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MOVING TOWARDS RIGHTS-BASED MENTAL HEALTH LAW: THE LIMITS OF LEGISLATIVE REFORM

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1. Introduction

This article examines the limitations of legislative reform in developing a rights-based model of mental health law. It argues that introducing a rights-based statutory framework is only the first step in ensuring the implementation of a model of mental health law that is truly engaged with safeguarding the rights of people with mental disorders.

Rights-based models of mental health law are now widely considered to be the norm. In many European states, including Ireland, the impetus behind the development of rights-based mental health law was the European Convention on Human Rights (ECHR).[1] The UN Convention on the Rights of Persons with Disabilities (CRPD) has added further momentum to this engagement with rights in the context of mental health law. The CRPD is understood as having introduced a paradigm shift in terms of rights discourse in relation to disability, including mental and psycho-social disabilities. At the heart of the CRPD is a commitment to positive rights, and this introduces a new perspective on discussions of rights-based mental health law.[2] This article argues that in order to achieve an effective rights-based model of mental health law a change in culture is required in addition to a new legal framework.

Despite the relatively recent commencement of the Mental Health Act 2001[3] (the "MHA 2001") mental health law in Ireland is experiencing a period of transition. The second review of the MHA 2001 is currently underway; the first review occurred very shortly after the introduction of the legislation and therefore was unable to reflect effectively on the operation of the statutory provisions in practice.[4] The Interim Report of the Steering Group on the Review of the MHA 2001 has been released and is discussed below. Another interesting aspect of Irish mental health law is that the context within which the MHA 2001 operates was transformed shortly after it became operational with the introduction of the CRPD, which Ireland signed in 2007 but has not yet ratified. The new approach to rights contained in the CRPD is beginning to filter through to policy development in this area in Ireland. This is a

* The author would like to thank Dr Mary Donnelly for her very helpful comments on an earlier draft of this article.

[1] The role of the ECHR in the development of Irish mental health law is discussed below. See also, references in Department of Health, *Green Paper on Mental Health* (Dublin, Stationery Office, 1992); and *White Paper, A New Mental Health Act* (Dublin: Stationery Office, 1995).

[2] Article 14 of the CRPD raises questions about the necessity for stand-alone mental health law, but a detailed discussion of this issue is outside the scope of this article. Article 19, which guarantees the right to live in and participate in the community, also requires a new approach to mental health law as the traditional model has developed around in-patient treatment.

[3] The substantive provisions of the MHA 2001 were commenced in November 2006 by the Mental Health Act (Commencement) Order 2006 (S.I. No. 411 of 2006). Prior to of November 1, 2006 commencement orders had been issued, bringing into effect sections of the MHA 2001 to set up the Mental Health Commission and to set out the underlying principles of the MHA 2001. See the Mental Health Act 2001 (ss.1–5, 7 and 31–55) (Commencement) Order 2002 (S.I. No. 90 of 2002).

[4] *Review of the Operation of the Mental Health Act 2001—Findings and Conclusions* was published in May 2007, available on the Department of Health website at: *www.dohc.ie* [Last Accessed February 22, 2013]. Section 75 of the MHA 2001 obliged the Minister to carry out a review of the operation of the MHA 2001 not later than five years after the establishment day, which was in April 2002.

positive development and may inform the revision of the MHA 2001. However, this article examines the factors that operate to undermine the practical effectiveness of a legislative rights-based model, which will continue to be relevant even if an improved statutory framework is put in place.

Introducing legislation intended to safeguard rights is only the starting point in ensuring adequate protection of the rights of people with mental disorders and mental disabilities. This article does not seek to undermine the importance of legislative reform. Rather, it argues that such reform is a necessary first step. Without enshrining rights in statute there is no impetus to change the existing position. The risk is that the introduction of rights-based legislation is seen as the ultimate goal and once it has been implemented there is no further questioning of its effectiveness. This article draws attention to the need for ongoing monitoring of mental health legislation intended to protect rights and also the need to engage with and inform those charged with the implementation of this legislation.

It is helpful to think of an effective rights-based model of mental health law in terms of layers. There are three layers: rights-based legislation, judicial interpretation of that legislation and implementation of the statutory provisions by those working within the mental health system. Part 2 of this article will briefly outline the relevant rights-based statutory provisions in Ireland. It is not suggested that the legislative provisions in place are ideal; indeed there are many criticisms which can be, and have been, made about the statutory framework.[5] It is hoped that the Review of the MHA 2001 will address some of these issues. The purpose of this article is not to discuss the shortcomings of the substantive provisions, but rather to argue that rights-based legislation alone, however good, is not sufficient to ensure a rights-based model of mental health law. Law does not exist in a vacuum and to be effective it must operate effectively in practice. It is therefore necessary to look beyond the mere statutory provisions and to consider the role of those charged with interpreting and implementing the legislation. This brings us to the second layer of the rights-based model. From a legal perspective the most obvious group engaged in the activity of interpretation are the judiciary.[6] Thus, Part 3 of the article interrogates the impact of judicial decision-making on the rights-based model in Ireland.[7] The experience in Ireland has been that the judiciary has significant power to dilute rights-based legislation. The courts in Ireland have also failed, in general, to engage with the ECHR and the jurisprudence of the European Court of Human Rights (ECtHR) in the context of mental health law, a factor which has contributed to the inadequate protection of rights.

Part 4 discusses the implementation of the legislative provisions on the day-to-day level by those charged with the operation of the mental health system. The need for engagement with those working within the mental health system to ensure an awareness of the rights-

[5] See *Mental Health Act 2001: A Review* (Amnesty International, 2011); Mary Donnelly, "Treatment for a Mental Disorder: The Mental Health Act 2001, Consent, and the Role of Rights" (2005) 40 *Irish Jurist* 220; Darius Whelan, "Mental Health Tribunals: A Significant Medico-Legal Challenge" (2004) 10(2) *Medico-Legal Journal of Ireland* 84; Darius Whelan, *Mental Health Law and Practice, Civil and Criminal Aspects* (Dublin: Round Hall, 2009); Claire Murray, "Safeguarding the Right to Liberty of Incapable Compliant Patients with a Mental Disorder in Ireland" (2007) 29 *Dublin University Law Journal* 279–311.

[6] There are many who work within the mental health system or who are involved in advocating for reform of the mental health system who would not consider the judiciary as an obvious group involved in the implementation and interpretation of the MHA 2001.

[7] Groups other than the judiciary also have a role in interpreting the legislation. For example, in Ireland the Mental Health Commission interprets legislation when developing Codes of Practice and drafting forms for use in the admission process. For further discussion of this see Claire Murray, "The Role of the Mental Health Commission in Irish Mental Health Law: Interrogating the Effectiveness of the Statutory Functions of the Commission" (2011) 17(2) *Medico-Legal Journal of Ireland* 93–104.

based model of mental health law has been highlighted through the Annual Reports of the Inspectorate of Mental Health Services and these will be discussed below.

