the time the decision is made understand the nature, purpose and effect of the proposed treatment and the consequences of accepting or rejecting it;
3. The three stage test enunciated in *In Re C (Adult: refusal of medical treatment)*[116] (whether the patient has comprehended and retained the information relating to the treatment; whether the patient has believed that information; and whether the patient has weighed the treatment information, any alternative options, and the likely outcomes in the balance in making their decision to refuse that treatment) is a useful tool;
4. The treatment information by reference to which the patient's capacity to refuse treatment is to be assessed is that information the physician is under a duty to disclose;
5. A refusal to consent founded on misunderstanding or misperception of the treatment information may be evidence of a lack of capacity, however a refusal to consent founded on irrational reasons is not evidence of a lack of capacity;

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[114] *Ryan and Fitzpatrick v FK and the Attorney General* (2008) IEHC 104; [2009] 2 IR 7, at 14.
[115] *Ryan and Fitzpatrick v FK and the Attorney General* (2008) IEHC 104; [2009] 2 IR 7, at 19.
[116] *In Re C (Adult: Refusal of Medical Treatment* [1994] 1 All ER 819; [1994] 1 WLR 290 (High Court)

6. Regard must be given to the gravity of the decision in terms of the likely consequences of acceptance or rejection of the treatment, and in terms of the civil law standard of proof the court should consider this in considering the weight to be given to the evidence before it.[117]

Laffoy J ultimately held that the order granted by Abbott J was justified in the circumstances of this case and that the physicians treating FK did not act unlawfully in administering the blood transfusion to her. In concluding that the physicians and the Court at the *ex parte* application acted reasonably in concluding that FK did not have capacity to refuse the proposed treatment, Laffoy J stated that "[o]n the evidence available before the making of the *ex parte* application, the plaintiffs were objectively justified in doubting Ms. K.'s capacity to refuse a blood transfusion."[118]

Fitzpatrick and Ryan v FK and the AG concerns general medical treatment. There is no Irish law on capacity to consent to mental health treatment outside of the MHA 2001's provisions for involuntary patients. With respect to mental health treatment clear boundaries are needed in respect of four distinct groupings of patients: (a) wards of court (who have no capacity to consent to or refuse treatment); (b) voluntary mental patients who have capacity; (c) voluntary mental patients who may not have capacity (the 'de facto detained' or 'compliant incapacitated' patients); and (d) involuntary patients.

Wards of court and involuntary patients are regulated for consent at statute. For voluntary patients, there are no authoritative Irish dicta on the meaning of capacity to consent to treatment in the context of mental health and accordingly English case law in this area may be of persuasive authority. The crux of the issue comes down to the court's construction of the voluntary patient's mental illness and its perceived impact on his capacity to consent to treatment.

[117] *Ryan and Fitzpatrick v FK and the Attorney General* (2008) IEHC 104; [2009] 2 IR 7, at 40-42.
[118] *Ryan and Fitzpatrick v FK and the Attorney General* (2008) IEHC 104; [2009] 2 IR 7, at 83.

Mention has already been made above of the leading case in this regard in England, the decision of the House of Lords in *In re C (Adult: Refusal of Medical Treatment)*[119] (as reiterated more recently in *Re W (Adult: Refusal of Treatment)*).[120] A three step test is laid down by these cases: (a) can the patient understand the information in relation to the treatment?; (b) can the patient believe the information?; and (c) can the patient weigh the information in the balance to arrive at a choice? This test is often interpreted as meaning that if the patient can understand the 'nature, purpose and effects' of a proposed treatment, then he has capacity to give or refuse consent to that treatment. The test applies equally to general medical treatment and mental health treatment.

In *In Re C*, the patient, who had been compulsorily detained at Broadmoor Mental Hospital since the 1960s for treatment of paranoid schizophrenia, was suffering from a gangrenous infection. His medical team feared that unless an amputation was carried out, the infection would lead to his death. C, however, refused the treatment, and the approval of the court was sought to carry out the amputation without his consent. This approval was not given as notwithstanding the symptoms of his mental illness (which included a delusional belief that he was a world-renowned medical doctor) the court felt that C had demonstrated an understanding of the nature, purpose and effects of the proposed amputation, and was accordingly perfectly within his legal rights to refuse to give consent to the treatment. C ultimately recovered from the gangrenous infection, without the need for amputation of his leg.

Some commentators argue that while the principle in *Re C* is sound, the true bone of contention lies in the courts' interpretations of when a mental illness may impact on a patient's understanding and when it may not. Several analyses have been put forward, including the suggestion that the courts' decisions are representative of a broader gendered approach toward mental illness which prevails in psychiatry and in society generally.[121] Alternatively, it is possible to construe the courts' decisions as being coloured by primarily by the urgency of the case – in short, the more urgent the

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[119] *In Re C (Adult: Refusal of Medical Treatment* [1994] 1 All ER 819; [1994] 1 WLR 290 (High Court).
[120] *In Re W (Adult: Refusal of Treatment)* [2002] EWHC 901 (Fam).
[121] *See* Bartlett, Peter, and Sandland, Ralph, *Mental Health Law: Policy and Practice*, 2nd ed. (Oxford: Oxford University Press, 2003), 352-358.

situation, the greater the likelihood of the courts interpreting the refusal to consent as being predicated on the symptoms of the patient's mental illness and therefore lacking in the requisite understanding.[122]

For example, in *Re C*, by the time the case came to the House of Lords, the infection had abated in response to more conservative treatment and C's life was no longer in danger. By contrast, in *B* v *Croydon Health Authority* a patient, suffering from a personality disorder, who was in imminent danger of starving to death while she refused to accept nutrition through a nasogastric tube, was held not to have capacity to make this healthcare decision and accordingly her refusal to consent was overridden.[123]

McMahon and Binchy warn that "paternalism... should not be let to run rampant, merely because the object of the benevolent intervention lacks the capacity to refuse it."[124] In light of the rulings described above, the conclusion must be that in the interpretation of when a mental illness may impinge on a person's capacity to consent to medical treatment, paternalism remains the guiding principle.

The third requirement for a valid consent to treatment is the rule that the consent must be given by a patient who has received appropriate information as to the details of the treatment. 'Informed' consent requires the disclosure of any information a reasonable patient would wish to have disclosed, however, there is confusion as to how this standard should apply for the purposes of determining ability to give a valid consent to mental health treatment, as the notion of a 'reasonable mental patient' feels axiomatic to conventional paternalist jurisprudence. As with the issue of capacity, there is a dearth of Irish case law on this issue, and accordingly it is necessary to look at English judgments for possible sources of guidance.[125]

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[122] Bartlett, Peter, and Sandland, Ralph, *Mental Health Law: Policy and Practice*, 2nd ed. (Oxford: Oxford University Press, 2003) 359-361.
[123] *B* v *Croydon Health Authority* [1995] 1 All ER 683 (Court of Appeal).
[124] McMahon, Brian, and Binchy, William, *Law of Torts*, 3rd ed. (Dublin: Butterworths, 2000), para 22.73.
[125] See *O'Donovan* v *Cork County Council* [1967] I.R. 173; *Dunne* v *National Maternity Hospital and others* [1989] IR 91; *Walsh* v *Family Planning Services and others* [1992] 1 I.R. 496; and *Geoghegan* v *Harris*, Unreported, High Court, 21 June 2000, for authoritative Irish decisions on the disclosure requirement in respect of consent to general medical treatment.