It is worth noting that in addition to the increased focus on rights in the context of mental health law there is also a developing body of work that questions the effectiveness of the rights-based protections that are available, and whether the right rights are being protected.[8] There is also a growing concern about the over-regulation of mental health law. This article fits within that discourse through the exploration of the role of legislative reform in ensuring effective rights protection.

2. Rights-based mental health legislation

As noted in the introduction, there is an increasing international focus on rights-based mental health law and any discussion of the statutory model in Ireland must be situated within this context. There are two core Conventions which are relevant: the ECHR and the CRPD. The EHCR has been central to the modernisation of mental health law in Europe. The provisions of the EHCR and the jurisprudence of the ECtHR have contributed to the development of domestic rights-based mental health law in Ireland. The Government White Paper on reforming mental health law in Ireland, published in 1995, noted that the existing legislation (the Mental Treatment Act 1945) was not ECHR-compliant.[9] This concern was also evident in the Dáil debates on the introduction of the Mental Health Bill. Keys notes that there was a sense of urgency in the debates to ensure that legislation was introduced that complied with the ECHR.[10] Following the enactment of the MHA 2001, but before the commencement of the substantive provisions of the Act, the ECHR was incorporated into Irish law in the European Convention on Human Rights Act 2003 (ECHR Act 2003). This requires that in interpreting and applying any statutory provisions or rule of law, a court shall do so in a manner compatible with the State's obligations under the ECHR provisions.[11] It also states that judicial notice *shall* be taken of Convention provisions and of any judgment of the European Court of Human Rights established under the Convention (emphasis added).[12] However, there has been a notable reluctance on the part of the Irish courts to engage adequately with and to consider the ECHR in the context of mental health cases, despite the statutory requirement to do so. The message this sends out from the courts is that the

[8] Bernadette McSherry and Penelope Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010).

[9] Department of Health, *White Paper, A New Mental Health Act* (Dublin: Stationery Office, 1995).

[10] Mary Keys, *Mental Health Act 2001, Irish Current Law Statutes Annotated* (Dublin: Round Hall, 2002) at 25-04. This sense of urgency was compounded by the fact that two Irish cases on mental health law (*Croke v Smith* [1998] 1 I.R. 101 and *O'Reilly v Moroney* [1992] 2 I.R. 145) had been deemed admissible before the ECtHR, although a friendly settlement was ultimately reached in both cases.

[11] Section 2 of the ECHR Act 2003 states: "In interpreting and applying any statutory provision or rule of law, a court shall, in so far as is possible, subject to the rules of law relating to such interpretation and application, do so in a manner compatible with the State's obligations under the Convention provisions."

[12] Section 4 of the ECHR Act 2003 provides that "Judicial notice shall be taken of the Convention provisions and of—

(*a*) any declaration, decision, advisory opinion or judgment of the European Court of Human Rights established under the Convention on any question in respect of which that Court has jurisdiction,

(*b*) any decision or opinion of the European Commission of Human Rights so established on any question in respect of which it had jurisdiction,

(*c*) any decision of the Committee of Ministers established under the Statute of the Council of Europe on any question in respect of which it has jurisdiction, and a court shall, when interpreting and applying the Convention provisions, take due account of the principles laid down by those declarations, decisions, advisory opinions, opinions and judgments."

provisions of the Irish Constitution, in addition to the "paternalistic" legislative framework, are adequate to protect the right to liberty and that the ECHR offers no additional safeguards.[13] However, a recent judgment of the High Court delivered by MacMenamin J. hints at the beginning of a shift in emphasis by the courts and this issue is discussed further in Part 3.

The ECHR approach to mental health law is grounded in a traditional liberal approach to rights, with a focus on liberty and autonomy rights. It provides that these rights are not absolute and can be restricted in certain circumstances. In relation to the right to liberty, contained in art.5, these grounds include where the person is of "unsound mind".[14] The term "unsound mind" is not defined in the Convention, but it was discussed by the ECtHR in the case of *Winterwerp v The Netherlands.*[15] In that case the court recognised the changing nature of the definition of "unsound mind" as the understanding of mental disorder develops. For this reason there is no static definition, but the court did set out three conditions which must be fulfilled in addition to the general requirements of art.5(1) in order for psychiatric detention to be acceptable. These are (1) the individual must be reliably shown, by "objective medical expertise", to be of unsound mind prior to committal,[16] (2) the mental disorder must be of a kind or degree warranting compulsory confinement, and (3) the detention remains compatible with art.5(1) only as long as the disorder persists. The existence of a mental disorder is, therefore, grounds for deprivation of liberty within this framework, provided that procedural safeguards are put in place to ensure that this deprivation lasts no longer than is necessary. One of the key safeguards available to a person detained in accordance with art.5(1) is the art.5(4) requirement that states provide a remedy whereby the lawfulness of the detention can be speedily determined.[17] Periodic independent review of detention has been found by the ECtHR to be essential.[18] Bartlett notes that while there has been much litigation before the ECtHR in relation to the procedures to detain a person of "unsound mind", there has been less discussion on the substance of what precisely is a mental disorder warranting compulsory confinement.[19] The core aim of art.5 is to protect against arbitrary detention and so the ECtHR can find a detention to be in breach of art.5 even where it is lawful in the

[13] This approach was adopted by McGuinness J. in *Gooden v Waterford Regional Hospital* [2005] 3 I.R. 617. It is important to note that this case was decided under the terms of the Mental Treatment Act 1945, which was still the governing legislation in 2005.

[14] Art.5(1) provides that no one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law. Para.(e) then provides for the lawful detention of persons of "unsound mind".

[15] (1979) 2 EHRR 387 at 402.

[16] Harris, O'Boyle and Warbrick, *Law of the European Convention on Human Rights* (London: Butterworths, 1995), p.123 state that "objective medical expertise" requires a personal medical exam, other than in an emergency situation. In *X v United Kingdom* (1981) 4 EHRR 188 the court found that the detention was lawful where there had been no examination prior to re-committal because of the emergency nature of the situation. This would suggest that failure to abide by all three *Winterwerp* criteria does not automatically render a detention unlawful.

[17] This is a necessary corollary to the third *Winterwerp* criterion, that detention remains compatible with art.5(1) only for so long as the disorder continues. For a further discussion, see Harris, O'Boyle and Warbrick, *Law of the European Convention on Human Rights* (London: Butterworths, 1995), p.153. See also Genevra Richardson, "The European Convention and mental health law in England and Wales: Moving beyond process?" (2005) 28 *International Journal of Law and Psychiatry* 127.

[18] See *X v United Kingdom* (1981) 4 EHRR 188 and *Herczegfalvy v Austria* (1993) 15 EHRR 437. In *Herczegfalvy* a period in excess of one year to review detention was found to be in breach of art.5(4) of the ECHR.

[19] Peter Bartlett, "A mental disorder of a kind or degree warranting confinement: examining justifications for psychiatric detention" [2012] 16(6) *International Journal of Human Rights* 831. For a summary of the case law, see Bartlett, Lewis and Thorold, *Mental Disability and the European Convention on Human Rights* (Leiden: Martin Nijhoff, 2007), Ch.2.

context of domestic law.[20] The procedural rights-based approach contained in the ECHR is reflected in the MHA 2001 in Ireland. Involuntary detention on the grounds of mental disorder is accepted, but the statute introduces procedures intended to safeguard individuals against unlawful deprivation of liberty. However, it is questionable whether Irish mental health law, as it has been interpreted by the courts, is in accordance with the principles of the ECHR, as interpreted by the ECtHR.[21]

The traditional liberal model contained in the ECHR can be contrasted with the CRPD, which has been instrumental in reconceptualising the nature of the rights which need to be protected in relation to persons with disabilities.[22] The focus in the CRPD is very much on the social model of disability which recognises that disabilities arise as a result of the interaction between societal structures and the impairments that people have.[23] The CRPD emphasises positive rights—such as the right to live in and participate in the community[24]—and alters the traditional understanding of rights as rights to be left alone. Non-discrimination, including the provision of reasonable accommodation, is a central principle of the CRPD. The CRPD can be viewed as the new benchmark against which to measure domestic statutory provisions directed towards persons with disabilities, including mental or psycho-social disabilities. The CRPD has the potential to require a fundamental reconceptualisation of mental health law, with art.14 being particularly relevant in this regard.[25] Given that Irish mental health law may not meet the requirements of the ECHR, it is very unlikely that it will meet the obligations imposed by the CRPD. This may explain, in part, the delay by Ireland in ratifying the CRPD.

The Irish Mental Health Act 2001

When it was introduced, the MHA 2001 was described as a significant departure from the previous model of mental health law contained in the Mental Treatment Act 1945, which was very paternalistic in nature. The MHA 2001 was referred to as modern rights-based mental health law that would bring Ireland in line with international standards which, at the time, were contained in the ECHR.[26] The MHA 2001 does contain a number of important safeguards and rights which had not previously existed in Ireland, such as automatic periodic review of detention by tribunals and second-opinion safeguards for certain invasive medical treatments. As such, the MHA 2001 was undoubtedly a welcome legislative reform. It is worth considering, briefly, the core provisions contained in the statute to illustrate the nature of the rights protections available before examining the extent to which these protections have been diluted in practice.

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[20] See *HL v United Kingdom* (2005) 40 EHRR 761 and *Storck v Germany* (2006) 43 EHRR 96. Detention which is properly motivated but disproportionate can also be in violation of art.5: see *Droogenbroeck v Belgium* (1982) 4 EHRR 443. The court will look at all the circumstances of the case: *Ashingdane v United Kingdom* (1985) 7 EHRR 528.

[21] See the discussion of *EH v St Vincent's Hospital* [2009] 3 I.R. 774, below.

[22] Gerard Quinn, "The United Nations Convention on the Rights of Persons with Disabilities: Towards a New International Politics of Disability" 15 *Texas Journal on Civil Liberties & Civil Rights*, Fall 2009 at 33–53.

[23] For further discussion on the social model of disability see Don McKay, "The United Nations Convention on the Rights of Persons with Disabilities" (2006–7) 34 *Syracuse Journal of International Law and Commerce* 323.

[24] Article 19: "States Parties to this Convention recognise the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community…."

[25] Article 14(1)(b) provides that: "the existence of a disability shall in no case justify a deprivation of liberty". For a very interesting discussion on the implications of the CRPD for mental health and mental capacity law in England and Wales, see Peter Bartlett, "The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law" (2012) 75(5) *Modern Law Review* 752.

[26] See discussion in Keys, fn.10 above, pp.25–03.

The MHA 2001 provides statutory safeguards intended to guard against unlawful deprivation of liberty and to protect the autonomy of capable patients to refuse treatment. To this end it establishes a system of automatic periodic review of involuntary detention operated by tribunals.[27] Once a person is involuntarily admitted to an approved centre, he or she is entitled to legal representation[28] and he or she is to appear before a tribunal not later than 21 days following the initial admission order.[29] The tribunal is composed of a psychiatrist, a legal practitioner and a lay person[30] and the tribunal has the authority to affirm or overturn the admission order on the basis that the person is or is not suffering from a mental disorder.[31] The MHA 2001 also includes a statement to the effect that a capable adult can refuse consent to treatment.[32] However, it also provides exceptions to this in respect of treatments such as electro-convulsive therapy (ECT)[33] and long-term medication[34] and stipulates that, where a patient is prescribed those treatments and is unable or unwilling to consent, the treatment can be imposed without consent subject to a second opinion from a consultant psychiatrist. The consultant psychiatrist treating the patient chooses the second-opinion psychiatrist rather than the second-opinion psychiatrist being appointed from an independent panel.[35]

The MHA 2001 also establishes the Inspectorate of Mental Health Services and the Mental Health Commission. Both of these bodies are charged with overseeing the operation of the mental health system. The Inspectorate's function is to visit all approved centres in Ireland and to report on compliance with the terms of the legislation and the codes of practice in operation.[36] The Commission is charged with developing codes of practice,[37] appointing tribunal members[38] and allocating legal representation to patients appearing before the tribunals.[39] These bodies also form part of the rights-based framework introduced by the MHA 2001.[40]

While the MHA 2001 is, from a rights perspective, an improvement, it is limited in scope. It applies only to those who are involuntarily admitted to an approved centre for treatment for a mental disorder.[41] However, the vast majority of people receiving treatment within the Irish mental health system are "voluntary" patients and these patients do not have access to any statutory safeguards.[42] Most significantly, they are not entitled to automatic, periodic review

[27] Section 17 and s.18 MHA 2001.
[28] Section17(1)(b) requires the Commission to assign a legal representative to represent the patient.
[29] Section 18.
[30] Section 48.
[31] Section 18.
[32] Section 56.
[33] Section 59.
[34] Section 60.
[35] Section 59(1)(b)(ii) and s.60(1)(b)(ii) both provide that the matter will be referred to the second-opinion psychiatrist by "the first-mentioned psychiatrist" who is the treating psychiatrist.
[36] Sections 50, 51 and 52.
[37] Section 33(3)(e).
[38] Section 33(3)(a).
[39] Section 17(1)(b).
[40] For further discussion of the role of the Inspectorate and the Mental Health Commission, see Claire Murray, "The Role of the Mental Health Commission in Irish Mental Health Law: Interrogating the Statutory Functions of the Commission", fn.7 above.
[41] The long title of the MHA 2001 states that it is: "An Act to provide for the involuntary admission to approved centres of persons suffering from mental disorders... ." Therefore the legislation applies only to people who are involuntarily admitted for treatment.
[42] Antoinette Daly and Dermot Walsh, *Activities of Irish Psychiatric Units and Hospitals 2011* (Dublin: Health Research Board, 2012) contains the most recent statistics on admissions to mental health units in Ireland. This states at p.3 that in 2011 only 9.5 per cent of all admissions were involuntary. There were 18, 992 admissions to psychiatric hospitals and units in 2011.

of the ongoing need to receive inpatient treatment.[43] They are, however, subject to Codes of Practice developed by the Mental Health Commission. The focus of the MHA 2001 is also only directed towards those people receiving inpatient treatment for a mental disorder. There are no safeguards in place for people receiving treatment in the community.[44] This is unfortunate given the emphasis in the report of the Expert Group on Mental Health, *A Vision for Change*,[45] on moving towards community mental health services. It is important to note that the MHA 2001 preceded the publication of *A Vision for Change*. However, if there is an increase in the delivery of community mental health services, the MHA 2001, and the safeguards contained therein, will apply to an even smaller proportion of mental health service users in Ireland than is currently the case.