The classic case with regard to informed consent to mental health treatment is *Bolam* v *Friern Hospital Management Committee*[126] which was discussed in detail at § 1.4.2 (c) above. In that case, as the omission to disclose the risks of not providing a muscle relaxant during the administration of electro-convulsive therapy (ECT) was in line with common medical practice at the time, there was no breach of the standard of care and accordingly there was no negligence. This principle was reiterated in *Sidaway* v *Board of Governors of the Bethlehem Royal Hospital and the Maudsley Hospital*,[127] in which a 1-2% risk of adverse side effects ranging from 'mild' to 'catastrophic', associated with the treatment, had not been disclosed to the patient. The court applied the ruling in *Bolam* and held that as the physician had acted in accordance with 'a practice accepted as proper by a body of responsible and skilled medical opinion' with respect to disclosure, there was no negligence. While the outcome of the differing rationales was the same, the *Sidaway* case contained a number of differing interpretations of the standard of care in respect of disclosure. These varied from the traditional *Bolam* view that disclosure is a matter of clinical discretion (Lord Diplock), to the more radical view that full disclosure of all material facts must be made (Lord Scarman). The interpretation of disclosure that has come to be accepted as the binding precedent of the *Sidaway* judgment is that of Lords Bridge and Keith, who endorsed the *Bolam* test but with the added element that disclosure of a risk is required if disclosure of that particular risk was "so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it."[128]

The later case of *Bolitho* v *City and Hackney Health Authority*[129] requires that any body of medical opinion relied on by a physician seeking to avail of the *Bolam* defence must be reasonable or responsible, and capable of withstanding logical analysis. This decision is sometimes interpreted as having overturned *Bolam*, however, such an analysis cannot be correct. *Bolitho* merely restricts the ambit of the

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[126] *Bolam* v *Friern Hospital Management Committee* [1957] 2 All E.R. 118.
[127] *Sidaway* v *Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871.
[128] *Sidaway* v *Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, 900. In that case Lord Templeman also gave judgment, holding that a physician must provide the patient with whatever information is necessary to make a balanced judgment. This would appear to fall somewhere between the middle ground of Lords Bridge and Keith, and the more demanding approach of Lord Scarman.
[129] *Bolitho* v *City and Hackney Health Authority* [1997] 4 All ER 771.

Bolam defence to sensible medical opinion, and surely no court would have permitted a physician to rely on an unreasonable, irresponsible, or illogical body of medical opinion, even under the original formulation of *Bolam*.

Thus, in upholding the traditional view that it is a physician's prerogative to decide which risks should be disclosed, and notwithstanding the requirement of disclosure of any risk that a reasonably prudent physician would disclose, and the *Bolitho* ruling, *Sidaway* still resonates with overtones of judicial and medical paternalism. Nonetheless, despite the desire to move away from the traditional paternalist attitudes, there are those who see some merits in the *Sidaway* approach to disclosure, as least insofar as the mental patient is concerned. This is because it is felt that a doctrine of informed consent which places the emphasis on disclosing as much information as the patient is capable of understanding may lead to disclosure being interpreted in light of capacity, with all of the concomitant problems discussed above. An over-emphasis on what the patient understands, rather than on what the patient wants, may be detrimental in the arena of consent to mental health treatment.[130]

In the Irish Medical Council's Guide to Ethical Conduct and Behaviour there is a requirement that a physician use appropriate terminology to facilitate a patient's understanding of a proposed treatment.[131] There is a danger here that the demerits of the informed consent approach (over-emphasis on a patient's ability to understand) may become allied with judicial tolerance of inappropriate medical paternalism (the physician decides what to disclose based on his interpretation of what the patient is and is not capable of understanding) to doubly disadvantage the mentally ill patient. The result may be court-sanctioned under-disclosure of the particulars of a treatment, grounded either in a physician's over-simplification of information (as a result of the informed consent approach) or a physician's decision not to provide information (as a result of paternalist beneficence).

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[130] See for example the discussion in Goldstein, J., "For Harold Lasswell: Some Reflections on Human Dignity, Entrapment, Informed Consent and the Plea Bargain" (1975) 84 *Yale Law Journal* 683, and the discussion in Hoggett, Brenda, *Mental Health Law*, 3rd edn. (London: Sweet and Maxwell, 1990) 209.

[131] Irish Medical Council, *Guide to Ethical Conduct and Behaviour*, 7th edn. (Dublin: Irish Medical Council, 2009), at 34 and 36.

The MHA 2001 Act, in Part 4 of the Act, does contain safeguards around the issue of consent for involuntary patients. This is a positive and encouraging step. Given the degree of control exercised over the autonomy and privacy of involuntary patients, as they are subject to a regime of legal compulsion, the importance of clear human rights based standards in respect of consent to treatment is paramount. Unfortunately none of the safeguards around consent to treatment are extended to voluntary patients.

Furthermore, as was noted at § 1.4.2 (c) above, the utilisation of the paternalist approach to interpreting the provisions of the MHA 2001 has resulted in a restrictive application of the protections in the Act. Rather than focussing on maximising the rights of patients to make decisions pertaining to their care and treatment, the case law to date has been concerned to safeguard the position of the patient's medical carers and legal representatives as decision-makers for the patient. In *EJW (APUM) v Watters* Peart J relied on s 4 of the MHA 2001 to hold that the paternalistic character of the mental health law regime required an incapacitated involuntary patient's right to privacy over her medical records be limited in her best interests, in order that her legal representative could have sight of her records prior to her Mental Health Tribunal hearing.[132] While the decision in this instance resulted in the right factual outcome for the patient, and in the maximisation of her right to fair procedures, the utilisation of the paternalist philosophy rather than a human rights based approach to achieve the outcome was disappointing.

The law in respect of consent to treatment continues to raise serious concerns in respect of the rights to dignity, autonomy, bodily integrity, and privacy. Both the legislative and common law regimes can accommodate a situation where a person with full capacity to consent to or to refuse treatment – voluntary patients, compliant incapacitated patients, and involuntary patients who have capacity in respect of this particular decision – may have their refusal overridden. It must be stressed that it is not the author's intention to suggest that clinicians would in a calculated fashion set out to abuse patients' human rights in this way, or that they would do so out of a carefree attitude to patients' rights. However, in the context of a legislative regime where clinicians are required by legislation to have due regard to the 'best interests'

[132] *EJW (APUM) v Watters and Ors* [2008] IEHC 462.

of the patient, coupled with a common law philosophy that stresses a paternalist approach to the determination of what is or is not in a patient's 'best interests', and that applies to the evaluation of their ability to consent, considerable room for error remains.

5.3.3 (c) Administration of ECT to 'unwilling' involuntary patients, and to voluntary and compliant incapacitated patients

Specific protection is given in the MHA 2001 to involuntary patients it is proposed to treat with ECT, in s 59(1) of the Act and in the regulatory Code published by the Mental Health Commission.[133] As was noted at § 1.4.2 (c) above the procedures providing for the administration of ECT to involuntary patients who lack the capacity to consent to it are the subject to a private members bill (the Mental Health (Involuntary Procedures) (Amendment) Bill 2008[134]) that currently stands adjourned before the Seanad pending the introduction of the proposed capacity legislation.[135] The amendments proposed in this legislation reflect the pressing concerns that have been highlighted by commentators on the area, most particularly the deletion of the provision in MHA 2001, s 59 providing for the administration of ECT to an involuntary patient who is 'unwilling due to their mental illness' to consent to the treatment.[136]

Additional criticisms of the ECT provisions in the MHA 2001, s 59(1) have been made in this work: (a) that there is no requirement that the treatment be 'necessary' or 'appropriate' beyond the paternalistically interpreted 'best interests' requirement in s

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[133] Mental Health Act 2001, s 59(2).
[134] Mental Health (Involuntary Procedures) (Amendment) Bill 2008 (Seanad) (Private Members Bill) (No. 36 of 2008).
[135] Moloney, John, Seanad Debates Vol. 190 No. 6 *Mental Health (Involuntary Procedures) (Amendment) Bill 2008: Second Stage* 25 June 2008, 491-492 <http://debates.oireachtas.ie/seanad/2008/06/25/00013.asp> accessed 23 January 2011.
[136] De Búrca, Déirdre, Seanad Debates Vol. 190 No. 6 *Mental Health (Involuntary Procedures) (Amendment) Bill 2008: Second Stage* 25 June 2008, 482, <http://debates.oireachtas.ie/seanad/2008/06/25/00013.asp> accessed 23 January 2011. *See* Donnelly, Mary, "Patients' Rights and ECT" *Irish Times Letters to the Editor* 2 July 2008 and College of Psychiatry of Ireland, *ECT Information Pack* (Dublin: College of Psychiatry of Ireland, 2010), 9, 'Tuesday 9th March 2010: Seanad All-Party Briefing on the administration of Electroconvulsive Therapy: College of Psychiatry of Ireland Recommendations', paras 1 and 2 <http://www.dohc.ie/issues/ect/ECT_information_pack.pdf?direct=1> accessed 23 January 2011.

4 of the Act, which we have seen is interpreted according to a paternalist, rather than a human rights, philosophy), and (b) that there is no requirement that the consultant psychiatrists reach their conclusion to approve of the treatment independently of one another.

None of MHA 2001 Part 4 protections apply to voluntary patients, who represent 80% of the recipients of ECT treatment in Ireland.[137] While involuntary patients receive the protection of detailed statutory provisions in respect of consent to ECT (and to other forms of psychiatric treatment, including medication and psycho-surgery), voluntary patients must rely on the protection of the common law.

The problems from a human rights perspective of relying on the paternalist approach to consent adopted in the common law principles have already been canvassed. Voluntary patients are further excluded from the review mechanisms of the Mental Health Tribunals, who oversee the administration of ECT under the compulsion powers in the MHA 2001, s 59(1).

It is possible that at law a voluntary mental health patient could be administered a course of ECT treatments against their wishes, and that the facility performing the treatment could successfully rely on the common law doctrine of necessity to defend their actions. The possibility of this occurring in respect of a compliant incapacitated patient is not in fact a remote one. It must be reiterated that it is not suggested that mental health physicians would undertake such a course of action lightly, or otherwise than in what they believed to be the patient's best interests.

The only alternative course to adopt in a situation where it is believed that ECT would benefit a compliant incapacitated voluntary patient would be admit the patient under the involuntary patient provisions of the MHA 2001. The 'escalation' of the use of compulsion in this manner is not always appropriate and the patient's physicians may wish for therapeutic reasons to avoid the use of the compulsory admission procedures under the MHA 2001. The complete absence of a human rights based review or

[137] Mental Health Commission, *Report on the Use of Electroconvulsive Therapy in Approved Centres in 2008* (Dublin: Mental Health Commission, 2009), 10, <http://www.mhcirl.ie/Publications/Report_on_the_use_of_ECT_in_Approved_Centres_in_2008.pdf> accessed 23 January 2011.

oversight of the administration of psychiatric treatments to voluntary or compliant incapacitated patients is a serious failing in the MHA 2001.

5.4 Equality Claims

Equality claims, or 'freedom from discrimination' claims, take as their core the entitlement to be treated in the same manner as other people who are similarly situated.[138]

In a mental health case an equality or non-discrimination claim may take the form of an argument seeking to achieve parity under the mental health law between particular categories of patients; or an argument that in the provision of a public service or in the workplace the claimant was subjected to discrimination on the basis of their suffering from a mental illness.

5.4.1 Equality Claims in International Human Rights

The UDHR[139] and the ICCPR[140] explicitly protect the right to equality and prohibit discrimination on specified grounds. Neither of these provisions, however, prohibits discrimination the basis of a mental health disability. That protection is to be found in Article 5 of the CRPD,[141] which provides for formal equality and for the provision of reasonable accommodation for people with disabilities where necessary to secure equality.

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[138] Kimber, Cliona, "Equality Disability (Part I)" (2001) 6 (9) *Bar Review* 494; Kimber, Cliona, "Equality Disability (Part II)" (2001) 7 (2) *Bar Review* 66; Smith, Olivia, "Side-Stepping Equality? Disability Discrimination and "Generally Accepted Qualifications" (2008) 30(1) *Dublin University Law Journal* 279; Doyle, Oran J., *Constitutional Equality* (Dublin: Thomson Round Hall, 2004); Gostin, Lawrence O. and Gable, Lance, "Global Mental Health: Changing Norms, Constant Rights" (2008) 9 *Georgetown Journal of International Affairs* 83.

[139] United Nations, *Universal Declaration of Human Rights*, (1948) G.A. Res. 217A, U.N. GAOR, 3rd Sess. U.N. Doc. A/311, Article 7.

[140] United Nations, *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, Article 26.

[141] United Nations, *Comprehensive and Integral Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities*, G.A. Res. 168, U.N. GAOR, 56th Sess., 88th plenary meeting, U.N. Doc. A/56/583/Add.2 (New York: United Nations, 2001), Article 5.

Importantly, the CRPD also requires that States safeguard the right of people with disabilities to legal capacity as persons before the law, and requires States to adopt a functional model of capacity rather than a status-based one.[142]

Article 14 of the ECHR[143] and Protocol 12 to the ECHR[144] also prohibit discrimination. The ECHR protection however, is an ancillary right only. In order to make a claim under Article 26 the discrimination that is complained of must have been a discrimination in the performance of an action that is encompassed by one of the other articles of the ECHR. In *Pretty v United Kingdom*[145] the ECtHR held that a discrimination may be permissible if there is an 'objective and reasonable justification" for it. In *Pretty* the United Kingdom's refusal to make accommodation for the applicant's disability (which would have necessitated granting impunity to her husband in assisting her to commit suicide) was justified in that the State in making the accommodation would "seriously undermine the protection of life which the 1961 Act was intended to safeguard and greatly increase the risk of abuse."[146]

5.4.2 Equality Claims Under the Irish Constitution

Article 40.1 of the Irish Constitution provides for a right for all citizens to be 'held equal before the law', subject to a proviso that the State may in its enactments take account of differences of 'capacity, physical and moral, and of social function.'[147] Academic commentators have interpreted Article 40.1 as a prohibition on arbitrary, unreasonable or unjust discrimination rather than as a guarantee of equality.[148]

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[142] United Nations, *Comprehensive and Integral Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities*, G.A. Res. 168, U.N. GAOR, 56th Sess., 88th plenary meeting, U.N. Doc. A/56/583/Add.2 (New York: United Nations, 2001), Article 12.

[143] European Convention on Human Rights, Article 14.

[144] Council of Europe, *Protocol Number 12* <http://conventions.coe.int/Treaty/Commun/ChercheSig.asp?NT=177&CM=8&DF=7/6/2009&CL=ENG> accessed 19 July 2010.

[145] *Pretty v United Kingdom*, Application No. 2346 of 2002 (judgment delivered 29 April 2002).

[146] *Pretty v United Kingdom*, Application No. 2346 of 2002 (judgment delivered 29 April 2002), at para 89.

[147] *Bunreacht na hÉireann 1937* (Dublin: Government Publications Office), Article 40.1.

[148] Casey, J. *Constitutional Law in Ireland*, 3rd edn. (Dublin: Round Hall Sweet and Maxwell, 2000), 450. *See* also Hogan, Gerard and Gerry Whyte, eds, *JM Kelly's The Irish Constitution*, 4th ed (Dublin: Butterworths, 1994), 1323-1324 and more generally Doyle, Oran J, *Constitutional Equality* (Dublin: Thomson Round Hall, 2004).

The case law interpreting the Article 40.1 equality provision has not been expansive in its approach to equality. In *Murphy v Attorney General* Kenny J held that an inequality will not be set aside as unconstitutional "...if any state of facts exists which may reasonably justify it."[149] This sets a very high bar to be met before a provision will be found to be unconstitutionally discriminatory. In *Draper v Attorney General* the cost involved in providing a postal vote to people with disabilities was held to be a reasonable grounds to justify the discrimination.[150] Casey describes this as "another example of extraordinary deference to legislative judgment."[151]

The decision in *State (H) v Daly*[152] demonstrates the consequences of this approach in the context of mental health law. The applicant in that case challenged the constitutionality of certain provisions of the 1945 Act under Article 40.1. The argument he made was that when the Minister for Justice appointed an inspector to review detained patients, the inspector was under a duty to provide a report on the legality of the detention of patients in institutions other than the Central Mental Hospital ('CMH'), but did not have to report on the legality of the detention of CMH patients. Finlay P held that since there was nothing preventing the inspector from providing such a report on his own initiative, and since the President of the High Court could order the provision of a report, the discrimination in the legislation affected 'nothing of substance'[153] and as such did not breach Article 40.1.

5.4.3 Audit of Irish Mental Health Law for Compliance with International Human Rights Standards: Equality Claims

The adoption of the Disability Strategy 2004 promoted the use of the functional model of disability and ushered in a series of enactments intended to mainstream disability services provision and improve access to disability services for people with

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[149] *Murphy v Attorney General* [1982] IR 241 (Supreme Court), at 284 (Kenny J).
[150] *Draper v Attorney General* [1984] IR 277. Casey describes this as an example of 'extraordinary deference' to the legislature, *see* Casey, J. *Constitutional Law in Ireland*, 3rd edn. (Dublin: Round Hall Sweet and Maxwell, 2000), 466.
[151] Casey, J. *Constitutional Law in Ireland*, 3rd edn. (Dublin: Round Hall Sweet and Maxwell, 2000), 466.
[152] *State (H) v Daly* [1977] IR 90 (Finlay P).
[153] Casey, J. *Constitutional Law in Ireland*, 3rd edn. (Dublin: Round Hall Sweet and Maxwell, 2000), 470.

disabilities[154] and ensure their equal participation in society.[155] The National Disability Strategy comprises the Education for Persons with Special Educational Needs Act 2004; the Disability Act 2005; and the Citizens Information Act 2007.