The MHA 2001, therefore, provides procedural safeguards to ensure the protection of the right to liberty and autonomy of a limited group of people who use the mental health services.[46] It is not a particularly nuanced rights-based model of mental health law and it does not encompass all of those with a mental disorder within its remit. The aims of the legislation are limited in scope. However, even those modest aims are not being achieved because legislation in and of itself is insufficient to ensure the protection of the rights of those targeted by the statutory framework. Other factors come into play following the enactment of the legislation and these must also be considered and addressed to ensure an effective rights-based model.

3. The impact of judicial interpretation on a legislative rights-based model

This part of the article considers three key Irish cases.[47] The first is the only Irish Supreme Court case to date interpreting the provisions of the MHA 2001: *EH v St Vincent's Hospital.*[48] This case clearly illustrates the impact judicial decisions can have on the development of a rights-based model as the judgment adopted a strongly paternalistic interpretation of the MHA 2001, which undermined the original intention of the legislature. This Supreme Court decision reflected the paternalistic tone of the majority of the preceding High Court

[43] The European Committee for the Prevention of Torture (CPT) commented on the lack of procedural safeguards available to voluntary patients in psychiatric institutions in Ireland in the latest *Report on Ireland's implementation of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment* (February 10, 2011, para.117). This report is available at: *www.cpt.coe.int/documents/irl/2011-03-inf-eng.pdf* [Last Accessed February 22, 2013]. Similarly the issue of the limited definition of "voluntary" patients was raised in the Concluding Observations of the UN Committee Against Torture in Ireland's periodic review under the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (June 17, 2011 at para. 28). This report is available at: *www2.ohchr.org/english/bodies/cat/docs/co/CAT.C.IRL.CO.1.pdf* [Last Accessed February 22, 2013]. The Irish Human Rights Commission published a policy paper on this issue in February 2010, available at: *www.ihrc.ie/download/pdf/policy_sec2_mentalhealthact_2001_201002.pdf* [Last Accessed February 22, 2013]. It has also been raised by Amnesty International in their review of the MHA 2001, see: *www.amnesty.ie/content/mental-health-act-2001-review* [Last Accessed February 22, 2013].

[44] People "receiving treatment in the community" refers to people being treated for a mental disorder by a GP. However, there is also no provision in Irish mental health law for compulsory care in the community or enforced community treatment orders.

[45] Department of Health and Children, *A Vision for Change, Report of the Expert Group on Mental Health Policy* (2006).

[46] According to the 2011 statistics, 9.5 per cent of the in-patient population are covered by the terms of the MHA 2001, see fn.42 above.

[47] For a detailed discussion of the decisions of the Irish courts interpreting the MHA 2001, see Darius Whelan, *Mental Health Law and Practice* (Dublin: Round Hall, 2009).

[48] [2009] 3 I.R. 774.

decisions.[49] In many cases this paternalistic approach that has been adopted by the judiciary is justified by reference to the principles contained in s.4 of the MHA 2001 and the need to give due regard to the best interests of the person.[50] For example, in *MR v Byrne and Flynn*[51] O'Neill J. found that "section 4 of the Act... in my opinion gives statutory expression to the kind of paternalistic approach mandated in the case of *Philip Clarke* and approved in the case of *Croke v Smith*...".[52] The second decision discussed is *PL v Clinical Director of St Patrick's Hospital*,[53] a recent High Court decision, which applied the precedent established by the Supreme Court in *EH*. The resulting judgment makes it clear that paternalism remains the overriding attitude among the judiciary in relation to persons with mental disorders. There is no acknowledgment of the legislative shift that has taken place with the introduction of the MHA 2001, which requires a greater emphasis on the rights of people being admitted and treated under the terms of the statute. There are, however, notable exceptions to the general approach. The decision of the High Court in *SM v The Mental Health Commission, the Mental Health Tribunal and the Clinical Director of St Patrick's Hospital*[54] is one such exception.[55] Another is the recent case of *M.X. [APUM] v Health Service Executive*.[56] This case represents the first detailed engagement by the Irish courts with the provisions of the ECHR and the CRPD in a mental health context. Ultimately, however, the judgment does affirm the paternalistic approach espoused by the Supreme Court in *EH* in the context of the right to liberty.

EH v St Vincent's Hospital

In this case the applicant was assessed as suffering from a mental disorder and was involuntarily admitted for treatment for that disorder. She was prescribed anti-psychotic medication which improved her condition considerably, to such an extent that she was discharged and a plan was put in place to assist her. The applicant refused to comply with this plan and ceased taking the medication. The applicant's physical condition deteriorated considerably and she was returned to hospital. She was then, once more, involuntarily admitted to a psychiatric unit. This admission was affirmed by a tribunal, as was the subsequent renewal.

The applicant ceased to be involuntarily detained on December 10, 2008, when the tribunal revoked the order on the basis that there had been a recording error on the form and

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[49] See for example *JH v Russell* [2007] 4 I.R. 242; *AMC v St Luke's Hospital, Clonmel* [2007] 2 I.R. 814; *MR v Byrne and Flynn* [2007] 3 I.R. 211; *AM v Kennedy* [2007] 4 I.R. 667; *RW v Clinical Director of St John of God's Hospital* [2007] IEHC 184. This is not an exhaustive list of the relevant decisions of the courts on this issue. For a detailed discussion, see Darius Whelan, *Mental Health Law and Practice, Civil and Criminal Aspects*, fn.47 above.

[50] Section 4(1)—in making a decision under this Act concerning the care or treatment of 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. Section 4(3)—in making a decision under this Act … due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.

[51] [2007] 3 I.R. 211. Similar sentiments were expressed by Peart J. in *JH v Lawlor and others* [2008] 1 I.R. 476. Peart J referred to "a purposive approach to the interpretation of the Act, consistent with its paternalistic and protective nature".

[52] Both these cases were decided under the terms of the Mental Treatment Act 1945, which was a paternalistic legislative framework and one that the MHA 2001 was specifically intended to repeal.

[53] [2012] IEHC 15.

[54] [2009] 3 I.R. 188.

[55] For a discussion of this case, see Claire Murray, "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* 273–290.

[56] *M.X. [APUM] v Health Service Executive, the Attorney General, and the Irish Human Rights Commission* [2012] IEHC 491.

therefore the tribunal lacked jurisdiction to renew the order detaining her. The applicant was informed that she was no longer detained. The consultant psychiatrist treating the applicant stated that she agreed to remain voluntarily. However, the applicant did not sign the voluntary admission form, and the records state that this was because she lacked capacity. The hospital records also noted that if the applicant attempted to leave the ward she would be involuntarily detained in accordance with s.23 of the MHA 2001. This in fact occurred on December 22, 2008. Following that incident the applicant was subject to a number of renewal orders, all of which were affirmed by the tribunal.

The applicant argued that she was unlawfully detained from December 10, 2008, on the basis that she lacked capacity to consent to voluntary detention. She further argued that this difficulty with the voluntary detention had an effect on the subsequent involuntary detentions rendering them unlawful as well. The applicant also sought a declaration that the definition of a "voluntary patient" by the High Court was incompatible with art.5 of the ECHR.[57] This was because the High Court stated that it was not necessary for a person to give a valid consent in order to be classified as a voluntary patient.

The judgment of Kearns J., with which the rest of the Supreme Court concurred, holds that the definition of a voluntary patient in the MHA 2001 does not specifically refer to a patient who gives full and free informed consent. Rather it is defined in s.2(2) as "a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order". This is a very narrow and circular definition of a voluntary patient. Essentially a voluntary patient is anyone who is not an involuntary patient. As such it is out of step with the common usage of the term "voluntary", which generally implies some form of choice on the part of the person. The court, however, noted the argument of the applicant that this definition should be interpreted and applied in accordance with the provisions of the Constitution and the ECHR. Kearns J. was of the opinion that any interpretation placed on the provisions of the MHA 2001 should be in accordance with the paternalistic intent of the legislation. In support of the assertion that the legislation was paternalistic, he cited the judgment of McGuinness J. in *Gooden v St Otteran's Hospital*,[58] which referred to the provisions of the 1945 Act. Kearns J. went on to note:

> "I do not see why any different approach should be adopted in relation to the Mental Health Act 2001, nor, having regard to the Convention, do I believe that any different approach is mandated or required by Article 5 of the European Convention of Human Rights."[59]

This is a questionable approach by the court as the parliamentary debates clearly indicate that the MHA 2001 was intended by the legislature to be a significant shift away from the approach taken in the 1945 Act.[60] A reliance on paternalism as the cornerstone of mental health law is out of line with the international move towards a rights-based model and also in direct conflict with the express provisions of the MHA 2001. Section 4 does refer to best interests, but it also states that "due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy" .These rights were overlooked by the Supreme Court in its desire to categorise the legislation as paternalistic.

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[57] The High Court judgment in this case was given by O'Neill J., *EH v Clinical Director of St Vincent's Hospital* [2009] IEHC 69.
[58] [2005] 3 I.R. 617.
[59] [2009] 3 I.R. 774 at 790.
[60] See Keys, fn.10 above, and the Government Green and White Papers, fn.1 above, also emphasised the different standards that were required by the ECHR.

The judgment of the Supreme Court concluded by observing that, just because s.17(1)(b) of the MHA 2001 provides for the assignment of a legal representative to a person following the making of an admission order, there should not be a "rush to court" .The court was of the opinion that only if there had been "a gross abuse of power or default of fundamental requirements" would a defect in an earlier period of detention justify release from a later one.[61] This perspective fails to acknowledge the significant breach of the right to liberty involved in keeping a person who lacks capacity in a hospital setting with the clear understanding that if he or she attempts to leave, that person will be prevented from doing so. In addition, it does not recognise the importance of the procedural review requirements in place or acknowledge that if a person is "voluntarily" admitted he or she cannot benefit from this form of automatic review to ensure that the admission remains necessary and is therefore not an unlawful deprivation of liberty.

The core of the judgment in *EH* emphasises the continuing understanding on the part of the Irish judiciary that mental health legislation is primarily paternal in character. This is amply demonstrated in the dismissal of the relevance of the decision of the ECtHR in *HL v United Kingdom*, which is an analogous case.[62] In *HL* the ECtHR found that the UK had violated the right to liberty of a severely autistic man, who lacked capacity, when he was informally admitted to a psychiatric ward. The consequence of informal admission was that the statutory safeguards, including automatic review, contained in the Mental Health Act 1983 were not available to HL. The ECtHR ruled that the right to liberty was too important and could not be lost simply because the person was not objecting to admission. In spite of the fact that the position of EH closely resembled that of HL, the Supreme Court in *EH* did not adequately consider the judgment of the ECtHR in *HL*, nor did it reflect on the consequences of that decision in the UK.[63] Following *HL*, the Deprivation of Liberty Safeguards (DOLS) were introduced in the UK in order to ensure that people lacking capacity would not be unlawfully deprived of their liberty.[64] The significance of this major shift in UK mental health law in response to a decision of the ECtHR was dismissed without any sufficiently detailed consideration in the judgment of Kearns J. It is difficult to reconcile this with the provisions of ss.2 and 4 of the ECHR Act 2003 outlined above.[65]

It should be noted that part of the difficulty in the case of *EH* arose from the particular circumstances, namely where the applicant was involuntarily detained in accordance with the provisions of the MHA 2001 at the time the habeas corpus application was made. The fact that her detention under the MHA 2001 was procedurally correct at the time she sought a declaration that she was unlawfully detained led the court to question whether the arguments before it were moot. The applicant argued that any earlier period of unlawful detention—when she was a voluntary patient but lacked capacity—would have a domino effect, rendering subsequent involuntary admissions invalid. This was rejected by the Supreme Court[66] and it provided a justification for the court's reluctance to engage adequately with the rights-based arguments advanced by the applicant. However, as Whelan notes, this glosses

[61] Fn.58 above, at 34.
[62] (2005) 40 E.H.R.R. 761.
[63] The discussion of *HL* runs to two paragraphs in the judgment of Kearns J. in *EH*.
[64] It is worth noting that there are difficulties with the operation of the DOLS as they are extremely complex. For a discussion of this see Phil Fennell, *Mental Health, Law and Practice*, 2nd edn (Bristol: Jordans, 2011), ch.6.
[65] Kearns J. did refer in his judgment to the obligation under s.2 of the ECHR Act 2003 to interpret statutory provisions of the MHA 2001 in a manner compatible with the State's obligations under the ECHR. To this end he accepted that art.5 of the ECHR was relevant. Significantly, however, Kearns J. did not mention s.4 of the ECHR Act, which requires judicial notice to be taken of decisions of the ECtHR.
[66] This is in marked contrast with the more rigorous approach adopted by the courts in the context of evidence obtained during the course of an unlawful detention, e.g. *The People (DPP) v Madden* [1977] I.R. 336.

over the fact that there was a period of time when the statutory protections were not available to the applicant.[67]

The consequence of the decision in *EH* was to undermine the rights-based ethos underpinning the MHA 2001, and also to enshrine a counter-intuitive understanding of the term "voluntary" into Irish mental health law. As noted in Part 2 of this article, the MHA 2001 is already a limited rights-based model and the judicial approach to its interpretation that was approved in *EH* further weakened the impact of the legislation. This dilution of the rights-based model was taken to the next logical step in the High Court decision in *PL v St Patrick's Hospital*, where the definition of a voluntary patient set down in *EH* was applied to a capable unwilling patient.