The Disability Strategy enactments provide significant and important protections against discrimination for people with disabilities, mandating the provision of a disability assessment[156] and a service statement including a statement of the health or education services (or both) to be provided to the recipient within a specified time period.[157] These provisions are currently in place for children who were under the age of five years on 1 June 2007.[158] Similarly, the Education for Persons with Special Educational Needs Act 2004 introduces a presumption that children with disabilities will be educated in mainstream schools and provides for assessments and the provision of education plans to ensure that reasonable accommodation is made in order to ensure the child receives education appropriate to their needs.[159] The Act provides for a presumption that a child with a disability will be educated in mainstream schooling so long as that is in the best interests of the child and that the child's presence would not prevent the effective education of other children,[160] for assessments of a child's special educational needs[161] and for the provision of educational plans.[162] Detailed provisions prohibiting discrimination in the workplace on the basis of a disability and in the provision of public services are provided by the Equal Status Act 2000, the Equality Act 2004 and the Employment Equality Act 1998.[163]

The constitutional status enjoyed by the right to equality and the significant legislative enactments in recent years seeking to promote equality and inclusion in society for

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[154] Department of Justice, *Announcement on the Launch of the National Disability Strategy* (Dublin: Government Publications, 2004) <http://www.justice.ie/en/JELR/Pages/National_Disability_Strategy> accessed 20 September 2010.
[155] Department of Health, *Towards 2016 Strategic Document: National Disability Strategy Vision Mission and Strategic Objectives* (Dublin: Government Publications, 2009) <http://www.dohc.ie/publications/pdf/nds_towards_2016.pdf?direct=1> accessed 20 September 2010.
[156] Disability Act 2005, s 9.
[157] Disability Act 2005, s 11.
[158] Disability Act (Commencement) Order 2007, S.I. No. 234 of 2007.
[159] Education for Persons with Special Educational Needs Act 2004, Long Title.
[160] Education for Persons with Special Educational Needs Act 2004, s 2.
[161] Education for Persons with Special Educational Needs Act 2004, s 4.
[162] Education for Persons with Special Educational Needs Act 2004, s 8.
[163] Employment Equality Act 1998, s 16, as amended by the Equality Act 2004, s 9; and Equal Status Act 2000, s 3(2)(g) and s 4.

people with disabilities are positive steps that assist in safeguarding the human rights of people with disabilities. In this much, Irish law is doing well in measuring up to the standards established in the international human rights framework.

However, the constitutional and legislative provisions on equality are limited in their scope and constricted in their interpretation by the narrow construction of equality adopted by the courts to date. In the context of the disparity in the protections afforded the three categories of (a) voluntary; (b) compliant incapacitated; and (c) involuntary patients the shortcomings of the equality provisions are very clear. Furthermore, the extent to which the Disability Strategy and the provisions of the 2001 Act succeed in meeting the requirements of the CRPD on non-discrimination remains questionable.[164]

5.5 Affirmative Rights Claims

'Affirmative rights claims' is the term used here to describe rights seeking to articulate an entitlement to a particular service or to a particular minimum standard of services, such as for example access to mental health care, or to particular mental health services. In the Irish context they have in recent years been presented as arguments for an entitlement to education where the provision of certain mental health treatments or services are argued to be essential to the ability of the claimant to participate in education, or where the provision of education is argued to be essential to the maintenance of the claimant's mental health.

5.5.1 Affirmative Rights Claims in International Human Rights

Article 25 of the UDHR provides for a right to a standard of living which is adequate for health and well-being, with specific recognition of the need for access to medical

[164] Flynn, Ellionóir, "Ireland's Compliance with the Convention on the Rights of Persons with Disabilities: Towards a Rights-Based Approach for Legal Reform?" (2009) 16 (1) *Dublin University Law Journal* 357.

care in circumstances of ill health and old age.[165] There is no right to health or to health care recognised in the ICCPR. Article 12(1) of the ICESCR contains an explicit protection of a right to health,[166] which is subject to the 'progressive realisation' standard of implementation.[167] Article 12 mandates that health care services must be available; accessible; appropriate to people's needs; and of a good quality.[168] General Comment 14 of the Committee on Economic, Social and Cultural Rights clarifies that the right to health does not imply a right to be healthy, but that it requires States to guarantee to individuals the freedom to control their health and body (essentially a right to autonomy) and to guarantee a system of health protection which provides equality of opportunity for that individual to enjoy the highest attainable level of health.[169]

Article 25 of the CRPD provides for a right to health in the context of protecting the rights of persons with disabilities.[170] The right to health protections in the UN human rights framework may be limited where the limitation is considered necessary to promote the general welfare of society.[171] The provisions of the numerous secondary UN human rights documents that deal specifically with the right to health have been discussed in detail at § 2.7.1 above.[172]

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[165] United Nations, *Universal Declaration of Human Rights*, (1948) G.A. Res. 217A, U.N. GAOR, 3rd Sess. U.N. Doc. A/311, Article 25.
[166] United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3, Article 12.
[167] United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3, Article 2.
[168] United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3, Article 12 (2).
[169] United Nations Office of the High Commissioner for Human Rights, *General Comment 14 of the Committee on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health* (Geneva: UNHCR, 2000), para 8.
[170] United Nations, *Comprehensive and Integral Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities*, G.A. Res. 168, U.N. GAOR, 56th Sess., 88th plenary meeting, U.N. Doc. A/56/583/Add.2 (New York: United Nations, 2001), Article 25.
[171] United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3, Article 4; UN Commission on Human Rights, *The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, 28 September 1984, E/CN.4/1985/4 <http://www.unhcr.org/refworld/docid/4672bc122.html> accessed 24 May 2010; and United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (New York: United Nations Secretariat Centre for Human Rights, 1991); (1991) G.A. Res. 119, U.N. GAOR, 46th Sess., U.N. Doc. A/46/49, Supp. No. 49, Annex, 188-92.
[172] United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (New York: United Nations Secretariat Centre for Human Rights, 1991); (1991) G.A. Res. 119, U.N. GAOR, 46th Sess., U.N. Doc. A/46/49, Supp. No. 49, Annex, 188-92; United Nations, *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities*, (1993) G.A. Res. 96, 48th Sess., U.N. Doc. A/48/627 <http://www.un.org/documents/ga/res/48/a48r096.htm>

The ECHR does not protect a right to health and the only circumstances within which health rights claims have been pleaded before the ECtHR are cases based on the right to life protected in Article 2 of the Convention. In *X v Ireland* the Court held that a child with profound disabilities had been provided with adequate medical treatment by the State, and that her parents' claim on her behalf that the failure of the State to provide additional treatment violated her right to life under Article 2 was unsuccessful.[173] Article 11 of the European Social Charter (ESC) protects the right to protection of health.[174] The ESC is enforced by means of a self-reporting mechanism in which the State sends regular reports on the progress achieved in the implementation of the rights under the Charter to the European Committee of Social Rights.

The right to education is protected under Article 26 of the UDHR[175] and under Article 13 of the ICESCR.[176] The UN has also published two General Comments on the right to education.[177] The ECHR in its main text does not provide for a right to education, but it features in Article 2 of Protocol 1 to the Convention. The ESC provides for access to education as a feature of the rights to vocational guidance (Article 9); to vocational training (Article 10); to the right of persons with disabilities to independence, social integration and participation in the life of the community (Article 15); and to the right of children and young people to social, legal and economic protection (Article 17).

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accessed 24 May 2010; United Nations Office of the High Commissioner for Human Rights, *General Comment 5 of the Committee on Economic, Social and Cultural Rights: Persons with Disabilities* (Geneva: UNHCR, 1996) <http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/CESCR%20General%20comment%205.En?Opendocument> accessed 1 October 2006; United Nations, *Declaration on the Rights of Disabled Persons* (New York: United Nations Secretariat Centre for Human Rights, 1975). G.A. Res. 3447, U.N. GAOR, 30th Sess., Supp. No. 34, at 92, U.N. Doc. A/10034 (1975); and United Nations Office of the High Commissioner for Human Rights, *General Comment 14 of the Committee on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health* (Geneva: UNHCR, 2000).

[173] *X v Ireland*, Application No. 6839/74, 7 DR 78 (1976).

[174] Council of Europe, *Revised European Social Charter 1996*, Article 11.

[175] United Nations, *Universal Declaration of Human Rights*, (1948) G.A. Res. 217A, U.N. GAOR, 3rd Sess. U.N. Doc. A/311, Article 26.