PL v St Patrick's Hospital

In *PL* a young man was originally admitted to hospital as a voluntary patient following a psychotic episode. He agreed to a care plan, which involved close observation and medication. He remained as a voluntary patient for a little over two weeks at which point he expressed a desire to leave. The provisions of ss.23 and 24 of the MHA 2001 were then invoked and he was detained as an involuntary patient.[68] This detention order was affirmed by a Mental Health Tribunal. Questions were raised at this point by the solicitor for the applicant about the capacity of the patient to consent to voluntary admission, but these were not considered to be relevant given the interpretation of "voluntary" in the MHA 2001 which was approved by the Supreme Court in *EH*. An order renewing the detention was subsequently made and this, too, was affirmed by a tribunal.

The day after the renewal order was upheld by the tribunal, the consultant psychiatrist treating the applicant revoked the order on the basis that the applicant was no longer suffering from a mental disorder as defined in the MHA 2001. However, this did not result in the applicant being discharged from the hospital. He remained in the locked ward he had been in as an involuntary patient. Peart J. stated in his judgment that "in reality he was simply discharged from his status as a detained patient under a Renewal Order, rather than being actually discharged from hospital as such".[69] The effect of this was that the applicant was no longer entitled to the statutory safeguards contained in the MHA 2001, such as automatic periodic review of detention and second opinions for treatment without consent, even though the treatment regime to which he was subjected remained the same. It appears that the reason the renewal order was revoked was that the treating consultant psychiatrist was of the opinion that the applicant was improving and was agreeable to remaining in the hospital and to engaging with the care plan.

Complications arose from this point. The applicant, now officially a voluntary patient, remained on a locked ward subject to restrictions. On a number of occasions he expressed a desire to leave the unit but was prevented from doing so. The evidence was that he was forcibly restrained on about 30 different occasions and was also verbally persuaded to stay on a number of other occasions. On November 21, 2011 the applicant three times expressed and demonstrated a desire to leave the unit in which he was residing as a "voluntary" patient and was prevented from doing so. This involved the applicant attempting to jump over a garden wall to leave the unit. Following this, the consultant psychiatrist determined that the applicant met the criteria for involuntary admission and so again invoked the procedures under ss.23 and 24 of the MHA 2001. However, the second-opinion psychiatrist, who examined the

[67] Darius Whelan, *Mental Health Law and Practice, Civil and Criminal Aspects*, fn.47 above, p.170.

[68] Sections 23 and 24 allow for the regrading of a patient from voluntary to involuntary. This is subject to a second opinion from a consultant psychiatrist other than the treating consulting psychiatrist.

[69] Above, fn.53, para.6.

applicant the day after the treating consultant psychiatrist, was of the opinion that the applicant did not require involuntary admission. He was also of the opinion that the applicant had capacity to consent to treatment and remaining as a voluntary patient.

This matter came before the High Court by way of judicial review proceedings. The applicant sought declarations that he was unlawfully detained on a number of specified dates, along with a declaration that the respondents were not entitled to prevent him from leaving the hospital without involuntarily admitting him in accordance with the MHA 2001. He also sought a declaration that the delay in carrying out a risk assessment for the purposes of deciding whether he could be moved to a less secure unit was a breach of his right to privacy and/or his right to receive treatment in the least restrictive environment "as guaranteed by the Constitution of 1937 and the European Convention of Human Rights 1950".[70]

Peart J., in his judgment, again relied on the paternalistic nature of the MHA 2001 to justify his decision.[71] He referred to s.28 (2)(a), which states that a patient should not be "inappropriately discharged" by way of arguing that a consultant psychiatrist may require that a patient "remains in the approved centre, even against his wishes, until he/she is satisfied that his discharge is not inappropriate". This may take a number of weeks and within this period the High Court was willing to accept that the patient is a voluntary patient even though he or she "may not be expressing consent and may in fact be expressing objection to not being discharged in the strongest possible terms".[72] During that period the patient would not be entitled to any statutory protections or safeguards, "yet it could not be said that he is being unlawfully detained given the clear paternalistic and protective intention of the section". This was precisely the situation the applicant in *PL* was in. He was a capable, unwilling "voluntary" patient who was refused permission to leave the hospital, with no possibility of an independent procedure to review the ongoing need for him to remain in the hospital, and the High Court refused to find that there was unlawful detention or deprivation of liberty involved. This is an extraordinary interpretation of the MHA 2001. It renders nonsensical the term "voluntary" in Irish mental health law and it sends out a very clear signal that the rights of service users are accorded very little weight in the Irish courts. It also concentrates significant power in the treating consultant psychiatrist, which is precisely the difficulty the rights-based model is designed to address. This is a neat illustration of the extent to which judicial interpretation has diluted rights-based mental health law in Ireland.

There is no consideration in this judgment of the provisions of the ECHR or the case law of the ECtHR. There is no mention of the decision in *HL* or of the judgment in *Storck v Germany*.[73] In *Storck* the applicant voluntarily presented herself at a psychiatric clinic with her father, but she subsequently made several attempts to run away. The ECtHR found that this was a deprivation of liberty within art.5 and that the right to liberty is not lost merely because the person voluntarily gives him- or herself up to be taken into detention. Together the decisions in *HL* and *Storck* highlight that voluntary or informal status does not mean that ECHR protections do not apply. It is puzzling to understand why this case law was not discussed in *PL* given its relevance to the situation before the court and the obligations set out in ss.2 and 4 of the ECHR Act 2003.

It is clear from the discussion of *EH* and *PL*, which are representative of the majority of decisions in Ireland,[74] that the judiciary, through their interpretation of the legislative provisions, have effectively undermined the rights-based ethos of the MHA 2001. The

[70] These reliefs are set out at para.15 of the judgment. Orders for damages and costs were also sought.
[71] "It is now well-established that this legislation is paternalistic in nature and should be interpreted accordingly." Above, fn.53, para.50.
[72] Above, fn.53, para.51.
[73] (2005) 43 E.H.R.R. 96.
[74] See above, fnn.49 and 51.

inclusion of best interests in s.4 has provided a justification for the continuing reliance on paternalism as the guiding principle in Irish mental health law. This issue was addressed in the *Interim Report on the Review of the MHA 2001*, discussed below.