[176] United Nations, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3, Article 13.

[177] United Nations Office of the High Commissioner for Human Rights, *General Comment 11 of the Committee on Economic, Social and Cultural Rights: Plan of Action for Primary Education (Article 14)* (Geneva: UNHCR, 1999), and United Nations Office of the High Commissioner for Human Rights, *General Comment 13 of the Committee on Economic, Social and Cultural Rights: The Right to Education (Article 13)* (Geneva: UNHCR, 1999).

5.5.2 Affirmative Rights Claims Under the Irish Constitution

There is no explicit right to health in the Irish Constitution, and any prospective constitutional claimant seeking to argue an entitlement to health care would need to frame their argument in the context of the unenumerated personal rights under Article 40.3 or in the context of an equality claim under Article 40.1. The right to 'free primary education' is guaranteed in Article 42 and has been interpreted to mean the provision of free education services to children up to the age of 18 years, irrespective of their abilities or whether they may have an ongoing need for educational services thereafter.[178]

The courts have viewed arguments for affirmative rights with suspicion and have refused to make orders providing for affirmative rights of any nature (whether to housing,[179] or to the provision of education on the basis of need past the age of 18 years,[180] or to health care[181]) on the grounds that to do so would infringe upon the separation of powers and involve the judiciary in decisions pertaining to the allocation of the resources of the State, a domain which was stated to be properly belonging to the executive branch of government. In *O'Brien v Wicklow Urban District Council*[182] the High Court appeared to soften its stance on the question of the justiciability of claims to the right to the provision of housing, but the door to an argument for justiciable rights to educational or health care services remains firmly shut.[183]

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[178] *Sinnott (a minor suing by his mother and next friend) v Minister for Education, Ireland and the Attorney General* [2000] IEHC 21; [2001] IESC 63; [2001] 2 IR 545; *O'Donoghue v Minister for Health* [1996] 2 IR 20; *T.D. (a minor suing by his mother and next friend M.D.) v Minister for Education, Ireland and the Attorney General, the Eastern Health Board and by Order of the Minister for Health and Children* [2001] IESC 101; [2001] 4 IR 259; and *O'Reilly and Ors v Limerick Corporation* [1989] ILRM 181.

[179] *O'Reilly and Ors v Limerick Corporation* [1989] ILRM 181.

[180] *Sinnott (a minor suing by his mother and next friend) v Minister for Education, Ireland and the Attorney General* [2000] IEHC 21; [2001] IESC 63; [2001] 2 IR 545; *O'Donoghue v Minister for Health* [1996] 2 IR 20; *T.D. (a minor suing by his mother and next friend M.D.) v Minister for Education, Ireland and the Attorney General, the Eastern Health Board and by Order of the Minister for Health and Children* [2001] IESC 101; [2001] 4 IR 259; and *O'Reilly and Ors v Limerick Corporation* [1989] ILRM 181.

[181] *F.N. v Minister for Education* [1995] 1 IR 509, Geoghegan J. (High Court).

[182] *O'Brien v Wicklow Urban District Council*, Unreported, High Court, 10 June 1994 (Costello J).

[183] *NWHB v HW & CW* [2001] 3 IR 622.

5.5.3 Audit of Irish Mental Health Law for Compliance with International Human Rights Standards: Affirmative Rights Claims

It is important to note at the outset of this auditing exercise that in respect of the protection of the affirmative right to access to health care, the standards established at the international human rights level are of a 'softer' character than those providing for the rights to, for example, liberty or to freedom from inhuman and degrading treatment or punishment. It would not be appropriate to expect the same degree of protection of these rights in Irish law as was expected in the audits performed at §§ 5.1 to 5.4 above, as that higher degree of protection is not mandated by the international human rights framework.

In certain respects of the protection of access to health care, Irish law is doing very well. The health care system as outlined at § 1.1 above, for the most part works well in the delivery of health care to the needy. While complaints about the length of time it can take to access services abound, the health care that is provided is of a high standard and is available free of charge.[184] The disability legislation regime contains strong entitlements to assessments; to services, education, and treatment plans; and to access to services, albeit subject to resources and to the need to take into account the welfare of other citizens.[185]

The arguments for and against the recognition of socio-economic rights has been a question of extreme controversy before the Irish courts. With the Supreme Court decisions in the right to education cases in the 1990s the non-justiciability of the right to education beyond the age of 18, and of the principles contained in the Directive Principles of Social Policy portion of the Constitution is now beyond question. Whyte has suggested that the only means of bringing socio-economic rights before the courts now would be to hold a referendum to amend the Constitution to give effect to the

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[184] *See* Burke, Sara, *Irish Apartheid: Healthcare Inequality in Ireland* (Dublin: New Island Press, 2009).

[185] *See* further Flynn, Ellionóir, "Ireland's Compliance with the Convention on the Rights of Persons with Disabilities: Towards a Rights-Based Approach for Legal Reform?" (2009) 16 (1) *Dublin University Law Journal* 357. In particular, see the author's detailed evaluation of the assessments of need provided for under the National Disability Strategy, which highlights several areas in respect of which the author argues convincingly that Ireland is failing to adhere to the principle of progressive realisation required by the international human rights documents.

Directive Principles of Social Policy, or to introduce new wording providing for justiciable socio-economic rights.[186] This would certainly achieve the effect of making a right to health care justiciable, but it would be a significant undertaking to secure the requisite political appetite for such a proposal, or to mobilise public sentiment to favour the referendum.

Furthermore, the utility of such an approach may be questionable. An account was provided at § 4.2.1 above of the jurisprudence of the South African Constitutional Court on the constitutional right to health under Section 27 of Chapter 2 of the South African Constitution.[187] It was noted that the right to health in South African constitutional law is to be achieved through progressive realisation.[188] The cases on Section 27 have interpreted the right as entitling applicants to expect that the State in its allocation of health care resources will act 'reasonably',[189] in essence amount to a test that one commentator refers to as a "review of the reasonableness of government policy and implementation."[190]

It is submitted that the utilisation of this 'reasonableness review of government policy and implementation' may provide a mechanism to litigants in Ireland to articulate health care claims that do not fall foul of the Supreme Court decisions in the *Sinnott*, *T.D.*; *O'D;* and *NWHB v HW & CW* cases. A description of the unsuccessful arguments put forward by the applicants in those cases – which were founded on either the non-justiciable Directive Principles of Social Policy, or on the existence of an as yet unrecognised unenumerated right to health care or to education beyond the age of 18 – was provided at § 3.10 above. A different approach, inspired by the South African constitutional jurisprudence, could seek to judicially review the

[186] Whyte, Gerard, *Social Inclusion and the Legal System: Public Interest Law in Ireland* (Dublin: Institute of Public Administration, 2001), 55.
[187] Constitution of the Republic of South Africa 1996, Chapter 2: Bill of Rights, s 27.
[188] Constitution of the Republic of South Africa 1996, Chapter 2: Bill of Rights, s 27(2).
[189] *Soobramoney v Minister of Health (Kwa-Zulu Natal)* (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997) <http://www.saflii.org/za/cases/ZACC/1997/17.html> accessed 10 January 2011; *Grootboom and Others v Government of the Republic of South Africa and Others* (CCT38/00) [2000] ZACC 14 (21 September 2000), <http://www.saflii.org/za/cases/ZACC/2000/14.html> accessed 10 January 2011; and *Minister of Health v Treatment Action Campaign (No. 1)* (CCT9/02) [2002] ZACC 16; 2002 (5) SA 703; 2002 (10) BCLR 1075 (5 July 2002) <http://www.saflii.org/za/cases/ZACC/2002/16.html> accessed 10 January 2011 and (No 2) (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) <http://www.saflii.org/za/cases/ZACC/2002/15.html> accessed 10 January 2011.
[190] Klug, Heinz, *The Constitution of South Africa: A Contextual Analysis* (Portland, Oregon: Hart Publishing, 2010), 140.

reasonableness of the decisions of the Department of Health, the Health Service Executive, or even the Mental Health Commission in the establishment of health care policy and in its implementation. In *Meadows v Minister for Justice Equality and Law Reform* the Supreme Court held that in judicial review proceedings where the decision is of a nature that affects constitutional or ECHR rights, the court's analysis of the reasonableness of the decision must include an assessment of the proportionality of the decision in light of the human rights restrictions it may occasion.[191]

Conclusion

The audit of the compliance of Irish mental health law with international human rights standards performed in this Chapter demonstrates mixed results. It can certainly be said that in many areas Ireland is doing well in meeting the standards established by the international human rights framework. The Irish Constitution contains strong statements of the rights to dignity; liberty; fair procedures; equality; education and personal rights, and these provisions are carefully guarded by the courts. The doctrine of unenumerated personal rights provides meaningful protection to the rights to autonomy, bodily integrity and privacy and to the right to freedom from torture and from inhuman and degrading treatment and punishment.

At statute, the Mental Health Act 2001 provides for human rights oriented system of compulsory admission, detention and treatment in the mental health context. In respect of the definitions of a mental disorder and in the grounds for admission to a mental hospital and for detention the Irish provisions have been shown to be less intrusive on the right to liberty of patients than the comparable provisions under the Mental Health Act 2007 in England. The provision for automatic reviews of admission and renewal orders and the availability of appeals from the decisions of the Mental Health Review Tribunals, to the Circuit Court on a point of law or to the High Court in judicial review, is a significant improvement on the previous regime under the Mental Treatment Act 1945. The review mechanisms provide effective and vital protection for the right to fair procedures.

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[191] *Meadows v Minister for Justice Equality and Law Reform* [2009] IESC 3.

However, shortcomings are still evident in respect of a number of issues. The paternalist philosophy adopted by the judiciary in the interpretation of the MHA 2001 is not in keeping with the human rights philosophy that the Act is intended to promote. The paternalist interpretive approach is utilised as a brake on the exercise by mental health patients of their rights to liberty and to autonomy in particular where the exercise of those rights would run contrary to their treating psychiatrist's views of their needs. In some instances this deferential model of interpretation minimises rather than maximises the ability of mental health patients to exercise their rights under the international human rights frameworks.

The need to introduce new legislation to protect the rights of people who have suffered a loss of capacity is imperative. A modern capacity regime which adopts a functional approach to assessments of capacity, and which can accommodate people suffering from temporary or intermittent losses of capacity in addition to people who have suffered permanent loss of capacity would be a significant improvement on the existing wardship regime. In tandem with new capacity legislation, recognition of Enduring Powers of Attorney for medical care and treatment decisions would bolster the protection afforded to the rights to dignity, autonomy, bodily integrity and privacy.

Linked to the problems with the outdated wardship regime, the law regulating consent to mental health treatments is insufficient. The inclusion of 'unwillingness' to give consent among the grounds for the compulsory administration of ECT to an involuntary patient who has capacity to consent to treatment is an unacceptable invasion of the rights to dignity, autonomy, bodily integrity and privacy. The complete lack of regulation or safeguards around psychiatric treatment for voluntary or compliant incapacitated patients, other than at common law, is a very serious omission to protect the same rights. The common law on consent to psychiatric treatment is uncertain in Ireland, and guidance may only be sought from the persuasive English authorities and on the Irish cases dealing with deprivations of liberty and the right to privacy in the mental health context. In the Irish cases the predominance of the paternalist approach to issues in this area makes the adoption of a more expansive human rights approach to consent to mental health treatment unlikely.

The definition of a mental disorder used in the MHA 2001, while considered by many commentators to be more human rights friendly than the comparative English provision, has also been criticised for its inclusion of people with intellectual disabilities within its remit. The inclusion of these people within the compulsory mental health regime without an explicit requirement that they be suffering from a mental illness in addition to an intellectual disability is an unjustifiable encroachment on their rights to liberty and to autonomy.

Finally, the lack of an enforceable right to access health care has been controversial. However, the degree of 'value added' by the recognition of this type of rights claim remains questionable. In South African constitutional law, where this type of right has been made justiciable before the courts, this has not resulted in the granting of orders specifying the provision of particular treatments or therapy to individual patients.

In the Conclusion, next, the author's recommendations for reforms that could be introduced into Irish mental health law in order to maximise its compliance with the international human rights norms are presented. These proposals for reforms are borne out of the conclusions drawn in this Chapter in respect of the degree to which Irish law succeeds in meeting the standards established by the international human rights framework in the area of mental health. The recommendation that capacity legislation be introduced, and the need for a change of approach on the bench from a paternalist to a human rights oriented interpretation of mental health law, are suggestions that have been made by other authors in the context of reviews that have focussed on compliance with the ECHR, or on the concept of paternalism as a legal doctrine, or on the ideal of autonomy.[192] The remaining recommendations are unique

[192] *See* Donnelly, Mary, "From Autonomy to Dignity: Treatment for Mental Disorders and the Focus for Patient Rights" (2008) 26 *Law in Context* 37; Donnelly, Mary, "Legislating for Incapacity: Developing a Rights-Based Framework" (2008) 30 *Dublin University Law Journal* 395; Donnelly, Mary, "The Right of Autonomy in Irish Law" (2008) 14 (2) *Medico-Legal Journal of Ireland* 34; Donnelly, Mary, "Treatment for Mental Disorders and Protection of Patients' Rights", *Mental Health and Human Rights Seminar, Centre for Criminal Justice and Human Rights, Law Faculty, University College Cork*, 25th October 2007; Murray, Claire, "Reinforcing Paternalism within Irish Mental Health Law – Contrasting the Decisions in *EH v St. Vincent's Hospital and Others* and *SM v The Mental Health Commission and Others*" (2010) 32 *Dublin University Law Journal* 273; Murray, Claire, "Safeguarding the Right to Liberty of Incapable Compliant Patients with a Mental Disorder in Ireland" (2007) 29 *Dublin University Law Journal* 279; Keys, Mary "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 24 *Dublin University Law Journal* 26; Keys, Mary,

to this work, and to the author's knowledge have not been made in the academic literature on Irish mental health law to date.

"Issues for the New Mental Health Act" (1997) 3 *Medico-Legal Journal of Ireland* 97; Keys, Mary, "Capacity – Whose Decision is it Anyway?" *Law and Mental Health Conference, Law Faculty, National University of Ireland Galway* 17th November 2007.

Conclusion: Recommendations

Having mapped out the mental health law regime in Ireland in Chapter 1, and the 'mental health rights' that exist at the level of the international human rights framework and in the Irish constitutional human rights framework in Chapters 2 and 3, together with a comparative analysis in Chapter 4, Chapter 5 provided an audit of the state of Irish mental health law. The protections provided for 'mental health rights' as defined by the international human rights standards in the Irish constitutional, statutory, and common law provisions in the area of mental health were evaluated.

i. Positive findings from the audit of Irish mental health law

In many respects, Irish mental health law is doing a good job of meeting the standards set at the international human rights level. In respect of the seven categories of 'mental health rights' claims that were put forward for assessment in this work, there are aspects of Irish law of which we can be proud in respect of each of them:

1. The right to dignity is protected in the Preamble to the Constitution and is referenced in numerous cases on the right to life, autonomy, bodily integrity, and privacy. It is also given explicit statutory protection in the Mental Health Act 2001 (MHA 2001).

2. The right to liberty is explicitly enumerated as a human right in the Constitution and is accompanied by a right to fair procedures and to bring a *habeas corpus* challenge to an unlawful detention. The grounds for a deprivation of liberty under the mental health law are set out in exacting detail in the MHA 2001, and an automatic and independent review tribunal mechanism operates to review decisions to compulsorily admit, detain and treat people under the mental health laws. The decisions of these review

tribunals are subject to scrutiny by the High Court in judicial review proceedings.

3. The rights to autonomy, bodily integrity and privacy, and the right to freedom from torture and from inhuman and degrading treatment and punishment are protected as unenumerated personal rights under the Constitution, and feature prominently in many landmark decisions of the Supreme Court on the right to life and on medical treatment. The MHA 2001 contains a presumption of capacity to consent to treatment, and detailed provisions on the administration of psychiatric treatments to patients who lack the capacity to give consent.

4. The constitutional protection of right to substantive equality is bolstered by extensive employment law and disability law regimes that provide for reasonable accommodation of difference in order to maximise the participation in society of people with disabilities, including mental health disabilities.

5. In respect of affirmative rights, the unique Directive Principles of Social Policy in the Irish Constitution pledge support to the infirm and protection for the 'strength and health of workers', and the right to free primary education until the age of 18 is explicitly enumerated as a protected and justiciable constitutional right. The State provides a comprehensive and high quality system of universal health care which is free of charge and available to all persons in need of its services. Finally, the MHA 2001 predicates the deprivation of liberty provisions on a 'treatability requirement' that mandates the provision of treatment aimed at the alleviation of mental disorder or the amelioration of its symptoms in order to justify any involuntary admission, detention, or treatment.

ii. Shortcomings found in the audit of Irish mental health law

However, a number of areas of concern also remain. The shortcomings in Irish mental health law's compliance with the international 'mental health rights' standards could be said to cluster around five areas:

1. The continued use by the judiciary of the outmoded paternalist philosophy in the interpretation of the new human rights based mental health regime.