MX v HSE

This case is of interest as the High Court did engage with the plaintiff's rights-based arguments grounded on the provisions of the ECHR and the CRPD. However, the court proceeded to draw a clear distinction between issues of liberty and those relating to the decision-making capacity of detained patients. In this case the plaintiff was detained in the Central Mental Hospital (CMH) with a diagnosis of treatment-resistant paranoid schizophrenia.[75] She was being administered antipsychotic medication, which required ancillary blood tests to monitor for any side effects.[76] The evidence before the court was that the plaintiff lacked capacity to consent to or refuse medical treatment. The plaintiff argued that the treatment under s.60—medication for a continuous period of three months—was repugnant to the Constitution, incompatible with the ECHR, and also failed to have due regard for the provisions of the CRPD.[77]

The court rejected the argument that the CRPD was directly applicable in Ireland,[78] although MacMenamin J. emphasised that just because the CRPD did not have direct effect did not mean that it was "entirely immaterial". This indication of a willingness to draw on the principles of the CRPD is a welcome development. In considering the issue of constitutionality the focus was placed on decision-making capacity. The issue of deprivation of liberty was not under consideration as was the case in *EH* and *PL*. This was explicitly referred to by MacMenamin J., who recognised the line of jurisprudence emphasising the paternalistic nature of the legislation in the context of deprivation of liberty, confirmed by the Supreme Court in *EH,* but distinguished the case before the court. The judgment in *MX* reads:

> "I do not think there is anything inconsistent with the avowedly paternalistic nature of the legislation or that jurisprudence, insofar as they concern liberty, in also ensuring that the wishes and choices of a person suffering from a disability, while under such care, should be guaranteed in a manner which, "as far as practicable", ..., vindicates his or her personal rights. *The interpretation of the Constitution in this area of the law should be informed by, and have regard to international conventions*".[79]

While recognition of the rights of persons with mental disabilities by the High Court is to be welcomed, this statement does raise the question why there is a distinction between the law relating to liberty of persons with mental disabilities and that relating to decision-making capacity. Why are constitutional provisions concerning liberty rights not also to be informed by international Conventions? In fact, previous decisions of both the High Court and Supreme Court indicate a disinclination to adopt such an approach in cases relating to the

[75] At times this caused the plaintiff to become aggressive and violent towards staff. She also, prior to being placed in the CMH, harboured urges to harm or kill small children.

[76] The legitimacy of carrying out these ancillary procedures had been before the court on a previous occasion: see *HSE v X [APUM]* [2011] IEHC 326.

[77] The plaintiff initially argued that the treatment was being provided under s.57 but this was rejected by the court as the evidence established that the treatment regime came under the terms of s.60. In the judgment MacMenamin J. methodically considers first the plaintiff's claim that the UNCRPD has direct application in Ireland because it was ratified by the EU, second the constitutionality of the statutory provisions, and finally a consideration of whether the plaintiff is entitled to a declaration of incompatibility under the ECHR Act 2003.

[78] However, the court did note that "the law in this area is evolving, both in the legislative and judicial realm". See para.47 of the judgment.

[79] Emphasis added. This is set out in para.59 of the judgment.

liberty of persons suffering from a mental disorder/disability. The judgment in *MX* does not provide a convincing reason for this distinction, and this is disappointing in a decision which, from a rights perspective, is very encouraging in other respects.[80] On the facts before the court the plaintiff was unsuccessful in her constitutional challenge, as her rights had been vindicated through the court process.[81]

Finally, following a detailed consideration of relevant ECtHR jurisprudence, the plaintiff was also unsuccessful in her application for a declaration of incompatibility under the ECHR Act 2003. Adherence to the s.60, constitutionally compatible, procedures was deemed sufficient to vindicate the plaintiff's rights under the ECHR.

As noted above, this decision is encouraging as it suggests a greater willingness on the part of the High Court to consider, and have regard to, the provisions of the ECHR and the CRPD in the context of treatment of involuntary patients under the terms of the MHA 2001. However, it must be noted that to date it is exceptional in that respect. The judgment is also disappointing, however, as it continues to emphasise paternalism as the guiding principle of the legislation in relation to the right to liberty. This being so, it has not materially changed the position of the judiciary on that issue and so the likelihood is that judicial interpretation will continue to undermine the rights-based model of mental health law in relation to liberty rights.

4. The importance of engagement with the rights-based model among service providers

While the judiciary is involved in the interpretation of the statutory provisions, as discussed above, it is not the only group with the power to influence how the law is applied and consequently how the mental health system is experienced by service users. Another group who can shape the law in action are the service providers. The people charged with the day-to-day operation of the mental health services have a significant role to play in determining whether the rights-based model of mental health law is given effect to in practice.

The annual reports of the Inspectorate of Mental Health Services following the commencement of the substantive provisions of the MHA 2001 in November 2006 have repeatedly highlighted the failure among certain members of the frontline staff to adopt the spirit of the legislation. In the 2010 Annual Report[82] the Inspector made some worrying comments in relation to carelessness by staff members in the completion of seclusion forms. As noted above, s.4(3) of the MHA 2001 requires that, in making a decision concerning the care or treatment of a person, "due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy". The rules and guidelines on seclusion, which require the completion of these forms, were developed in accordance with the principles set out in s.4 of the MHA 2001 in order to protect the rights of people subject

[80] The court went on to state that the vindication of constitutional "personal capacity rights" must be informed by the CRPD and also the principles set out in the judgments of the ECtHR. This was because of the incursion into bodily integrity and other capacity rights of those subject to treatment under s.60 of MHA 2001. Emphasis was placed on the importance of hearing the voice of the patient in this process; this could be heard directly or through a representative. This need not be a legal representative—carers, social workers and family members were also mentioned as appropriate parties.

[81] Significantly the court stated that Form 17, used as part of the s.60 procedure, would have to be reviewed to allow space for the patient's decision or choice to be recorded and due regard be given to it. This is not the first judgment which has required the Mental Health Commission (MHC) to alter the wording or layout of a form it has developed. In *SM v The Mental Health Commission and Others* [2009] 3 I.R. 188 McMahon J. criticised the MHC as it was the wording of Form 7 which had led to the invalidity of the order in that case.

[82] Mental Health Commission, *Annual Report 2010* (Dublin: 2011). This is available on the Mental Health Commission's website: *www.mhcirl.ie* [Last Accessed February 22, 2013].

to this practice. The Inspector correctly identified that failure to comply with the guidelines indicates at best a lack of understanding of the significance of patient rights on the part of the service providers. The Inspector referred to "examples of glaring ignorance of aspects of the Mental Health Act" and stated that "lack of respect for the Act can only be interpreted as lack of respect for service users/patients".[83] This was a particularly strong statement from the Inspectorate. The Inspector's recognition of the link between rights and respect was significant and encouraging. However, from a rights perspective, the comments of the Inspector reinforced the realisation that there is a lack of fit between the provisions of the legislation and the operation of the mental services in practice. It is vital that those operating the mental health services understand the importance of respecting the rights of service users.