2. The need to introduce capacity legislation to reform the definition of a mental disorder to safeguard against inappropriate admissions in both the voluntary and involuntary categories of mental health patient and to provide for a modern guardianship regime and the recognition of Enduring Powers of Attorney in respect of health care and treatment decisions.

3. The need to reform the provisions in the MHA 2001 in respect of the involuntary administration of psychiatric treatment, most particularly in the area of electro-convulsive therapy (ECT);

4. The expansion of monitoring and review mechanisms, in the form of the extension of the remit of the Mental Health Commission to include a statutory entitlement to receipt of reports on the admission and treatment of voluntary and compliant incapacitated patients.

5. The expansion of the judicial review test of reasonableness applied to the decisions of State bodies to increase the degree of scrutiny applied to the formulation and management of policies pertaining to mental health care.

Proposals for reforms that could be introduced to address each of these issues are presented here, once again taking each of the 'mental health claims' in sequence.

iii. Recommendations: Dignity, Liberty and Fair Procedures

It is submitted that the adoption of a human rights approach in these cases would require the judiciary to look at the s 4(3) enjoinder in a different way. It would require courts to look at the legitimacy of an alleged infringement of dignity from a perspective of maximising dignity, bodily integrity, privacy and autonomy. To do this would bolster the protections provided in the MHA 2001 around deprivations of liberty and consent to treatment and increase the degree of Ireland's compliance with the international human rights standards not just in respect of dignity, but also in respect of the core human rights to liberty and autonomy.

Three proposals for reforms to Irish law are suggested to improve the degree to which Irish mental health law complies with the requirements of the international human rights framework in respect of the right to liberty.

First, the adoption of a human rights approach to the interpretation of the MHA 2001 in preference to the paternalist approach that is currently favoured would require a more searching scrutiny of the legitimacy of deprivations of liberty under the Act, most particularly in respect of compliant incapacitated patients. This would be a first step in bringing Irish law closer to the standards adopted by the ECtHR in *HL v United Kingdom*.

Second, the introduction of a modern guardianship regime based on a functional approach to capacity rather than a status approach, and providing for a guardianship system in replacement of the current wardship regime, would regularise the position at statute of compliant incapacitated patients. In this regard the recommendations of the Irish Human Rights Commission in respect of the need to require an assessment of capacity at the point of voluntary admission to a mental hospital, and to protect patients who may fall into the 'compliant incapacitated patient' category, should be adopted.[1]

[1] Irish Human Rights Commission, *Policy Paper concerning the Definition of a "voluntary patient" under s.2 of the Mental Health Act 2001* (Dublin: Irish Human Rights Commission, February 2010) at 29-30.

Finally, the role of the Mental Health Commission and the Inspector of Mental Health Services to include a strengthened supervisory function in respect of the admission and 'detention' of voluntary and compliant incapacitated patients in addition to involuntary patients could be expanded. It was noted at § 4.2.2 above that the South African Mental Health Care Act 2002 provides a mechanism whereby periodic reviews of all patients' detentions and treatment must be submitted to the Mental Health Review Board in the form of an annual report.[2] In Ireland the Mental Health Commission's inspection and review processes are curtailed in their application to voluntary patients, despite calls from the Commission for the extension of its remit in order to be able to provide additional protection to these patients (and in particular to compliant incapacitated patients present in mental hospitals on an ostensibly voluntary basis) in addition to involuntary patients.[3]

Under the present position the Inspector of Mental Health Services has a general power to review the quality of services provided to all persons receiving care in mental hospitals, and to do so may inspect any reports or request information in respect of any patient, irrespective of their status. The deployment of the full review mechanisms of the Mental Heath Tribunals' reviews of admission and renewal orders and of treatment to voluntary patients would be an unnecessary and cumbersome step, and would run counter to the therapeutic benefits of the voluntary receipt of mental health care. However, it is submitted that the introduction of a reporting obligation whereby mental hospitals provided to the Inspector of Mental Health Services a review of the status and treatments administered to each voluntary patient on an annual basis would represent a significant improvement in the protections afforded to compliant incapacitated patients in particular. This reform could be introduced in the context of the reform of the wardship procedures and alongside the introduction of guardianship mechanisms in the proposed capacity legislation.

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[2] Mental Health Care Act 2002 (South Africa), ss 34 and 37.
[3] *See* Keys, M., *Mental Health Act 2001* (Dublin: Round Hall Sweet & Maxwell, 2002), 50.

iv. Recommendations: Autonomy, Privacy and Bodily Integrity, and Freedom from Inhuman and Degrading Treatment and Punishment

The problems of the mental health law regime under the MHA 2001 and at common law in respect of the protection of patients' rights to autonomy, privacy and bodily integrity, and to freedom from torture and inhuman and degrading treatment and punishment, could be addressed by (a) the adoption of a human rights based approach to the interpretation of the regime by the courts; and (b) the expansion of the role of the Mental Health Commission and the Inspector of Mental Health Services to include a greater supervisory function in respect of the administration of psychiatric treatments to voluntary and compliant incapacitated patients in addition to involuntary patients, in the context of reform of the law on capacity.

The problems endemic in the common law on consent to treatment are described in great detail above. There is no Irish case law directly on the question of a voluntary mental patient's capacity to refuse mental health treatments recommended by his treating psychiatrist, however, the prevailing judicial preference for the paternalist approach to mental health questions would suggest that in the event that a challenge was brought before the courts an expansive and human rights based interpretation of the persuasive English authorities on this issue would be unlikely. The prevalence of the paternalist approach to the question of a mental health patient's capacity to give or to refuse consent to a particular treatment does not accord with the reality that the majority of mental patients do in fact have capacity to make these decisions.[4]

The adoption of a human rights approach to these questions would require the judiciary to favour more strongly a functional approach to capacity that did not defer to the treating psychiatrist's view of the necessity of a particular treatment but rather engaged in a more meaningful manner with the patient's ability to consent and with the reasons for the patient's decision to refuse the treatment.

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[4] *See* Appelbaum, Paul S., and Grisso, Thomas "The MacArthur Treatment Competence Study. I Mental Illness and competence to consent to treatment" (1995) 19 (2) *Law and Human Behaviour* 105-126.

The role of the Mental Health Commission and the Inspector of Mental Health Services to include a supervisory function in respect of the admission and 'detention' of voluntary and compliant incapacitated patients in addition to involuntary patients could be expanded. It has already been noted at § 5.2.5 that the introduction of an automatic reporting mechanism whereby an annual review of the admission status and any capacity concerns in respect of voluntary and particularly compliant incapacitated patients would be provided to the Inspector of Mental Health Services as part of the annual review of the standards of care provided in mental hospitals.

The introduction of a reporting obligation whereby mental hospitals provided to the Inspector of Mental Health Services a review of the status and treatments administered to each voluntary patient on an annual basis would represent a significant improvement in the protections afforded to compliant incapacitated patients in particular. A reporting obligation of this nature would provide substantial protection for voluntary patients' rights to autonomy, bodily integrity and privacy, and to freedom from torture and inhuman and degrading treatment or punishment, without imposing an administrative burden of the magnitude of the roll-out of review tribunals, or endangering the therapeutic benefits of the provision of treatment on a voluntary basis.

As was noted at § 5.2.5 above, it is submitted that this reform could be introduced in the context of the reform of the wardship procedures and alongside the introduction of guardianship mechanisms in the proposed capacity legislation.

v. Recommendations: Equality

The constitutional status enjoyed by the right to equality and the significant legislative enactments in recent years seeking to promote equality and inclusion in society for people with disabilities are positive aspects of Ireland's equality framework in terms of its assessment against the standards established by the international human rights framework.

However, as has been noted, the constitutional and legislative provisions on equality are limited in their scope and constricted in their interpretation by the narrow construction of equality adopted by the courts to date, most particularly in the context of the disparity in the protections afforded the three categories of (a) voluntary; (b) compliant incapacitated; and (c) involuntary patients the shortcomings of the equality provisions is very clear.