In the 2010 Report the Inspector also observed that the existence and quality of individual care plans remained disappointing, with some service providers viewing it as a "paper only" exercise and deliberately deciding not to implement the plans. This is a clear illustration of the power of service providers to shape the way in which the service user experiences the mental health system and to render insignificant the rights-based protections contained within the legislation. There appears to be a failure on the part of many service providers to buy into the concepts of patient-centredness and a recovery approach to mental disorder. In the 2010 Report it was firmly stated that "the absence of proper care planning is emblematic of the failure by a number of teams … to embrace the philosophical underpinnings of a modern mental health service".[84] This emphasises the importance of providing ongoing training and information to service providers on the significance of the rights-based model of mental health law contained in the MHA 2001 and the key concepts at the core of a modern mental health framework. Only with education and training will it be possible to create the necessary culture shift within the mental health services.

While the 2011 Report noted an overall improvement in the levels of compliance with rules, regulations and codes of practice it was also noted that certain services which were previously compliant had regressed.[85] While this could be explained by inadequate staffing or poor governance, it nonetheless, highlights the importance of ongoing monitoring to ensure that the statutory standards are adhered to, and reinforces the argument that the mere existence of these standards is not sufficient to ensure that service users benefit from them. Significantly, in the 2011 Report the Inspectorate noted "a lack of much-needed training among clinicians of the mental health services".[86] The areas where training relating to day-to-day practice was required included: training in the operation of the Mental Health Act, how to ensure the human rights of service user/patient, recovery and the criteria for admission and discharge.[87] These are fundamental aspects of the legislative framework which governs the operation of the mental health system and it would seem obvious that those implementing the system on the ground should be in receipt of regular training on these issues. The Inspectorate recommended a rebalancing of training in the mental health services with greater emphasis being placed on these crucial day-to-day concerns.

It is unrealistic to expect a complete culture change to occur in an organisation from the top down. If a proper engagement with the rights-based model of mental health law is to take place in Ireland it is vital that adequate education and training be provided to those implementing the statutory framework on a day-to-day basis. This position has been clearly adopted by the Inspectorate in the most recent annual report.

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[83] Fn.82, p.91.
[84] Above, fn.82, p.89.
[85] Mental Health Commission, *Annual Report 2011* (Dublin: 2012). Available at: *www.mhcirl.ie* [Last Accessed February 22, 2013].
[86] Fn.85, p.79.
[87] Above, fn.85, p.80.

Interim Report of the Steering Group on the Review of the Mental Health Act 2001

The Interim Report on the Review of the MHA 2001 was released in June 2012.[88] A commitment to review the operation of the MHA 2001 was given in the Programme for Government, which stated that the review would occur "in consultation with service users, carers and other stakeholders, informed by human rights standards".[89] This review of mental health law is taking place in parallel with the development of mental capacity legislation in Ireland. The hope is that, ultimately, Ireland will have a mental health and mental capacity framework which respects the rights of people with mental and psycho-social disabilities and which dovetail effectively. The complete report on the review of the MHA 2001 is due to be published in 2013. What is significant for the purposes of this article is that the Interim Report clearly articulates the part played by the judiciary in undermining the effectiveness of the existing rights provisions within the MHA 2001.

The Interim Report identifies a number of key themes and recommendations, and first in the list is human rights and paternalism. The Report recognises that the MHA 2001 introduced a human rights ethos into mental health law in Ireland and that the principle of "best interests" was included with the intention of protecting the rights of the patient. However, the Report goes on to state that "the reality is that the principle has been interpreted by the Courts in a paternalistic manner. This paternalistic interpretation of the 2001 Act is undermining the significant advances in mental health law which the Act was intended to enshrine, and has given rise to concerns that the human rights aspects of the legislation have been diluted and diminished."[90]

This constitutes a clear statement on the part of the Steering Group that the judiciary has effectively undermined the intention of the legislature in relation to the operation of mental health law in Ireland. This has been broadly welcomed by civil society groups working in the mental health field.[91] Recognising the role of the judiciary in reinforcing paternalism in mental health law is the first step towards addressing this issue. The Interim Report goes on to outline recommendations on how to ensure the rights-based ethos is protected within the legislative framework. The Steering Group recommend that "the guiding principles of the revised Act should be human rights focused with the right to autonomy and self-determination being the key principle".[92] The Report also recommends the inclusion of principles such as dignity, bodily integrity, recovery and least restriction. In order to avoid the problems which currently exist, whereby the courts are given no guidance on how to balance best interests with the other rights and principles, the Interim Report suggests that the Act should list a hierarchy of rights to guide decision-making in order to "ensure that there will be no carry over of paternalism into any new legislation". The Steering Group further recommends consultation with service users and other stakeholders in determining the hierarchy of rights to be included.

While redrafting the legislation to provide guidance to the judiciary and to emphasise the rights of service users is important, it is submitted that this alone is not sufficient to address

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[88] Department of Health, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001*.

[89] This was set out at p.8 of the Programme for Government 2011, available at: *per.gov.ie/wp-content/uploads/ProgrammeforGovernmentFinal.pdf* [Last Accessed February 22, 2013].

[90] Above, fn.88, p.9.

[91] Amnesty International Ireland press release: www.amnesty.ie/news/amnesty-welcomes-mental-health-act-review-pledges [Last Accessed February 22, 2013]; Mental Health Reform press release: *www.mentalhealthreform.ie/blog/mental-health-reform-welcomes-interim-report-on-mental-health-act-2001/* [Last Accessed February 22, 2013].

[92] Above, fn.88, p.11.

this issue. As argued throughout this article, the terms of the statute are only the first step. Awareness-raising among the judiciary is also important if it is to make the leap from paternalism to an engagement with rights in this context. Nevertheless, it is encouraging that the Interim Report was so forthright in identifying this obstacle to effective rights-based mental health law in Ireland.

Conclusion

In this article it has been argued that the introduction of rights-based legislation is not enough, in and of itself, to ensure effective protection of the rights of vulnerable groups in society. It is necessary to look beyond the statutory framework at the practical implementation of the legislative provisions to determine the impact of the rights-based model and to begin to address any shortcomings. In addition, the article identified judicial interpretation of the legislation as one of the potential barriers to giving effect to the intention of the legislature. One way of addressing this difficulty would be to introduce judicial training and information sessions on the intent and purpose of rights-based mental health law. Another potential barrier that was discussed was the failure on the part of those working within the mental health services to engage with the rights-based model of mental health law. There needs to be a widespread change in culture among service providers if the rights of service users are to be properly respected in Ireland. The first step in creating that shift in culture is to ensure that there is adequate information and training provided to those operating the mental health system on a day-to-day basis, so that they are aware of the legislative changes that have been introduced, the importance of them and when they are to be used. As noted in the introduction, the development of a rights-based model of mental health law involves a process of layering. The first layer is rights-based legislation. This must be reinforced by a judiciary that is alert to the importance of rights in this context and interpret the legislation in this spirit. Finally, the day-to-day operation of the mental health system must be informed by an awareness of the significance of respecting the rights of service users. Only when all three layers are in place can we develop an effective rights-based model of mental health law.

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