The disability and employment legislation protections in respect of non-discrimination would have no purchase in these situations, and the jurisprudence on Article 40.1 could rationalise the difference in treatment on the basis of, for example, medical diagnosis or temporary fluctuations in capacity that make the patient unsuitable for admission as an involuntary patient. In this respect the introduction of the proposed new capacity and guardianship regime would have the potential to result in significant improvements in terms of the equal treatment of different groups of mental health patients.

vi. Recommendations: Affirmative Claims

The arguments for and against the recognition of socio-economic rights has been a question of extreme controversy before the Irish courts. With the Supreme Court decisions in the right to education cases in the 1990s the non-justiciability of the right to education beyond the age of 18, and of the principles contained in the Directive Principles of Social Policy portion of the Constitution is now beyond question.

Whyte has suggested that the only means of bringing socio-economic rights before the courts now would be to hold a referendum to amend the Constitution to give effect to the Directive Principles of Social Policy, or to introduce new wording providing for justiciable socio-economic rights.[5] This would certainly achieve the effect of making a right to health care justiciable, but it would be a significant undertaking to secure the requisite political appetite for such a proposal, or to mobilise public sentiment to favour the referendum.

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[5] Whyte, Gerard, *Social Inclusion and the Legal System: Public Interest Law in Ireland* (Dublin: Institute of Public Administration, 2001), 55.

Furthermore, the utility of such an approach may be questionable. An account is given in § 4.2.1 above of the jurisprudence of the South African Constitutional Court on the constitutional right to health that is provided for in Section 27 of Chapter 2 of the South African Constitution[6] that is to be achieved through progressive realisation.[7] The cases on Section 27 have interpreted the right as entitling applicants to expect that the State in its allocation of health care resources will act 'reasonably',[8] which in essence amounts to a test that one commentator refers to as a "review of the reasonableness of government policy and implementation."[9]

It is submitted that the utilisation of this 'reasonableness review of government policy and implementation' may provide a mechanism to litigants in Ireland to articulate health care claims that do not fall foul of the Supreme Court decisions in the *Sinnott*, *T.D.*; *O'D;* and *NWHB v HW & CW* cases. A description of the unsuccessful arguments put forward by the applicants in those cases – which were founded on either the non-justiciable Directive Principles of Social Policy, or on the existence of an as yet unrecognised unenumerated right to health care or to education beyond the age of 18 – was provided at § 3.10 above.

A different approach, inspired by the South African constitutional jurisprudence, could seek to judicially review the reasonableness of the decisions of the Department of Health, the Health Service Executive, or even the Mental Health Commission in the establishment of health care policy and in its implementation. In *Meadows v Minister for Justice Equality and Law Reform* the Supreme Court held that in judicial review proceedings where the decision is of a nature that affects constitutional or ECHR rights, the court's analysis of the reasonableness of the decision must include

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[6] Constitution of the Republic of South Africa 1996, Chapter 2: Bill of Rights, s 27.
[7] Constitution of the Republic of South Africa 1996, Chapter 2: Bill of Rights, s 27(2).
[8] *Soobramoney v Minister of Health (Kwa-Zulu Natal)* (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997) <http://www.saflii.org/za/cases/ZACC/1997/17.html> accessed 10 January 2011; *Grootboom and Others v Government of the Republic of South Africa and Others* (CCT38/00) [2000] ZACC 14 (21 September 2000), <http://www.saflii.org/za/cases/ZACC/2000/14.html> accessed 10 January 2011; and *Minister of Health v Treatment Action Campaign (No. 1)* (CCT9/02) [2002] ZACC 16; 2002 (5) SA 703; 2002 (10) BCLR 1075 (5 July 2002) <http://www.saflii.org/za/cases/ZACC/2002/16.html> accessed 10 January 2011 and (No 2) (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) <http://www.saflii.org/za/cases/ZACC/2002/15.html> accessed 10 January 2011.
[9] Klug, Heinz, *The Constitution of South Africa: A Contextual Analysis* (Portland, Oregon: Hart Publishing, 2010), 140.

an assessment of the proportionality of the decision in light of the human rights restrictions it may occasion.[10]

A successful claim utilising this blended 'reasonableness and human rights proportionality' approach would not secure the elusive orders of *mandamus* from the courts requiring the provision of a specific medication, treatment or therapy to an individual person. Within its grasp, however, in the context of mental health context, might be a declaration that the manner in which a particular policy was formulated did not pay sufficient cognisance to the human rights of the applicant particularly and to a particular group of mental health patients more generally, and an order of mandamus requiring the respondent body to reassess the policy in place and reformulate it in a manner that more effectively protects the human rights of the applicant.

It must be noted however, that even if a litigant could persuade a court to monitor the reasonableness of an affirmative claim to mental health services in this fashion, this mechanism would not be a solution to all of the shortcomings of the current mental health law regime. Claims that would argue for the expansion of the consent to treatment protections under the MHA 2001, for example, or for the introduction of new capacity legislation, would not come under the umbrella of this type of application. In one context in particular, however, it may provide significant value added to mental health patients. The State has since the mid 1960s proclaimed a policy of transitioning the provision of mental health services from the current institutional model over to a community-based approach, but progress in achieving this goal has stalled.[11] The potential might exist for a mental health patient to argue that the decisions made by the health care bodies of the State in the conception and implementation of the successive mental health care policies could be characterised as unreasonable in that their impact on, for example, his right to receive treatment in the least restrictive setting necessary (as identified in the ECHR jurisprudence on the

[10] *Meadows v Minister for Justice Equality and Law Reform* [2009] IESC 3.

[11] See for example the *Commission of Inquiry into Mental Illness 1966* (Dublin: The Stationery Office, 1966); Department of Health, *The Psychiatric Services – Planning For The Future* (Dublin: The Stationery Office, 1984); Department of Health, *Shaping A Healthier Future: A Strategy for Effective Healthcare in the 1990s* (Dublin: The Stationery Office, 1987) and Department of Health, *Equality and Fairness: A Health System for You* (Dublin: The Stationery Office, 2001).

right to liberty[12]) is disproportionate to the aims of the decision (in particular given that international experience has demonstrated that the provision of mental health care in the community is more efficient and less of a burden on the public purse[13]).

Conclusion

The results of this 'human rights audit' of Ireland's new mental health law regime may be said to be mixed. On the one hand the constitutional, statutory and legislative protections afforded to the rights to dignity, autonomy, bodily integrity, privacy, and freedom from torture and from inhuman and degrading treatment and punishment are of a high standard. The same could not be said of the protections of the rights to equality, and to an affirmative claims to access to mental health services (albeit the 'value added' of the latter type of rights claims has been questioned).

In a number of areas, however, significant problems persist which prevent Irish mental health law from achieving its lofty goal of matching the international human rights standards in mental health. These problems cluster around the prevailing paternalist approach to the interpretation of mental health law; the lack of a modern scheme for the assessment of capacity and the protection of people who have suffered a loss of capacity; the questionability of the inclusion of intellectual disability and dementia as grounds in and of themselves for involuntary admission to a mental hospital; and the failure to extend the protections around consent to treatment to all mental health patients.

Suggestions have been provided above for the adoption of measures that could address these shortcomings, most important of which is the urgent need to adopt new capacity legislation to reform the wardship jurisdiction, close the 'Bournewood gap', and extend the protections around consent to treatment to a broader swathe of mental

[12] See for example *Aerts v Belgium* (1998) Application No. 25257/94, (1998) 29 EHRR 50; *Winterwerp v Netherlands* (1979) Application No. 6301/73, [1979] 2 EHRR 387; and *Johnson v United Kingdom* (1997) Application No. 22520/93, (1997) 27 EHRR 296.

[13] *See* Browne, Gina, Roberts, Jacqueline, Gafni, Amiram, Weir, Robin, Watt, Susan, and Byrne, Carolyn, "More effective and less expensive: lessons from five studies examining community approaches to care" (1995) 34 *Health Policy* 95 and O'Shea, Eamonn, Gannon, Brenda, Kennelly, Brendan "Eliciting preferences for resource allocation in mental health care in Ireland" (2008) 88 (2-3) *Health Policy* 359.

health patients. The possibility of adopting a more expansive approach to the judicial review of decisions on the formulation and administration of policies in the area of mental health services was also suggested as a means to compel that decision-makers in this area accord more significance to the human rights of mental health patients in the formulation and administration of mental health policies.

The adoption of these reforms, it is submitted, would result in substantial benefits to mental health service users in Ireland, would greatly improve the protection of the human rights of mental health patients, and would finally enable Irish mental health law to achieve that lofty goal of compliance with the international human rights standards on mental health.

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